Hampshire County Council

NOTICE OF MEETING

Meeting	Health and Adult Social Care Select Committee
Date and Time	Tuesday, 8th March, 2022 at 10.00 am
Place	Ashburton Hall - HCC
Enquiries to	members.services@hants.gov.uk

Carolyn Williamson FCPFA
Chief Executive
The Castle, Winchester SO23 8UJ

FILMING AND BROADCAST NOTIFICATION
This meeting may be recorded and broadcast live on the County Council's website and available for repeat viewing, it may also be recorded and filmed by the press and public. Filming or recording is only permitted in the meeting room whilst the meeting is taking place so must stop when the meeting is either adjourned or closed. Filming is not permitted elsewhere in the building at any time. Please see the Filming Protocol available on the County Council's website.

AGENDA

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

2. DECLARATIONS OF INTEREST

All Members who believe they have a Disclosable Pecuniary Interest in any matter to be considered at the meeting must declare that interest and, having regard to the circumstances described in Part 3 Paragraph 1.5 of the County Council's Members' Code of Conduct, leave the meeting while the matter is discussed, save for exercising any right to speak in accordance with Paragraph 1.6 of the Code. Furthermore all Members with a Personal Interest in a matter being considered at the meeting should consider, having regard to Part 5, Paragraph 4 of the Code, whether such interest should be declared, and having regard to Part 5, Paragraph 5 of the Code, consider whether it is appropriate to leave the meeting while the matter is discussed, save for exercising any right to speak in accordance with the Code.

3. MINUTES OF PREVIOUS MEETING (Pages 5 - 12)

To confirm the minutes of the previous meeting

4. DEPUTATIONS

To receive any deputations notified under Standing Order 12.

5. CHAIRMAN'S ANNOUNCEMENTS

To receive any announcements the Chairman may wish to make.

6. COVID 19 UPDATE (Pages 13 - 38)

To receive a combined update on the response to the Covid pandemic in Hampshire from the Director of Public Health, Director of Adults Health and Care and representatives of the Hampshire Southampton and Isle of Wight Clinical Commissioning Group. (an update from Frimley Health NHS Foundation Trust is appended as a written only update)

7. ISSUES RELATING TO THE PLANNING, PROVISION AND/OR OPERATION OF HEALTH SERVICES (Pages 39 - 190)

To consider a report of the Chief Executive on issues brought to the attention of the Committee which impact upon the planning, provision and/or operation of health services within Hampshire, or the Hampshire population.

a) Stage 2 Independent Investigation Report – Southern Health NHS Foundation Trust: Update on Action Plan

b) Care Quality Commission Inspection Report – Southern Health NHS Foundation Trust (published February 2022)

c) Primary Care Update

d) Urgent Treatment Centre model

e) Dental Services Update

8. PROPOSALS TO VARY SERVICES (Pages 191 - 202)

To consider the report of the Chief Executive on proposals from the NHS or providers of health services to vary or develop health services in the area of the Committee.

a) Integrated Primary Care Access Service – update (Commissioners)

b) Alton Community Hospital – new ward (Southern Health NHS Foundation Trust)

9. WORK PROGRAMME (Pages 203 - 216)

To consider and approve the Health and Adult Social Care Select Committee Work Programme.

ABOUT THIS AGENDA:

On request, this agenda can be provided in alternative versions (such as large print, Braille or audio) and in alternative languages.

ABOUT THIS MEETING:

The press and public are welcome to attend the public sessions of the meeting. If you have any particular requirements, for example if you require wheelchair access, please contact members.services@hants.gov.uk for assistance.

County Councillors attending as appointed members of this Committee or by virtue of Standing Order 18.5; or with the concurrence of the Chairman in connection with their duties as members of the Council or as a local County Councillor qualify for travelling expenses.

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AT A MEETING of the Health and Adult Social Care Select Committee of HAMPSHIRE COUNTY COUNCIL held at the castle, Winchester on Tuesday, 18th January, 2022

Chairman:
* Councillor Bill Withers Lt Col (Retd)

* Councillor Ann Briggs
* Councillor Nick Adams-King
* Councillor Pamela Bryant
* Councillor Rod Cooper
a Councillor Tonia Craig
a Councillor Debbie Curnow-Ford
* Councillor Alan Dowden
* Councillor David Harrison
* Councillor Adam Jackman
* Councillor Lesley Meenaghan
* Councillor Sarah Pankhurst
* Councillor Neville Penman
a Councillor Lance Quantrill
* Councillor Kim Taylor
* Councillor Andy Tree
* Councillor Jackie Branson
a Councillor Graham Burgess
* Councillor Tim Groves

*Present

Co-opted members
*Councillor Cynthia Garton
*Councillor Julie Butler
*Councillor Diane Andrews
a Councillor Karen Hamilton

Also present with the agreement of the Chairman: Councillor Liz Fairhurst, Executive Member for Adult Services and Public Health

44. APOLOGIES FOR ABSENCE

Apologies were received from Councillor Debbie Curnow-Ford. Councillor Jackie Branson as the Conservative standing deputy, was in attendance in their place. Apologies were also received from Councillor Lance Quantrill and apologies from the second Conservative standing deputy Councillor Burgess.

Apologies were received from Councillor Tonia Craig. Councillor Groves as the Liberal Democrat standing deputy, was in attendance in their place.

Apologies were also received from co-opted member Councillor Cllr Karen Hamilton.

45. DECLARATIONS OF INTEREST

Members were mindful that where they believed they had a Disclosable Pecuniary Interest in any matter considered at the meeting they must declare that interest at the time of the relevant debate and, having regard to the circumstances described in Part 3, Paragraph 1.5 of the County Council's Members' Code of Conduct, leave the meeting while the matter was discussed, save for exercising any right to speak in accordance with Paragraph 1.6 of the Code. Furthermore Members were mindful that where they believed they had a

personal interest in a matter being considered at the meeting they considered whether such interest should be declared, and having regard to Part 5, Paragraph 5 of the Code, considered whether it was appropriate to leave the meeting whilst the matter was discussed, save for exercising any right to speak in accordance with the Code.

No declarations were made.

46. MINUTES OF PREVIOUS MEETING

The Minutes of the meeting of the Health and Adult Social Care Select Committee (HASC) held on 23 November 2021 were confirmed as a correct record and signed by the Chairman.

47. DEPUTATIONS

The Committee did not receive any deputations.

48. CHAIRMAN'S ANNOUNCEMENTS

The Chairman made the following announcements:

SP23 Working Group
The Chairman invited Councillor Penman, Chairman of the SP23 Working Group, to give an update on the work of the group. It was reported that the SP23 Social Inclusion and Grants HASC Working Group had progressed well over the past 3 months, meeting 3 times with the last meeting being the day before, with good attendance at all times, and very open and robust Member and Officer engagement and discussion throughout.

Budget Items at this Meeting
The Chairman reminded the co-opted Members on the Committee that under the Scheme of Voting Rights for Co-opted Members of the Health and Adult Social Care Select Committee, their role on this committee includes being able to 'exercise a vote in considering items of business relating to the planning, provision and operation of the Health Service in the County Council's area.' Voting rights did not apply in relation to any other business considered by the HASC. Therefore, the co-opted members did not have a vote on Items 9 and 10 of this meeting's agenda as the subject of these items was the County Council's budget.

Frimley Park Hospital Plans for re-development
A briefing had been circulated to HASC Members on 30th December regarding notification that Frimley Health NHS Foundation Trust were in the early stages of plans to replace the hospital building at Frimley. As residents in the north of Hampshire use Frimley services the HASC will wish to keep informed on this topic, particularly as the HASC is already aware of the plans of Hampshire Hospitals to build a new hospital in the coming years.

Opening of new Detox Service

The Dame Carol Detoxification Service was opened in Fareham on the 11th of January 2022 by Dame Carol Black, author of the 2021 Government commissioned independent review of national drug policy. National funding had been made available to fund this new residential unit for people requiring intensive support to reduce severe dependence on alcohol or drugs.

The nine-bed unit will serve patients in the South and South East England and will be managed by a specialist substance misuse treatment provider, Inclusion, part of the Midlands Partnership NHS Foundation Trust, and Two Saints. Two Saints offers housing and support to people who are homeless, vulnerable or at risk of becoming homeless.

The unit will accept referrals from 20 Local Authority areas across the South of England – with Hampshire County Council acting as lead commissioner for the service - and will provide medically-managed, 24 hour detox support to those aged 18 and over with an acute drug or alcohol dependence issue. Providing this type of support will help to reduce the need for emergency hospital admissions through the offer of planned, structured treatment.

49. **COVID 19 UPDATE**

The Committee received a joint report from the Director of Adults' Health and Care, Director of Public Health and Chief Executive of the Hampshire Southampton and Isle of Wight Clinical Commissioning Group, on the ongoing response to the pandemic in Hampshire (see Item 6 in the Minute Book).

Members heard that infection levels were high but stabilising. Numbers of infections was higher than January 2021 but the number of hospitalisations was lower. Staff sickness in the NHS was around 7% compared to a norm of 5%, so had not increased as much as had been feared. There remained demand pressure across the system.

It was a government requirement that community social workers be vaccinated against Covid by the 1st of April, so the Adults Health and Care Department were working on what was needed in response to this requirement.

Members asked questions and heard:

- The impact on the NHS of supporting those with long covid was as yet unquantified
- Those remaining resistant to having the vaccine was often due to lack of trust in it and mis information.
- The estimate remained that the pandemic would be in the endemic phase by summer 2022, however new variants could develop and change the picture
- While immunity from the vaccine wanes over time, the evidence suggested prevention of hospitalisation was sustained for longer

RESOLVED:

The Health and Adult Social Care Select Committee note the update.

50. **ISSUES RELATING TO THE PLANNING, PROVISION AND/OR OPERATION OF HEALTH SERVICES**

a) Stage 2 Independent Investigation Report – Southern Health NHS Foundation Trust

The Committee considered a report from the Hampshire Southampton and Isle of Wight Clinical Commissioning Group and a report from the Southern Health NHS Foundation Trust on the response to the Stage 2 Independent Investigation Report into Southern Health (see Item 7a Appendix 1 and 2 in the Minute Book).

An Independent Investigation had been undertaken into the cases of five people who died in Southern Health NHS Foundation Trust's care between 2011 and 2015. The Trust accepted the findings of the stage 1 report and issued an unreserved apology to the families concerned. The report from stage 2 was published in September 2021 and the Trust Board had accepted the recommendations and approved an action plan to respond to the areas identified.

Members asked questions and heard:

- The Trust were engaging with Hampshire Healthwatch, who would take account of the Independent Review Report in planning their work. The Trust was likely to commission them to undertake pieces of work. Anything Healthwatch produce would be published on their website
- The Integrated Care System (ICS) would be developing an overarching plan to monitor quality issues at providers which would be monitored at the ICS Quality Board. The new approach would include triangulating evidence from other sources so as not to be reliant on information from the provider
- Options for mediation with the bereaved families had been explored but had been unsuccessful. Any process would need to have a clear outcome to aim for that all parties could agree upon. In some cases, the families had already been through other routes such as the Ombudsman
- The Trust would be launching a Carers and Patients Support Hub to improve upon the existing Patient Advisory and Liaison Service
- Improvements would be measured by independent inspections by regulators and satisfaction of families when issues arise. The triangle of care was being implemented
- The Trust were looking to increase staffing in quality improvement

RESOLVED:

1. The Committee notes the actions the Trust has set out it intends to take in response to the recommendations made in the Independent Investigation Report.
2. The Committee request that the Trust attend the HASC meeting on 8 March 2022 to provide an update on implementation of the actions with a target completion date of the end of January and end of February.
3. The Committee request that the HS&IOW CCG/HS&IOW ICS attend the HASC meeting on 27 September 2022 to provide an update on the steps they have taken to assure themselves that the Trust has made the

required improvements, and progress with strengthening mental health and learning disability service delivery in the new ICS structure.

b) Development of Integrated Care Systems in Hampshire

The Committee considered a report from the Hampshire Southampton and Isle of Wight Clinical Commissioning Group and the Frimley Clinical Commissioning Group on progress with moving to Integrated Care Systems (ICS) covering the Hampshire population (see Item 7b Appendix 3 in the Minute Book).

Members heard that the anticipated date for the move to ICS's had been delayed from April 2021 to July 2021. Governance of the ICS includes an Integrated Care Board (ICB) which would be NHS focused. The ICB would allocate the NHS Funding for the area, including commissioning services that had previously been commissioned at a national or regional level such as dentistry and ophthalmology. There would also be an Integrated Care Partnership (ICP) including wider partners such as local authorities with a remit to work on the wider socio economic influences on health.

Members asked questions and heard:

- Local place arrangements would remain important and some work would remain at locality level
- The ICP is joint between the NHS and Local Authorities so would need to be agreed collectively. The ICB was required to have Local Authority representation. Who to nominate to the Local Authority positions was under discussion with partners. Members commented that there were a large number of local authorities involved and only a small number of seats available on the relevant ICBs. The ICPs would have a potentially large membership from a range of bodies. Members were concerned that enabling the voice of the Local Authorities to be commensurate with their impact on health would be a challenge
- Members also commented on the importance of the voice of patients and service users, which could be through elected representatives, and this didn't appear to have been considered
- Part of the role of the ICS would be to look at prevention of ill health

RESOLVED:

1. The Committee request that commissioners attend the HASC meeting on 5 July 2022 to provide an update on implementation of Integrated Care Systems in Hampshire.
2. That this update include further detail on the governance structures as part of the ICS and how this is anticipated to relate to existing parts of the system including health scrutiny and Health and Wellbeing Boards.

51. **PROPOSALS TO VARY SERVICES**

Southern Health: Adult Forensic Ward Upgrade

The Chief Executive of Southern Health NHS Foundation Trust presented a report on the temporary re-location of patients to enable building works (see

report, Item 8a and Appendix 1 in the Minute Book). Members heard that the building works would include creating a safe seclusion unit that meets modern standards, improving on the current space for this.

RESOLVED:

1. That the Committee support the temporary re-location of patients from Oak Ward at Southfield to Ashhurst Ward at Ravenswood.
2. That the Committee be notified when the works have been completed and patients returned to Oak Ward.

b) Abbey Ward Update

The Chief Executive of Southern Health NHS Foundation Trust presented a report providing an update on the creation of a new 10 bed female psychiatric intensive care unit (see report, Item 8b and Appendix 2 in the Minute Book).

RESOLVED:

That the Committee be notified when a date for the new ward opening is confirmed.

52. **REVENUE BUDGET 2022/23 ADULTS' HEALTH AND CARE**

The Committee considered a report of the Director of Adults' Health and Care, Director of Public Health and Director Of Corporate Operations regarding the proposed revenue budget for 2022/23 for the Adults Health and Care Department, prior to decision by the Executive Member for Adult Services and Public Health on 18 January 2022 (see item 9 in the Minute Book).

Members heard that savings to be achieved in order to balance the budget in 2023 had already been agreed by Council in November 2021 so these proposals did not contain any new savings proposals. A one year settlement for local government had been announced by the government in December 2021; funding in future years would be subject to changes in the formula used for allocating the funding which was subject to a survey in Spring 2022.

The Adults Health and Care Department faced a number of challenges to meet the budget requirements, including delivery of outstanding savings from previous transformation programmes, workforce/recruitment challenges and care cost increases. It was also anticipated that the care cap announced by the government would impact local authorities negatively. Hampshire was offering to be a pilot area for the changes as an opportunity to evidence the implications and inform implementation.

Councillor Harrison proposed that the Health and Adult Social Care Select Committee not support the proposed budget, to make a statement that the funding being provided by government was not sustainable going forwards to deliver the required services. This was put to the vote but not carried (4 for and 7 against). The recommendation as written in the report was put to the vote and carried (8 for and 3 against), and therefore it was:

RESOLVED:

That, in regards to the revenue budget for Adults' Health and Care, the Select Committee supports the recommendations being proposed to the Executive Member for Adult Services and Public Health.

53. CAPITAL PROGRAMME 2022/23 TO 2024/25 ADULTS' HEALTH AND CARE

The Committee considered a report of the Director of Adults' Health and Care and Director of Corporate Operations regarding the proposed capital programme for Adults Health and Care, prior to decision by the Executive Member for Adult Services and Public Health on 18 January 2022 (see Item 10 in the Minute Book).

The recommendation as written in the covering report was put to the vote and carried (9 for and 3 against), therefore it was:

RESOLVED:

That, in regards to the capital programme for Adults' Health and Care, the Select Committee supports the recommendations being proposed to the Executive Member for Adult Services and Public Health.

54. WORK PROGRAMME

The Chief Executive's representative presented the Committee's work programme (see Item 11 in the Minute Book).

Councillor Tree requested an update on the Whitehill and Bordon Health Hub for the May 2022 meeting.

RESOLVED:

That the Committee's work programme be approved, subject to any amendments agreed at this meeting.

Chairman,

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HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date:	8 March 2022
Title:	Covid Update
Report From:	Director of Adults' Health and Care, Director of Public Health and Chief Executive of the Hampshire Southampton and Isle of Wight Clinical Commissioning Group

Contact name: Members Services

Tel: 0370 779 0507 **Email:** members.services@hants.gov.uk

Purpose of this Report

1. The purpose of this report is to provide an update to the Select Committee on the response to the Covid-19 pandemic in Hampshire.

Recommendation

2. The Health and Adult Social Care Select Committee note the update.
3. That the Health and Adult Social Care Select Committee approve that these COVID-19 updates are now stood down although the Committee may request updates in the future.

Executive Summary

4. The Health and Adult Social Care Select Committee has received updates on the response to the pandemic since July 2020 from the NHS, the Director of Public Health and the Director of Adults' Health and Care. Sections of the report have been provided by:
    - The Director of Public Health (paragraphs 5 to 19)
    - The Clinical Commissioning Group regarding the NHS (paragraphs 20 to 29)
    - The Director of Adults' Health and Care (paragraphs 30 to 66)

Public Health Update

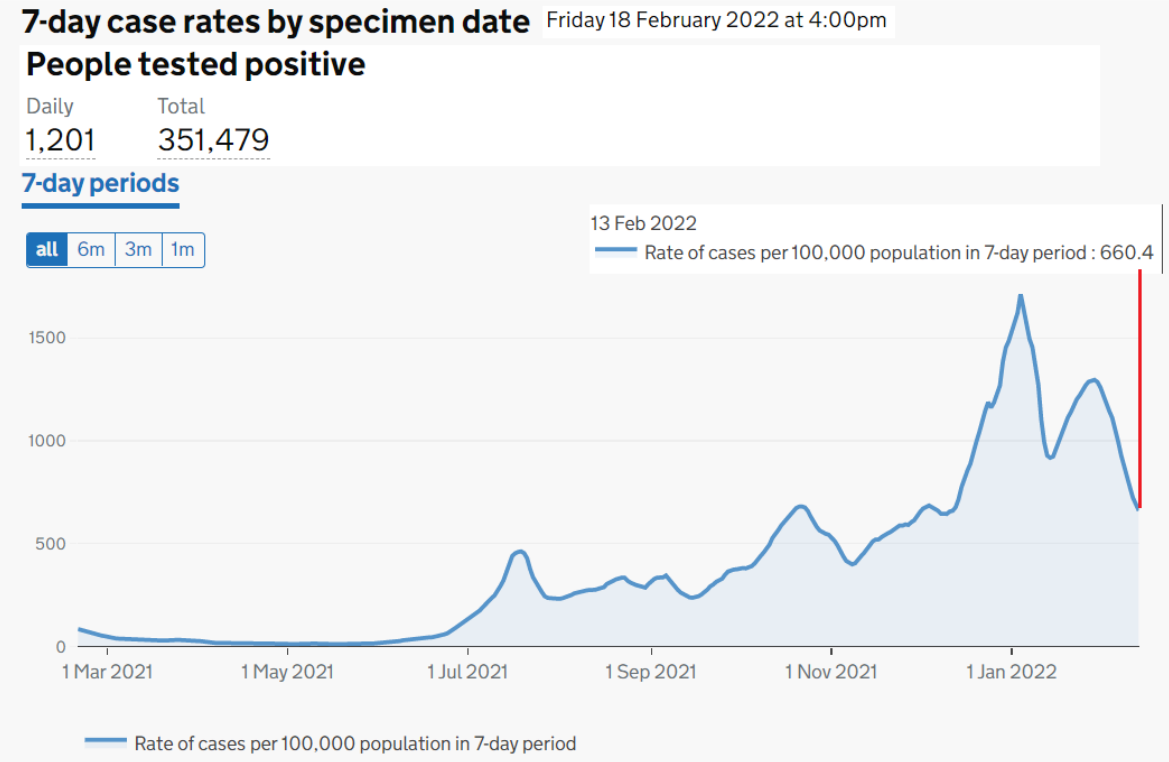
5. This is an update on the epidemiology of COVID-19 and the core COVID-19 response arrangements in Hampshire.
6. Inevitably there will be dimensions of this report which will be increasingly out of date immediately after publication. Officers will highlight these data caveats in the presentation of the report at the HASC meeting.
7. The overall epidemiological situation in Hampshire continues to be characterised by a high overall case notification rate that has been decreasing,

and a low stable death rate. This situation is largely driven by high transmissibility of the Omicron variants. Case rates are currently highest among children aged 10-14 years of age. Overall, case rates are still high in Hampshire's Districts, suggesting sustained community transmission. Although there has been a high uptake of the COVID-19 vaccine so far, a significant number of people still need to come forward for a first or second dose, and booster if eligible, to top-up immunity.

COVID epidemiology

8. The overall COVID situation in Hampshire continues to be characterised by a high overall case notification rate at 660.4 cases per 100,000 population in the 7-day period as of 18th February 2022, against the National 7-day rate of 565 cases per 100,000 population. The current Hampshire rate is falling week on week. Whilst reported case numbers appear tare declining, the pandemic is not over and we need to remain vigilant around the risk of new variants and not let our guard down. It is important that we stress the need to continue to protect the clinically vulnerable and continue messaging on behaving responsibly.

Rates of infections

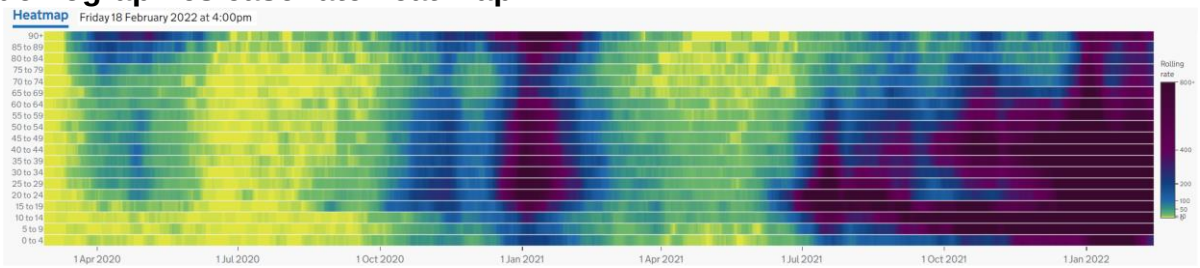


Source: GOV.UK Coronavirus (COVID-19) in the UK dashboard

9. Age demographic data suggest case rates are high in all age groups as of 18th February 2022. Case rates are highest among children aged 10-14 years of age (1,082 cases per 100,000 population). Among older people aged 60 and over, rates are still high at 360.2 per 100,000 population. Reassuringly, rates in younger children aged 0-4 years are relatively lower for now, at 290.9 per 100,000 population. The Government's COVID-19 response: Living with COVID-19, mean we all still have a collective responsibility to keep protecting people who are at greatest risk from COVID-19. People should continue to self-isolate when symptomatic or testing positive while prevalence of infection remains so high and modify

their behaviours to reduce spreading the virus especially to those who are vulnerable. This includes getting COVID-19 vaccinations and boosters**.**

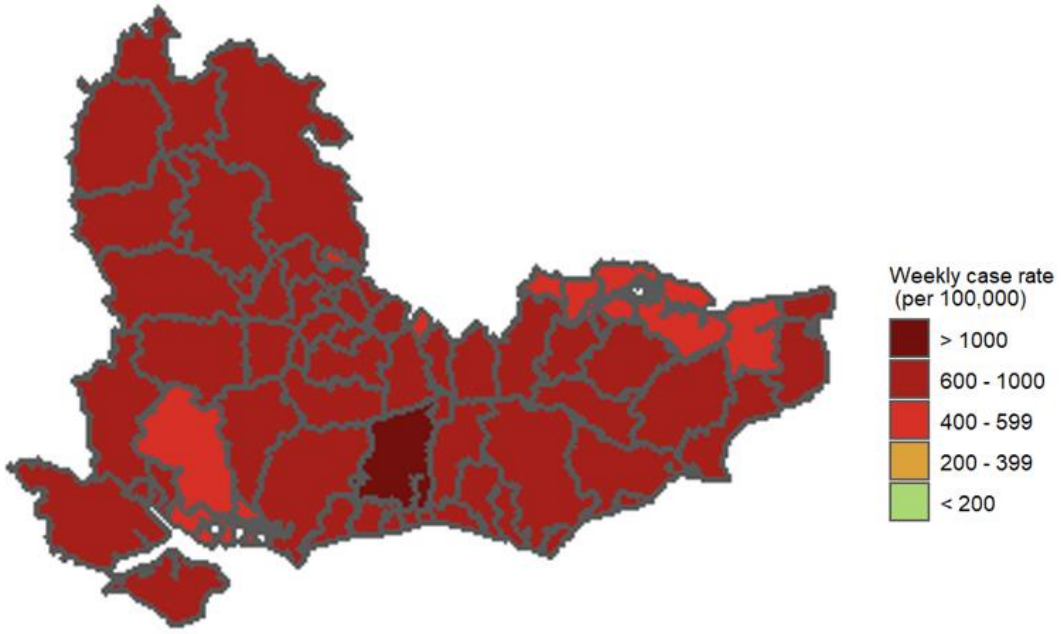
Age demographics case rate heat map



Source: GOV.UK Coronavirus (COVID-19) in the UK dashboard

10. Overall, all-age case rates are high in Hampshire's Districts, suggesting stubbornly high community transmission. Rushmoor has the highest 7-day all age (833.8 cases per 100,000 population) and over 60 year case rates (471.5 cases per 100,000 population) for the period between 7th and 13th February 2022. In the face of high levels of infection and an incomplete vaccination programme, it is essential that partners work with the County Council continue to work collaboratively to protect and support our communities, especially the most vulnerable ones, as we move into a new phase of managing COVID-19**.**

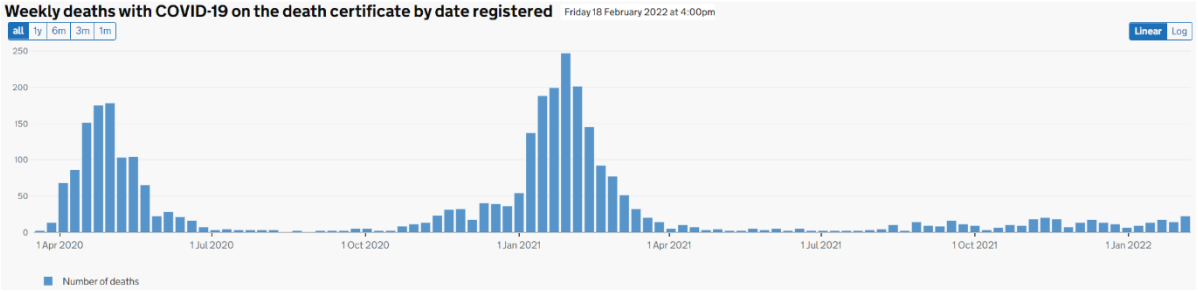
Case rate map



Source: Situational Awareness Report, UK Health Security Agency Local Authority Report Store

11. The number of deaths involving COVID-19 have continued to fall and people who had three vaccine doses have a lower risk of death involving COVID-19 relative to unvaccinated people. Currently, the County is experiencing a stable, but overall low death rate. The important message here is that being fully vaccinated and boosted is more protective than being unvaccinated, and thus a key part of the policy response for reducing hospitalisations and deaths. Although we are in a much better position now, COVID-19 is not over, and we should continue to use our freedoms responsibly to protect those at highest risk.

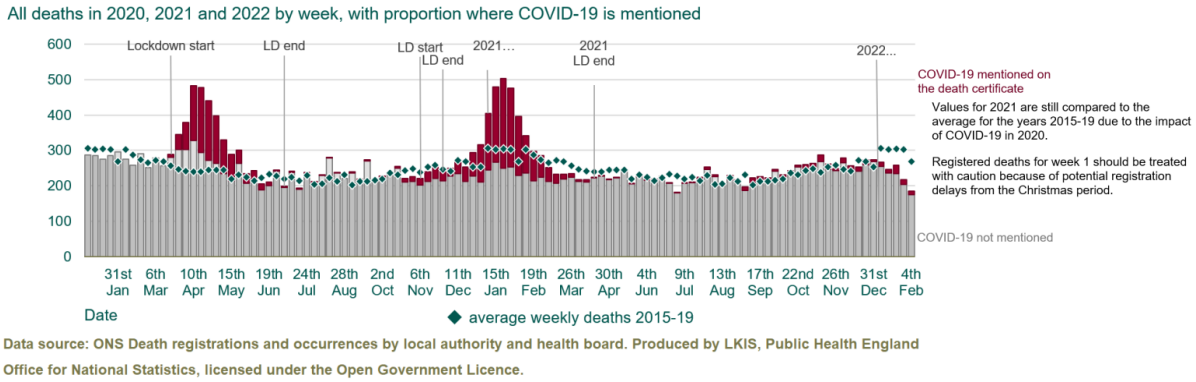
COVID-19 deaths



Source: GOV.UK Coronavirus (COVID-19) in the UK dashboard

12. Overall, excess deaths above the five-year average for 2015-19 are below or comparable to what we would expect for this time of year, with some spikes, following an initial substantial drop from the very high excess death peaks during wave one and wave two. In the pandemic so far (13 March 2020 to 11 February 2022), there have been a total of 2,399 excess registered deaths above the five-year average in Hampshire.

Excess deaths

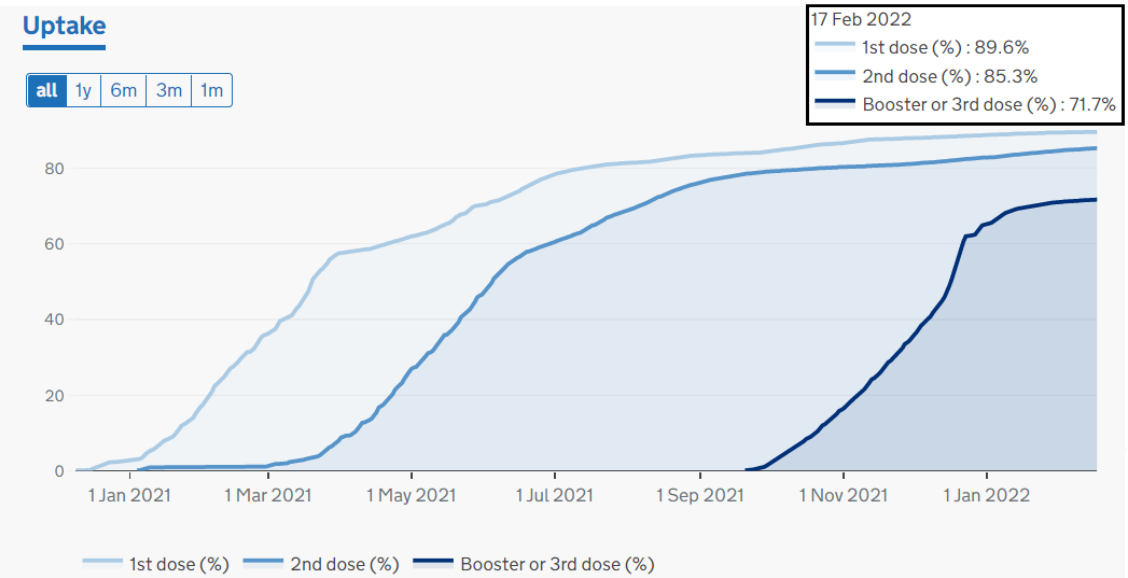


13. Although still high, numbers of people in hospital with COVID-19 continue to decline. However, staff absences against a background of system pressures - care backlog, urgent care, patient flow, ambulance services, long COVID and non-COVID-19 conditions continue to characterise this phase of the pandemic, though the situation is improving, and detailed further in the NHS update.

COVID-19 response arrangements

14. **Vaccination -** Vaccines have enabled a largely protected population. Latest data at time of writing (and to be updated verbally at HASC) was that around 89.6% of the Hampshire over-12 population have received a COVID-19 vaccination, with 85.3% having had two doses, and 71.7% boosted, as of 17th February 2022. An estimated 82% of adolescents aged 16-17 years and 73.3% of children aged 12-15 years have received a COVID-19 vaccination. Vaccine uptake is high but needs to be even higher, especially where there are inequalities in uptake and every effort should be made to maximise uptake among unprotected individuals who are susceptible to infection. Those aged 5-11 who are clinically vulnerable are now eligible for a vaccination.

COVID-19 vaccinations



Source: GOV.UK Coronavirus (COVID-19) in the UK dashboard

Living with COVID

15. Test, Trace, and Self-Isolation – The Test, Trace, and Self-Isolation system has been a critical tool in breaking chains of transmission to manage the virus over the autumn and winter. The Government announced the Living with COVID-19 Strategy on 21 February 2022, setting out a new approach to managing the virus, focusing on vaccinations and treatments as the first line of defence in managing the pandemic going forward.

16. The Public Health Team will continue to work with the UK Health Security Agency to manage outbreaks in settings to prevent further spread and to protect individuals

17. Symptomatic or asymptomatic testing has previously helped to find people who have the virus, enabled their contacts to be traced and helped ensure people self-isolate and/or get tested to prevent onward spread. From 24 February 2022, in line with the removal of the legal requirement to self-isolate if positive for COVID-19, routine contact tracing ceased, and the Hampshire Local Tracing Partnership was decommissioned.

18. Until 1 April 2022, people that have test positive for COVID-19, or are symptomatic in line with other infectious diseases should follow ‘Stay at Home’ guidance, although this can no longer be legally enforced. Post April 2022, the guidance will change again, focusing on keeping others safe if you are unwell.

19. From 1 April 2022, free access to symptomatic and asymptomatic testing will be removed for the majority of the population. Those individuals that are classified as vulnerable and those in ‘high-risk’ settings will continue to access testing modalities. Public Health are working with the UK Health Security Agency to ascertain the ongoing requirements for fixed testing sites across the County. Mobile Testing Units are likely to be retained as part of the national infrastructure for use in outbreak situations.

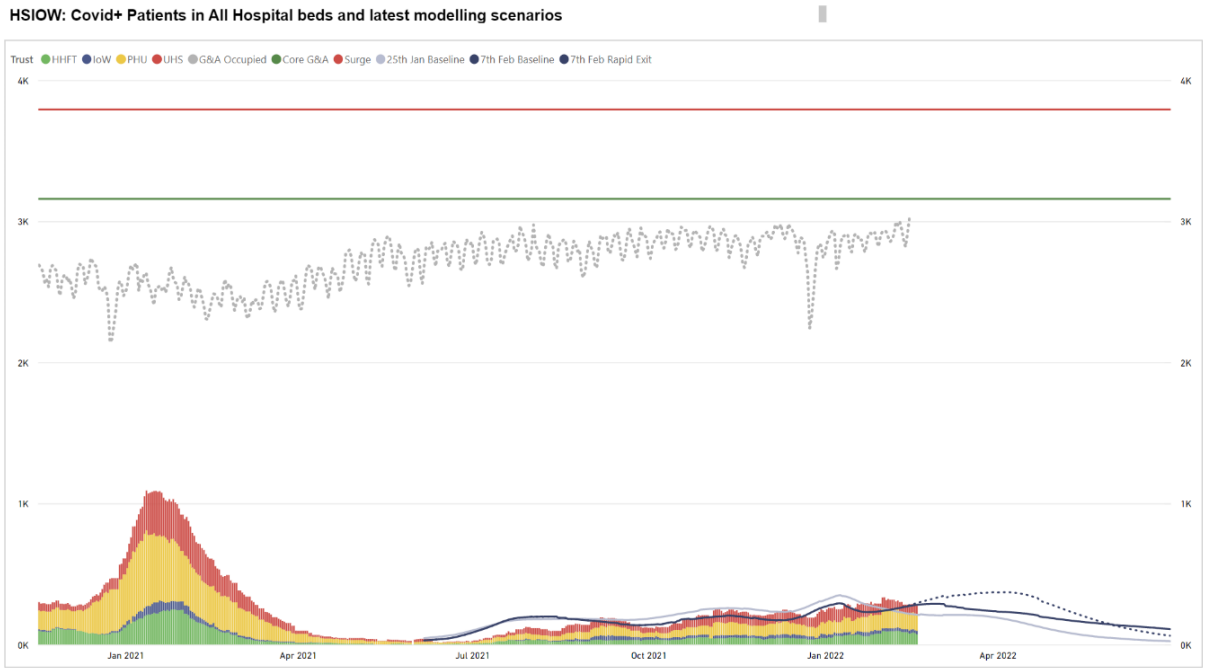
NHS Update

20. The wave of the Omicron variant of COVID-19 had a significant impact on NHS services but there are now signs that pressures directly caused by the virus are now starting to ease.

21. Across the area we have seen a marked increase in non-COVID-19 related demand for care. At present:

    - Emergency Department (ED) activity volumes are now consistently higher than pre-pandemic levels. Demand for 111 services and 999 services are also now consistently higher than the same periods in 2019.
    - Primary care remains exceptionally busy. Some routine primary care services across England were paused in December 2021 and January 2022 due to the vaccination programme, but it should be noted there were more GP practice appointments in December 2022 compared to pre-pandemic levels in December 2019 across Hampshire and Isle of Wight. In late January NHS England and Improvement asked all practices to move to restoring those routine services which had been paused. GP practices are being asked to focus on continued delivery of general practice services, the management and treatment of symptomatic COVID-19 patients, and ongoing delivery of the vaccination programme. Further details about our work to support primary care can be found in the additional paper provided to the committee.
    - We continue to work closely with our health and care partners across the Hampshire and Isle of Wight Integrated Care System (ICS) footprint to improve the flow of patients s out of hospital and into a community setting or home in a safe and timely way, once they have received all of the acute care they need.

22. The graph below shows the number of daily COVID-19 cases in our hospitals since mid 2020. Please note this involves patients who have been admitted for conditions unrelated to COVID-19 but are COVID-19 positive. While the number of overall COVID-positive cases has fluctuated slightly since the New Year, the number of cases in critical care beds has been steadily declining since November 2021.



Improving patient flow across the local health and care system

23. Learning from the earlier waves of the pandemic helped partners across the health and care system in Hampshire and Isle of Wight system prepare for the latest peak in admissions. Additional step down capacity, to support patients to be discharged out of our acute hospitals and into community settings, was been set up as a result.

24. To support safely discharging patients out of hospital to their home and to put in place changes to benefit the system in the long term, two Multi Agency Discharge Events (known as MADE) were held in each of our local systems. During these week-long event, health and care partners formed a number of teams, each of which focused on one of two wards at an acute hospital.

25. Organisations involved included commissioners, local authorities, community providers, mental health providers, primary care representatives and acute trust providers. These teams captured the progress of each patient on the ward along their agreed care pathway, highlighted and challenged delays, and supported safe and timely discharges. Each patient's journey was critically reviewed to understand what next steps were required to reach discharge and ensure sure critical interventions took place without delay. Each MADE team documented its progress and challenges, which were fed up to the central team each day.

26. At the end of each MADE event, a debrief was held to capture the learning and ensure actions were identified, ensuring the continuation and sharing of best practice. These events have been successful in discharging more patients out of acute settings and to their home or safe community settings in a more timely way, once they had received all of the acute care they needed.

Recovery of services

27. We continue to work closely with our health and care partners to respond to COVID-19 while also focusing on the continued recovery of services and local delivery of the vaccination programme. We are monitoring the situation closely

and ensuring we are as prepared as possible for any potential future impact of the pandemic in our communities, including new variants.

28. Collectively, our providers are managing to maintain around 90% of elective activity. This compares favourably to normal winters and we are now starting to see a decline in the number of total elective cancellations across Hampshire and Isle of Wight.

29. In light of the scale of recovery required since the pandemic, we are actively considering ways this can be increased. Part of this will through establishing Community Diagnostic Centres (CDCs). These create an opportunity to provide additional capacity of a broad range of elective diagnostic services. CDCs would be standalone or mobile facilities in accessible locations away from main acute hospital sites.

Adults Health and Care Update

30. The following provides an update on the impact of the pandemic on social care.

Pressure on services and market interruption

31. As outlined in previous reports there are continued comparatively high volumes of demand and complexity of demand across community and hospital settings due to a range of factors. The social care market in Hampshire is continuing to experience significant pressures with regards to the recruitment and retention of staff.

32. As detailed in previous updates, Adults' Health and Care continues to provide high levels of support to the care sector. The department continues to work closely with care and support providers to maintain required levels of care and ensure stability in the market. This includes the Call2Care campaign which was detailed in a previous report and is designed to attract new people to work in the care sector.

33. Adults' Health and Care commissioning teams continue to co-ordinate the effective and rapid distribution of national funding streams to providers. We will have distributed a further £11Million grants to care providers between January and February 2022. This figure includes a workforce grant of £5.9Million which we have stipulated that provides should use as bonus payments for their staff, to recognise and reward their efforts. We are acutely aware of the challenges of both recruitment and retention to maintain a resilient workforce.

34. It is important to recognise that Hampshire County Council have distributed close to £80m of Government grant support to the social care sector over the last two financial year and also made additional payments in the last financial year of £18m to support the sector. However, notwithstanding these measures a recent survey undertaken by Hampshire Care Association (HCA) identifies critical challenges, here and now and also into the future reported by HCA members. A link to the HCA survey results can be found here https://hampshirecare.org/wp-content/uploads/2022/02/HCA-Survey-Findings-January-2022.pdf.

Mandatory Vaccinations

35. We have had a continued focus on promoting the vaccine among care staff, through regular communications and targeted calls with providers where uptake

for vaccines and boosters has been low. This has also been a collaborative effort with health colleagues to ensure that we are signposting providers to the available walk-in vaccination centres.

36. In Hampshire, as at 11 February 72% of staff working in care homes have received their booster vaccination. For domiciliary care providers, 90% of all care workers have been double-vaccinated and 58% of care workers have received their booster. There are an estimated 6% of the domiciliary care workforce that have not had any vaccine (570 carers).

37. The decision was taken at the end of January to revoke the regulations which were due to come into effect in April 22, making vaccination a mandatory employment requirement for all health and social care staff. A further consultation is now underway to determine whether this decision should be revoked for care home staff also. While we await this decision, we continue to advocate vaccination as a way to prevent the spread of Covid, and we do note that out of the 59 outbreaks reported during February, 40 of these were in care home settings where booster uptake was flagged as being relatively low.

Home Visiting

38. Previous reports have discussed increases in the number of safeguarding incidents as a result of a number of factors relating to the pandemic. These included disruptions to the provision of care, including closure of services offering day care and respite, and increased pressure on carers.

39. When Plan B was introduced by the Government, Adults' Health and Care revised its *Home and Service Visits Guidance* to ensure that staff had a clear understanding about when they should still carry out face to face visits. This enabled visits to continue where face to face contact was required to carry out the County Council's statutory duties, and/or the purpose of the contact could not be achieved without face-to-face contact.

40. With the lifting of the Plan B restrictions, the focus now is on carrying out more home visits where appropriate to do so. The *Home and Service Visits Guidance* has also been updated, largely to reflect the changes relating to testing for Social Workers and other social care professionals (see following section).

Workforce Covid-19 Testing

41. New testing guidance for Social Workers and other social care professionals came into effect on the 16 February. All Social Workers, Senior Case Workers, Case Workers, business support and managers of all resident-facing teams will be required to take a lateral flow test before working anywhere other than at home.

42. It is the responsibility of individual members of staff to ensure that they order sufficient quantities of lateral flow tests. After taking the test staff are required to record all results (positive, negative or void) online via the gov.uk website and request confirmation so they can show current status if asked

Practice Recovery

43. With the easing of many of the Covid-19 restrictions, the Adult Social Care workforce in Hampshire needs to refocus some areas of practice in order to best respond to the needs of people as they have changed during the pandemic.

44. The training offer for staff has been redeveloped to meet the needs of staff and the situation as we exit the pandemic, with a key focus on areas such as safeguarding, Domestic Abuse and Lone Working. The ability to maintain online and virtual training in certain fields, whilst re-instating face-to-face training in others, means that required training can be delivered as efficiently, and in the most appropriate way possible.

45. The Senior Social Work position that was introduced in October and the focus on developing Senior Social Workers as professional leaders will drive practice recovery and practice excellence. In their role as practice leaders, senior social workers each specialise in one of four areas: safeguarding, practice educator, liberty protection or professional development.

46. As part of its recovery, the department is also placing additional emphasis on the final developments to, and launch of, its new case management system, CareDirector, which is due to replace the current Adult's Information System (AIS) later this year. The new system will deliver a number of efficiencies, such as enabling staff to record case notes whilst they are visiting customers, rather than needing to do it when they return to the office / home, which aligns with new hybrid ways of working.

Workforce Recovery

47. The issues of recruitment and retention of staff that are being experienced in the wider care market are also impacting upon Adults' Health and Care teams. In response to the number of vacancies, particularly in front line social care teams, and the level of recruitment, required to fill them, the recruitment for vacancies in Younger Adults' and Older Adults' community teams is now co-ordinated centrally, by one team within the department. This means that activities previously done by team managers such as downloading applications, shortlisting, scheduling interviews, completing the offer approval form, liaising with Corporate Recruitment over any queries, rejecting unsuccessful candidates, are now done centrally, thus freeing up Team Managers' time to focus on core activities. It also means that details of appointable candidates are shared across teams to ensure the best compatibility for candidates and roles.

48. The focus has been on the recruitment into Case Worker, Senior Case Worker, Social Worker and Community Development Worker vacancies. Across these posts:

- a total of 297 applications have been received to date (majority have been Case Worker/Senior Case Worker roles i.e. unqualified posts).
- 158 interviews have been scheduled for unqualified posts and 13 for Social Worker posts.
- 50 job offers have been made for unqualified posts, of which 34 people have started in post
- 4 job offers have been made for Social Worker posts, of which 1 person has started in post.

Day Services Recovery

49. Most people who attended a building-based day service before Covid have now returned. All Older Adults' service users who had a day service provision pre-

covid and wished to/ were able to return, have returned to a buildings-based service.

50. Most Younger Adults' clients have also been supported to return, with over 1200 people now attending day services again. Work is ongoing to reintroduce shared transport wherever possible; this enables people to provide each other with peer support in many cases, reduces issues around transport capacity and availability and also has positive financial benefits.

Winter Resilience (HCC Care)

51. As previously reported the County Council's own provider HCC Care, continues to experience the same workforce and other pressures as the wider care market. Despite strong vaccination uptake, the current and ongoing impact of Covid-19 transmission, increased levels of sickness as well as pressures driven by NHS demands are all placing increasing pressures on service delivery.

52. The previously reported mitigation, involving a managed temporary closure of two under-occupied residential units and temporarily redeployment of staff to neighbouring services was completed early December. Nevertheless, recruitment and retention continue to be challenging and workforce resilience is fragile. The service is working closely with Connect2Hampshire which has been able to support a proportion of unfilled shifts.

53. Although the service is seeing other pressures – such as seasonal chest infections and Norovirus, these are being managed within the service to maintain the safety and wellbeing of residents, visiting relatives and staff, referring to guidance from the UK Health Security Agency when required.

54. In addition, the onset of winter pressures on local hospital systems has required a greater proportion of bed-based capacity to support Short-Term step down provision to expedite hospital discharges for people with complex needs who are then being assessed for their long-term support requirements in a more homely setting.

Winter Plan (Supporting the NHS)

55. The foundation of the Winter Plan was to build upon the Discharge to Assess (D2A) and Short-Term services approaches that have been supporting the Hampshire system throughout the year. Winter demand saw these services hit their surge levels, with increases in Live in Carers and domiciliary hours occurring across Hampshire, and in further beds being provided in specific areas of pressure.

56. In previous years, we have consistently experienced a 20% increase in demand during November and December and a further 10% increase in demand between January and March. With hospital systems having operated under Winter levels of demand since Summer 2021, the Hampshire system experienced an increase over and above this. Hospitals have continued to experience large numbers of people presenting to emergency departments, which together with the impact of Infection Prevention and control (IPC) measures due to the Omicron variant, have led to significant occupancy pressures, with most systems remaining at Opel 4 throughout the Winter. This has resulted in increasing demand for social care support with discharges.

57. The pressures of Omicron have also led to difficulties for Short-Term bed based services, with Hampshire experiencing periods of closure for Infection reasons

across all the STS sites, despite staff following all IPC guidance. Consequently, HCC staff have worked extremely hard to ensure that we continue to provide support with discharges at the rate required.

58. Work continues on reducing demand at the front door, and in order to improve processes within the hospitals, several local multi-agency discharge events (MADE) have been held across Hampshire as part of an NHS wide initiative. HCC has been an active participant working with partners to maximise opportunities to support people to leave the hospital in a timely way, with good outcomes.

Update on Recovery

59. In line with the Department's managed transition from a Response to Recovery model, and the embedding of Recovery planning and activity within business as usual ways of working, the Adults' Health and Care Recovery Escalation and Steering Group was stood down in December, as planned, following Departmental Management Team (DMT) approval. In its place, a new Senior Management Team (SMT) Network has been established, working within existing Departmental governance frameworks and across operational and Headquarters services, to ensure sustainability of the Department's approach to Recovery for the longer-term. The primary aims of the SMT Network are to:

- share information and stage manage cross-service commonalities, issues and solutions in support of co-ordinated departmental planning;
- highlight, develop and strengthen consistent ways of working;
- provide peer support, reflecting on complexities and celebrating good practice;
- escalate to DMT as appropriate for decision, and provide a regular, collective update on hot topics at the bi-monthly DMT/SMT meeting.

60. Following the lifting of Plan B restrictions and in line with the approach being taken by the wider organisation, the Department has returned to full hybrid working arrangements. Staff are once again enabled to work within office accommodation and conduct face to face meetings in a Covid secure way, should they wish or need to do so, although service specific arrangements continue to be managed within individual operational areas. Use of the new meeting technology has been effective in ensuring flexibility and productivity to support this hybrid way of working for the long-term. Arrangements for Director-approved face-to-face learning continue with the emphasis upon continuing to observe measures to reduce the risks of Covid-19. Supporting the wellbeing and resilience of staff remains central to the Department's values and ability to deliver effectively for our local residents, and support has been put in place for those who may be anxious about returning to the office.

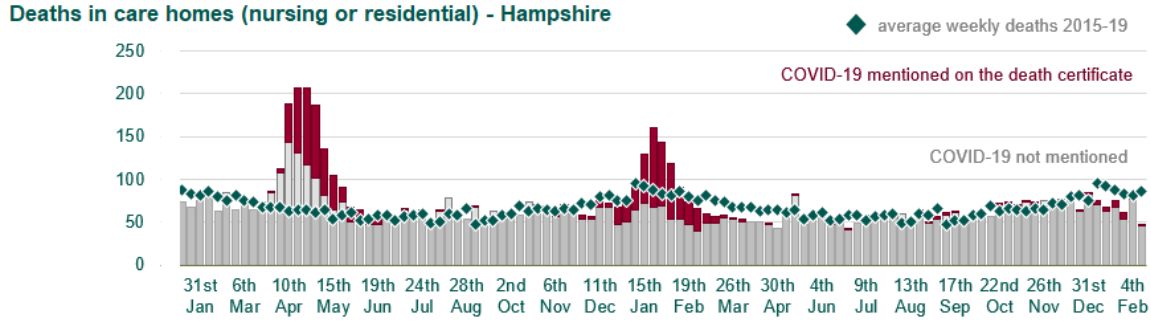
Progress of Covid-19 within Hampshire's care homes

61. For the time period requested – from 1 February 2020 to 11 February 2022 (ONS week 6 2020 to week 6 2022) and registered up to the 19 February 2022

    - there have been **7,773** deaths from all causes in Hampshire care homes (nursing or residential)

- **1,047** of these deaths had COVID-19 mentioned on the death certificate. These figures are based on date of death occurrence as opposed to date of registration. They reflect all deaths registered as at the 19 February 2022 and are subject to revision, especially the most recent weeks.

*The source of the underlying data is - Death registrations and occurrences by local authority and health board published by ONS. The graphs are adapted from Latest excess mortality and place of death analysis – up to Week 6 released by LKIS South East, Public Health England.



Data source: ONS Death registrations and occurrences by local authority and health board. Analysis produced by LKIS South East, Public Health England. Figures for most recent weeks are subject to revision and should be treated with caution. This includes all deaths that occurred up to the 11th February 2022 but were registered up to 19th February 2022.

Care Home Market Overview

62. Occupancy levels remain steady at around 87% of total beds reported as being available but remain below the 90% target that care providers state is their break-even point and with significant variation in occupancy levels in different homes.

63. The strain on the workforce remains high and we are increasingly hearing that staff are exiting the sector as a result of fatigue. Between September and December 2021 the reported workforce across care homes reduced by 824 people. Between December and end January there has been an increase of 397 workers which is a positive sign, but the sector is below full strength. There is a continued high reliance on Agency staff, at increased fees. Workforce funding (the equivalent of £214 per staff member) was issued in January to support with staff retention. Our stipulation to providers was to use this grant to reward their workforce directly.

64. Recruitment remains a big challenge across the care sector, and there has been significant competition for resources from other sectors. As part of our Call to Care campaign we have established a dedicated recruitment team within our partner organization Connnect2Hampshire. This team is recruiting carers for the independent sector, has filled 14 posts and is actively working to fill 30 plus roles across 12 homes.

65. An update on vaccinations within the care sector is provided in paragraphs 35-37.

66. There are continuing signs that Covid outbreaks are on the rise in line with the ongoing national picture, with 55 homes currently closed to admissions and 5 partially closed to admissions. There have been 58 Outbreaks reported to UKHSA (16 February). We continue to reinforce IPC guidance to help to

contain outbreaks, we have provided care homes with links to a support pack to support winter contingency planning and our Quality team are providing ongoing support and monitoring. A new requirement for staff to conduct daily testing comes into effect from 16 February and the impact of this on reducing outbreaks will be monitored closely.

Climate Change Impact Assessment

67. Hampshire County Council utilises two decision-making tools to assess the carbon emissions and resilience impacts of its projects and decisions. These tools provide a clear, robust, and transparent way of assessing how projects, policies and initiatives contribute towards the County Council's climate change targets of being carbon neutral and resilient to the impacts of a 2℃ temperature rise by 2050. This process ensures that climate change considerations are built into everything the Authority does.

Climate Change Adaptation and Mitigation

68. The carbon mitigation tool and climate change adaptation tools were not applicable on this occasion because this is an update and not seeking a decision.

Conclusions

69. This report is presented in order for the Health and Adult Social Care Select Committee to maintain an overview of the response to the pandemic locally, which is a key issue for the health and care sector in Hampshire at present. This gives the Committee the opportunity to remain informed and identify any areas that may warrant further scrutiny.

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	no
People in Hampshire live safe, healthy and independent lives:	yes
People in Hampshire enjoy a rich and diverse environment:	no
People in Hampshire enjoy being part of strong, inclusive communities:	no

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. **Equality Duty**

The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

Due regard in this context involves having due regard in particular to:

- The need to remove or minimise disadvantages suffered by persons sharing a relevant protected characteristic that are connected to that characteristic;
- Take steps to meet the needs of persons sharing a relevant protected characteristic that are different from the needs of persons who do not share it;
- Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low.

2. **Equalities Impact Assessment:**

An impact assessment has not been undertaken as this report is providing an update not proposing any change for decision.

Hampshire Health and Adult Social Care Select Committee
8th March 2022

Frimley Health NHS Foundation Trust
Covid-19 Update

Lorna Wilkinson
Chief of Nursing and Midwifery

Summary

- Omicron continues to have an impact on the health and care services both on the number of patients and admissions but also on staffing levels. There has been a considerable level of staff sickness across the NHS during the recent period, this has been the picture at FHFT as elsewhere.

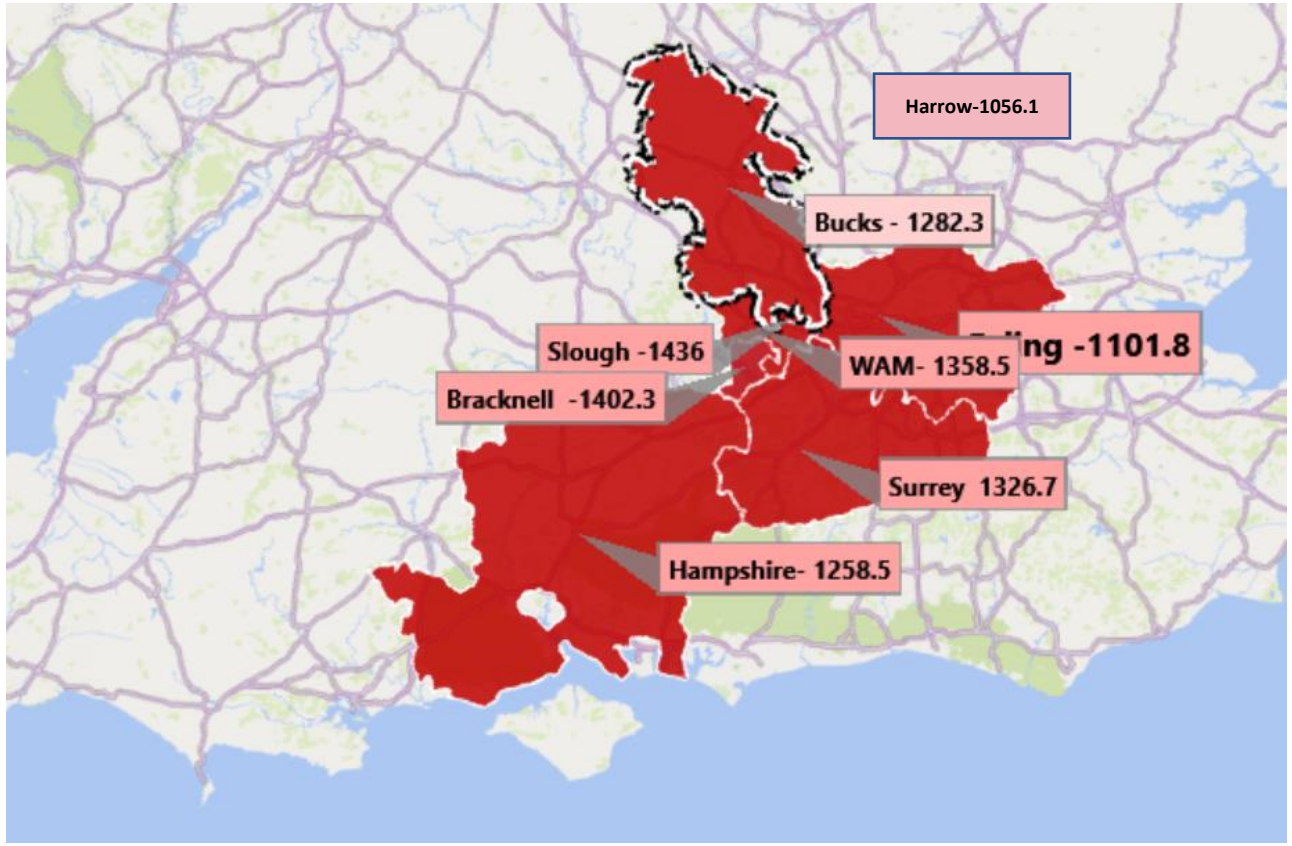
- The national vaccination programme continues to deliver across the nation with now more than four in five adults over the aged of 18 having now received their life-saving booster vaccines.

NHS Priorities and Planning Guidance

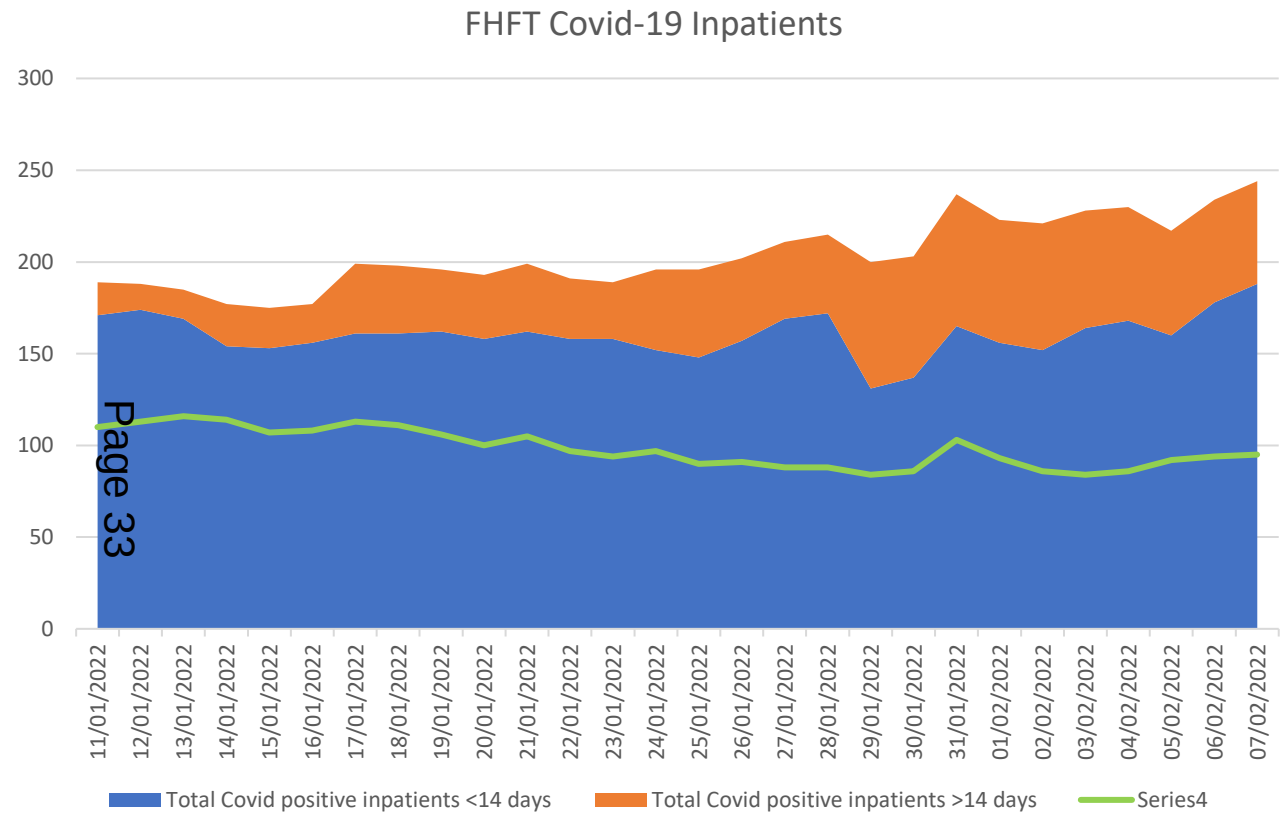
- The NHS has published its priorities and operational planning guidance for 2022-23. The guidance clearly sets out the priorities for the year ahead. Despite the challenging environment, the guidance reconfirms the need to continue to recover and restore our services to pre-covid levels and beyond. There are new demands on health and care services and a backlog of demand for elective care services as a direct result of the pandemic

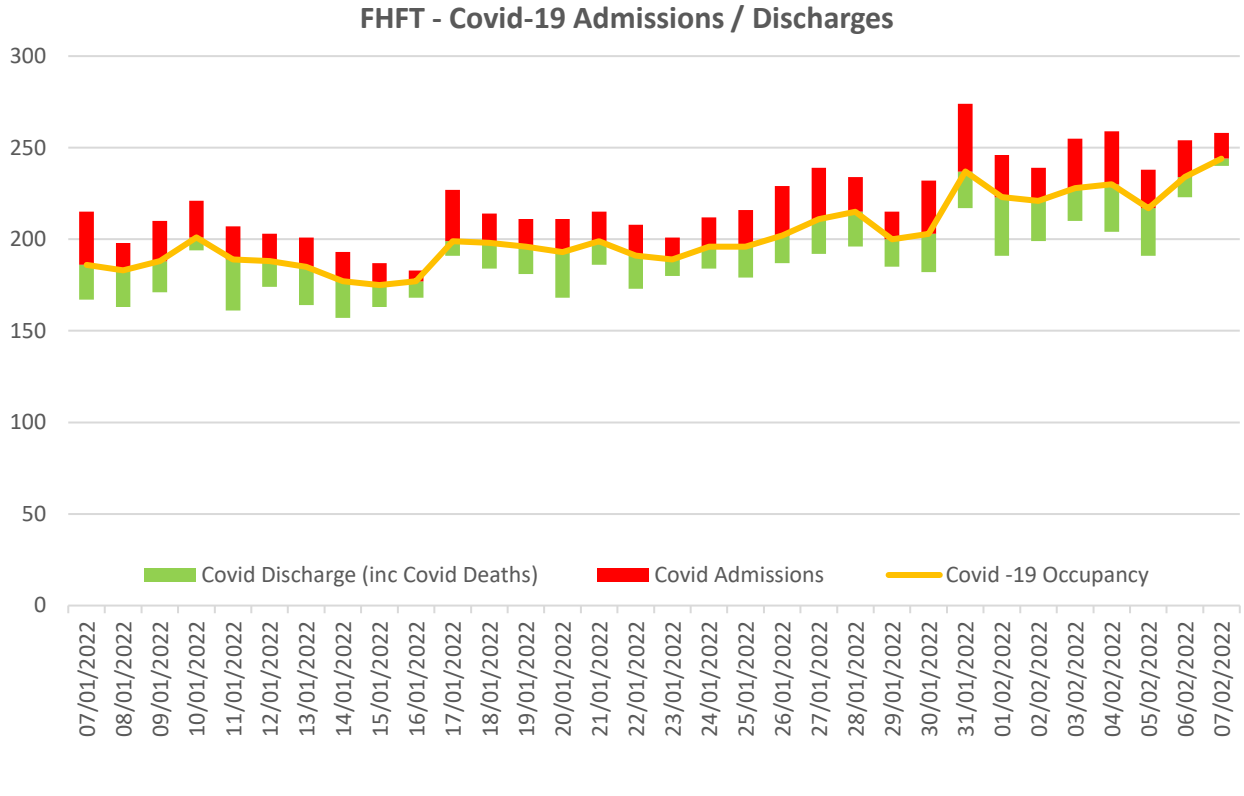
Covid Context

- The desired reduction in Covid Incidence has stalled
- The Covid ED / admissions volumes have remained at similar levels with Slough and Bracknell of particular interest
- Incidence in the catchment is higher than national incidence of 1006.8(last week 994).



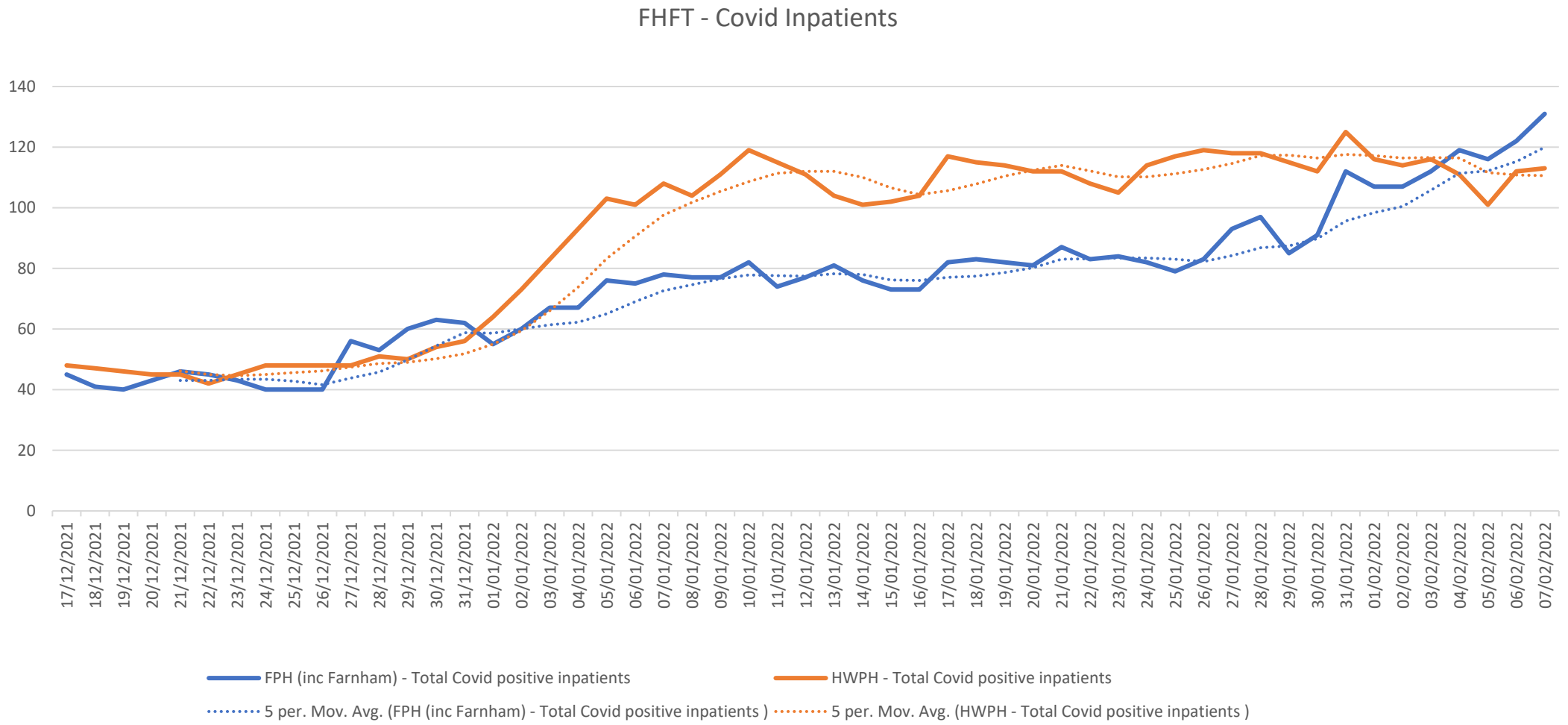
The following slides provide the most recent Covid Operational Update as at Monday 7th February 2022





Date	Total Covid positive inpatients <14 days	Total Covid positive inpatients >14 days	New admission reason: Covid	Total Covid positive inpatients
07/02/2022	188	56	95	244

Date	Covid inpatient	Covid Discharge (inc Covid Deaths)	Covid Admissions
07/02/2022	244	4	14


FHFT - Covid Inpatients
140
120
100
80
60
40
20
0
17/12/2021
18/12/2021
19/12/2021
20/12/2021
21/12/2021
22/12/2021
23/12/2021
24/12/2021
25/12/2021
26/12/2021
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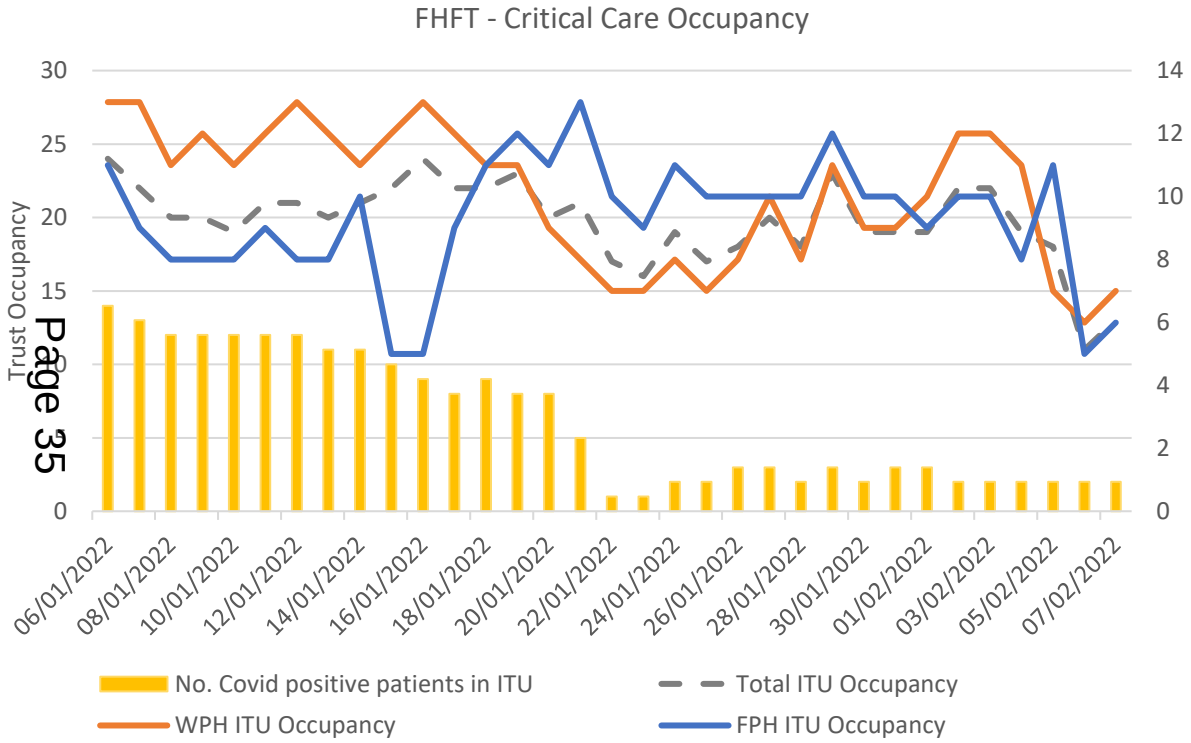
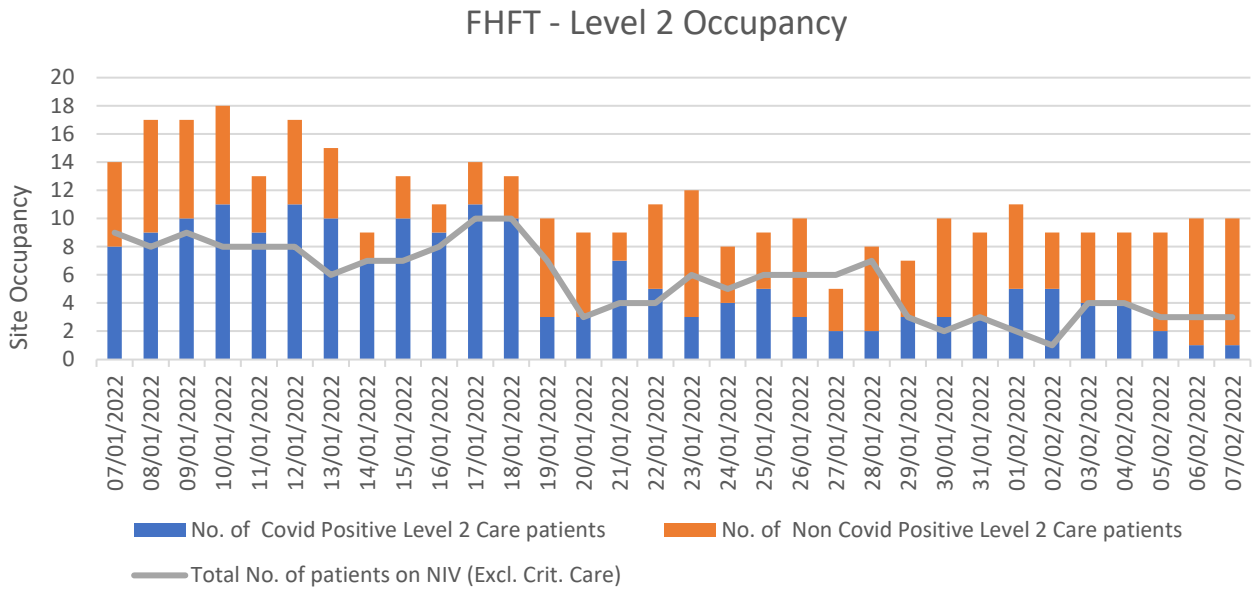
30/01/2022
31/01/2022
01/02/2022
02/02/2022
03/02/2022
04/02/2022
05/02/2022
06/02/2022
07/02/2022
FPH (inc Farnham) - Total Covid positive inpatients
HWPH - Total Covid positive inpatients
5 per. Mov. Avg. (FPH (inc Farnham) - Total Covid positive inpatients)
5 per. Mov. Avg. (HWPH - Total Covid positive inpatients)


FHFT - Critical Care Occupancy
Trust Occupancy
30
25
20
15
10
5
0
14
12
10
8
6
4
2
0
06/01/2022
08/01/2022
10/01/2022
12/01/2022
14/01/2022
16/01/2022
18/01/2022
20/01/2022
22/01/2022
24/01/2022
26/01/2022
28/01/2022
30/01/2022
01/02/2022
03/02/2022
05/02/2022
07/02/2022
No. Covid positive patients in ITU
Total ITU Occupancy
WPH ITU Occupancy
FPH ITU Occupancy


FHFT - Level 2 Occupancy
Site Occupancy
20
18
16
14
12
10
8
6
4
2
0
07/01/2022
08/01/2022
09/01/2022
10/01/2022
11/01/2022
12/01/2022
13/01/2022
14/01/2022
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31/01/2022
01/02/2022
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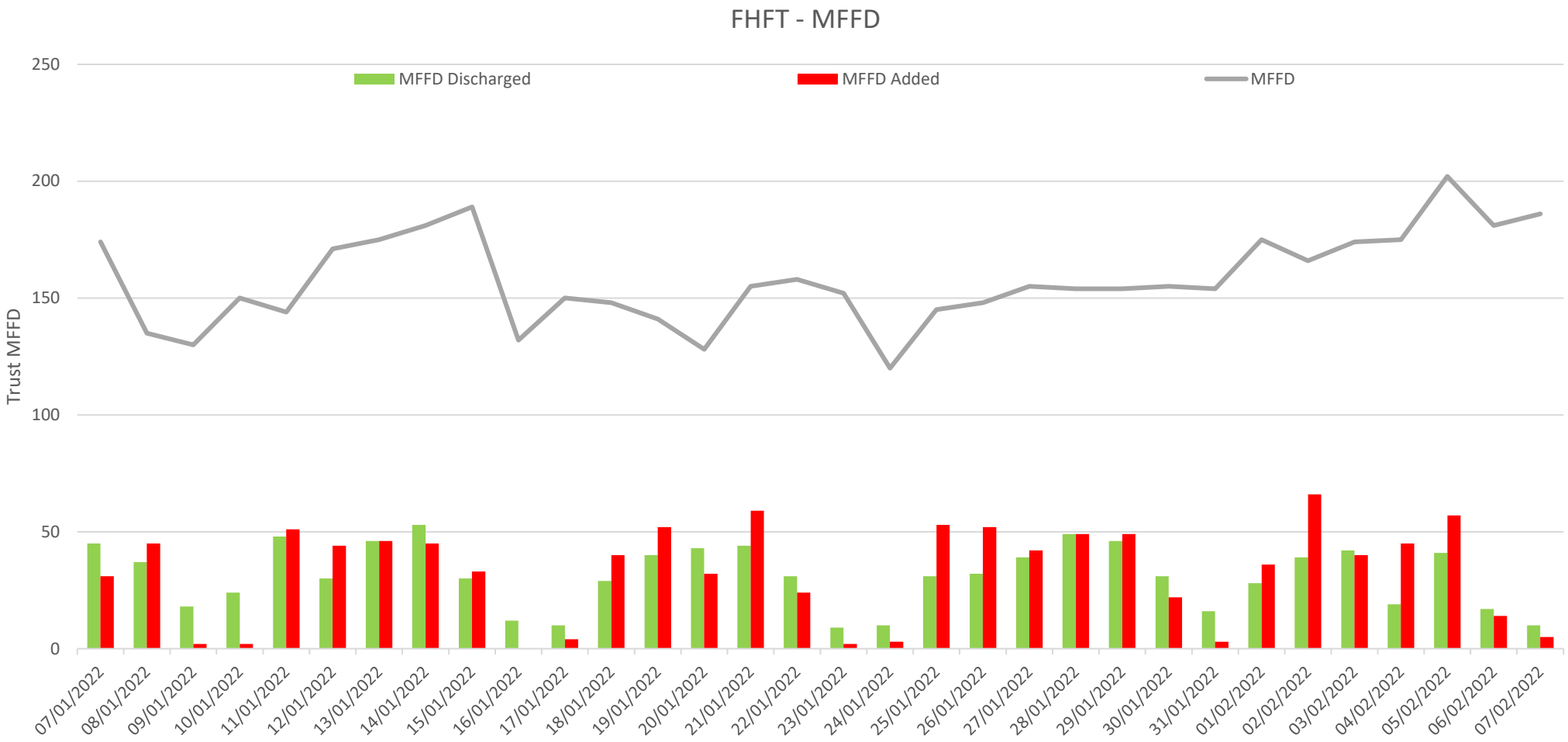
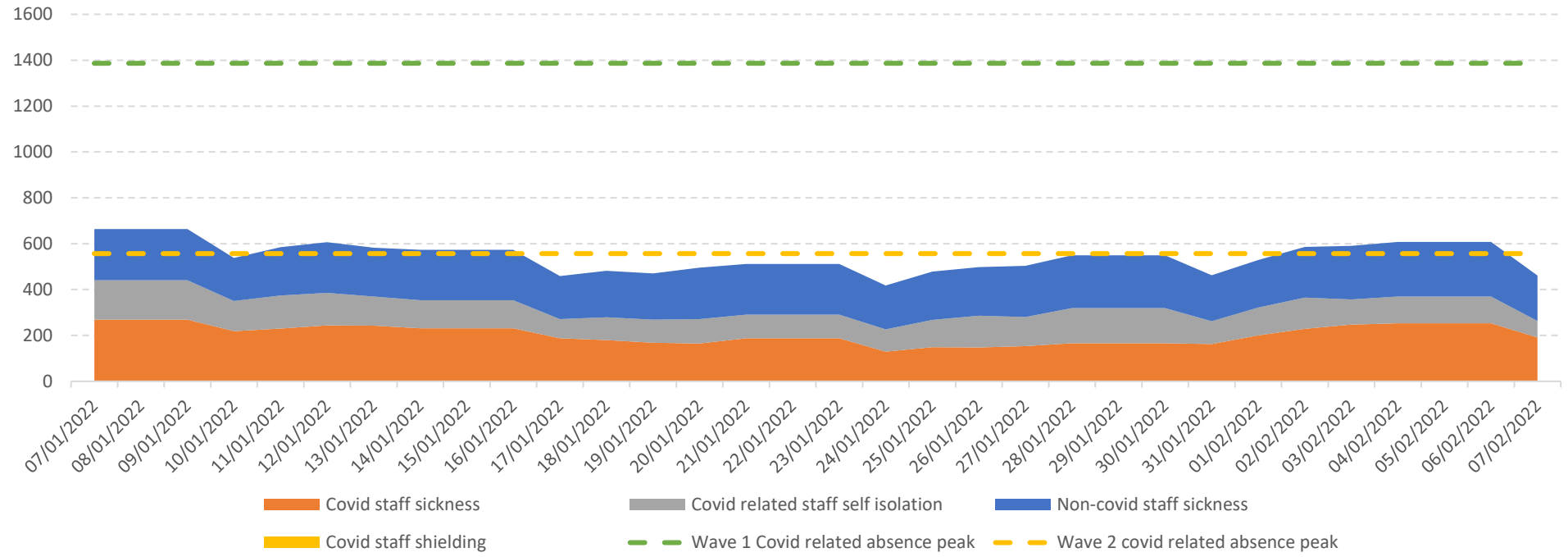
04/02/2022
05/02/2022
06/02/2022
07/02/2022
No. of Covid Positive Level 2 Care patients
No. of Non Covid Positive Level 2 Care patients
Total No. of patients on NIV (Excl. Crit. Care)



	FHFT Total MFFD	MFFD Added Yesterday	MFFD Discharged Yesterday
07/02/2022	186	5	10

FHFT Staff Sickness



- **FHFT:** 252 (down by 116) staff with COVID-19 related sickness or self-isolating (out of total 451 sickness, down by 157) Covid absence equates for 56.1% of absence at FHFT. Current overall absence rate from HealthRoster 2.6%
- **Frimley Park**: 128 (down by 76) staff with COVID-19 related sickness or self-isolating (out of total 222 sickness, down by 93) Covid absence equates for 57.7% of absence at FPH. Current overall absence rate from HealthRoster 2.4%
- **Wexham Park**: 109 (down by 38) staff with COVID-19 related sickness or self-isolating (out of total 195 sickness, down by 53) Covid absence equates for 55.9% of absence at WPH. Current overall absence rate from HealthRoster 3.0%

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HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date:	8 March 2022
Title:	Issues Relating to the Planning, Provision and/or Operation of Health Services
Report From:	Chief Executive

Contact name: Members Services

Tel: 0370 779 0507 **Email:** members.services@hants.gov.uk

Purpose of this Report

1. This report provides Members with information about the issues brought to the attention of the Committee which impact upon the planning, provision and/or operation of health services within Hampshire, or the Hampshire population.

2. Where appropriate comments have been included and copies of briefings or other information attached. Where scrutiny identifies that the issue raised for the Committee's attention will result in a variation to a health service, this topic will be considered as part of the 'Proposals to Vary Health Services' report.

3. New issues raised with the Committee, and those that are subject to on-going reporting, are set out in Table One of this report.

4. Issues covered in this report:

   a) Stage 2 Independent Investigation Report – Southern Health NHS Foundation Trust: Update on Action Plan
   b) Care Quality Commission Inspection Report – Southern Health NHS Foundation Trust (published February 2022)
   c) Primary Care Update
   d) Urgent Treatment Centre model
   e) Dental Services Update

Recommendations

   a) Stage 2 Independent Investigation Report – Southern Health NHS Foundation Trust: Update on Action Plan

5. The Committee welcomes the actions the Trust has taken to date in response to the recommendations made in the Independent Investigation Report.

6. The Committee request that the Trust attend the HASC meeting on 27 September 2022 alongside commissioners, to provide an update on evidence that the changes made have improved the experience of patients and their families.

b) Care Quality Commission Inspection Report – Southern Health NHS Foundation Trust (published February 2022)

7. The Committee note the latest CQC report on Southern Health.

8. The Committee request the Trust provide their response to a future meeting, outlining how it is planned to respond to the areas of improvement identified by regulators.

c) Primary Care Update

9. The Committee note the update on Primary Care.

10. The Committee request a further update in 2023, focusing on an assessment of primary care demand trends post pandemic and the workforce issues associated with meeting that demand.

d) Urgent Treatment Centre model

11. The Committee note the briefing on the UTC model.

e) Dental Services

12. *To be confirmed following late receipt of update*

Executive Summary

Table 1

Topic	Relevant Bodies	Action Taken	Comment
a) Stage 2 Independent Investigation Report: Action Plan update (concerning the tragic deaths of five people who were in the care of Southern Health in the period 2011-	Southern Health NHS Foundation Trust and the HS&IOW CCG	The Trust presented their Action Plan setting out their response to the Independent Report recommendations at the January 2022 meeting (Appendix 2 Southern Health Stage 2 Pascoe	Attached is an update from Southern Health NHS FT at Appendix 1.

Topic	Relevant Bodies	Action Taken	Comment
2015, and the Trust's response to the families of those who died)		Report Action Plan.pdf (hants.gov.uk). At that meeting the Committee requested they provide an update to this meeting, as some actions were due to be completed by the end of February 2022.	
b) Care Quality Commission Inspection Report – Southern Health NHS Foundation Trust	CQC and SH NHS FT	The Trust sent a letter to stakeholders regarding the inspection report (see Appendix 2) and the full report is attached (see Appendix 3). The Trust have been invited to comment on the findings at this meeting, although their formal response is not yet finalised.	CQC undertook an inspection of Southern Health's mental health services in October 2021 and published their report in February 2022. The overall rating for the Trust has gone down from 'Good' to 'Requires Improvement'.
c) Primary Care Update	HS&IOW CCG	The HASC received an item on this at the November 2021 meeting (Appendix 1 primary care update.pdf (hants.gov.uk) and requested a further update for this meeting.	An update provided by commissioners is attached at Appendix 4. At the last meeting members remained concerned that there was high demand for GP services that was not being adequately met face to face.

	Topic	Relevant Bodies	Action Taken	Comment
d)	Urgent Treatment Centre model	HS&IOW CCG	The Chairman of HASC requested a briefing on the UTC model for the committee, following a visit to Petersfield UTC in November 2021.	A briefing outlining the Urgent Treatment Centre Model has been provided at Appendix 5.
e)	Dental Services Update	NHS England	The HASC received an item on this at the November 2021 meeting (Appendix 2 Dental Services update.pdf (hants.gov.uk) and requested a further update for this meeting.	An update has been provided (see Appendix 6) At the last meeting members remained concerned that the capacity in NHS dental care was not sufficient to meet the demand.

Scrutiny Powers

11. The Health and Adult Social Care Select Committee has the remit within the Hampshire County Council Constitution for 'Scrutiny of the provision and operation of health services in Hampshire'. Health scrutiny is a fundamental way by which democratically elected local councillors are able to voice the views of their constituents, and hold relevant NHS bodies and relevant health service providers to account. The primary aim of health scrutiny is to act as a lever to improve the health of local people, ensuring their needs are considered as an integral part of the commissioning, delivery and development of health services.

12. The Committee has a role to 'review and scrutinise any matter relating to the planning, provision and operation of the health service in Hampshire'. Health scrutiny functions are not there to deal with individual complaints, but they can use information to get an impression of services overall and to question commissioners and providers about patterns and trends. Health scrutiny can request information from relevant NHS bodies and relevant health service providers, and may seek information from additional sources for example local Healthwatch.

13. The Committee has the power 'to make reports and recommendations to relevant NHS bodies and to relevant health service providers on any matter that it has reviewed or scrutinised'. To be most effective, recommendations should be evidence based, constructive, and have a clear link to improving the delivery and development of health services. The Committee should avoid duplicating activity undertaken elsewhere in the health system e.g. the work of regulators.

Finance

14. Financial implications will be covered within the briefings provided by the NHS appended to this report, where relevant.

Performance

15. Performance information will be covered within the briefings provided by the NHS appended to this report where relevant.

Consultation and Equalities

16. Details of any consultation and equalities considerations will be covered within the briefings provided by the NHS appended to this report where relevant.

Climate Change Impact Assessment

17. Consideration should be given to any climate change impacts where relevant.

Conclusions

18. Regarding the Independent Investigation Report on Southern Health NHS Foundation Trust: as a major provider of mental health services in Hampshire, the Committee has an interest in receiving assurance that the improvements identified by the independent investigation are delivered.

19. Regarding the Care Quality Commission Report on Southern Health NHS Foundation Trust: the Committee will be disappointed that the overall rating for the Trust has declined and will wish to monitor the Trusts plans to improve on the areas identified by regulators as requiring improvement.

20. Regarding Primary Care, the Committee will welcome that there has been a 6% increase in general practice appointments in 2021 compared to 2019. However, Members may wish to monitor in future whether there remains further unmet demand, due to the knock on effect of services being suspended at times during the pandemic, and the sustainability of the GP workforce to meet demand in future.

21. Regarding the Urgent Treatment Centre model, the briefing provides a summary of the role of this element of urgent care.

22. Regarding Dental Services, the Committee will want to be assured that efforts continue to increase capacity in NHS dentistry to meet demand and ensure patients are directed appropriately based on their level of need.

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	no
People in Hampshire live safe, healthy and independent lives:	yes
People in Hampshire enjoy a rich and diverse environment:	no
People in Hampshire enjoy being part of strong, inclusive communities:	no

Other Significant Links

Links to previous Member decisions:	
Title	Date
Issues Relating to the Planning, Provision and/or Operation of Health Services report	18 January 2022
Direct links to specific legislation or Government Directives	
Title	Date

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. Equality Duty

The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

Due regard in this context involves having due regard in particular to:

- The need to remove or minimise disadvantages suffered by persons sharing a relevant protected characteristic that are connected to that characteristic;
- Take steps to meet the needs of persons sharing a relevant protected characteristic that are different from the needs of persons who do not share it;
- Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low.

2. Equalities Impact Assessment:

This is a covering report for items from the NHS that require the attention of the HASC. It does not therefore make any proposals which will impact on groups with protected characteristics.

Southern Health
NHS Foundation Trust

Stage 2 Independent Investigation Report: *'Right First Time'*

Status Report February 2022

1. Trust update

1.1. The table below summarises the work done by the Trust to realise the ambitions of the Stage 2 report. The table describes the actions taken since the report was considered at the HASC meeting on 19th October 2021 **in bold**. Clearly since November we have been responding to the impact of critical incident level 4 being called but we have continued to prioritise these important workstreams..

1.2. Progress towards the completion of the actions set out below are being monitored by the Trust Board and its sub-committees. These assurance processes are taking place during March and will be then considered by the Quality Governance leads in both the ICS and Regional Office. This report therefore should be considered as an update rather than confirmation of completion.

Recommendations		Status Report
R1	SHFT's Complaints, Concerns and Compliments Policy and Procedure documents should be urgently reviewed and reformed. They should be combined into a single document. The policy should prioritise service users, family members and carers. SHFT should work with these groups to co-produce it. It must be clear, straightforward and in an easily understood format. All members of staff must undertake mandatory training on the new Policy and Procedure.	The Trust's procedure and practice for dealing with complaints has already been revised. The practice now is that frontline service managers and clinicians respond the same day by contacting the complainant, clarifying what it is that they are unhappy about, agreeing timescales and what needs to be done to achieve resolution. We are clear that complaints are locally managed with central support, and this is reflected in the revised policy. 87% of all complaints in 2020/21 were completed through early resolution at source. For all complaints that were escalated the response time has reduced from a median of 57 days (March 2020) to a median of 23 days (January 2022).
R2	SHFT should clarify what complaints management system is actually in place in the organisation, whether this is centralised or locally managed, and further go on to ensure the system is publicised and shared in clear language with staff, service users, family members and carers.	The Trust is a pilot site for the new complaints standards issued by the Parliamentary and Health Service Ombudsman (PHSO). The Trust's Policy has now been revised to reflect current practice. The policy was developed through extensive consultation and engagement with stakeholders. This included the Parliamentary Ombudsman Assessment focus groups, the Working in Partnership Committee, staff and the Patient Experience and Caring group.

		The updated policy was shared with the Working in Partnership Committee on 17.2.22 and was approved by the Quality and Safety Committee on the 15th February 2022. The policy will be published on the Trust website. A program of training via the Parliamentary and Health Service Ombudsman (PHSO) pilot is being implemented between now and Autumn, when the new complaint standards will be rolled out.
R3	SHFT should clarify and define the role of PALS and if proceeding with it, co-design and co-produce a strategy and implementation plan for its development throughout the organisation. The service must be accessible, supportive and responsive to service user and carer needs.	The Carers and Patient Support Hub was launched in January 2022. We are currently identifying pilot sites for a physical presence as well as access via email, text messaging and telephone for the rest of the Trust. Sites identified to date include Lymington hospital and St. Denys community centre. This approach was agreed with the Patient Experience Group who will continue to develop the Hub based on feedback.
R4	SHFT should urgently implement a process to monitor the quality of the investigation of complaints, complaint reports and responses and the impact of recommendations from complaints. That system should test the extent to which outcomes and judgments are evidence-based, objective and fair.	Complaints reports and responses are quality assured by Executive Directors/Chief Executive. A comprehensive report on complaints is scrutinised by the Quality and Safety Committee. Since January 2021 we put in place a follow up contact with people who have complained to gain feedback; these surveys and the qualitative information are fed into the Patient Experience and Caring Group on a quarterly basis.
R5	SHFT should re-develop its Complaints Handling leaflet that reflects the complaints process, outlines expectations and timelines for service users, family members and carers. It must be co-designed and co-produced with these groups. The documents should be widely available to all in paper and digital format.	Leaflets have been co-designed and co-produced with the Working in Partnership committee, service users and staff. They are available in paper format as well as online and it is made clear that we can provide these forms in additional languages. An easy read leaflet will also be produced via our easy read group of service users.
R6	During the investigation of complaints, SHFT should offer the opportunity for face-to-face meetings as a matter of course. These meetings should provide the time to discuss with complainants about how they wish their complaint to be handled and a timeframe for a response, should be agreed. SHFT should maintain	As part of our changed practices around working with complainants, we offer the opportunity for face-to-face meeting. Our routine practice now includes earlier intervention by our clinical teams, dialogue directly with people to understand their preferences for resolution and putting these in place, regular keeping in touch during the response and improving the way we communicate our findings.

	communication with the complainant throughout, with a full explanation for any delays.	
R7	SHFT should ensure that all complainants that go through its complaints handling process, have access to advocacy services where required. SHFT should be alert to the importance of perceived independence of representation. Therefore, it should look to Third sector organisations that it can facilitate access or signpost their availability for complainants. This should be co-ordinated so as to be part of the complaints handling process.	We have identified local advocacy services and actively promote them through our website and via the Carers and Patient Support Hub. A document for staff has been produced listing all available support services and we are actively working with Connect to Support Hampshire to promote their directory of services
R8	There is a vital and continuing need for SHFT to re-build trust and confidence with the population it serves. To achieve this end SHFT should continue its move away from a past unresponsive culture and defensive language. Today, SHFT acknowledge the need to balance accountability and responsibility by ensuring that it meets the Duty of Candour and admits its mistakes. To achieve this, SHFT needs to ensure all staff are trained and understand the Duty of Candour and take a positive pro-active approach in all future engagement with families, carers, and service users, to ensure that their needs are met.	The Duty of Candour is promoted in staff training and in practice. Compliance is reviewed at the Patient Experience Group via a quarterly report. Our Investigating Officers and Family Liaison Officers openly engage with families when they are part of an investigation and also check that the service lead has shared information openly and honestly. It is also something that is considered by the corporate SI panel. Patients or family members are always offered a copy of the investigation.
R9	SHFT should co-produce with service users, carers and family members, a Communications Strategy to identify a 'road map' for improving communications. This should include, but is not limited to, mandatory training on communication across the whole of SHFT, including improving internal communications and the development of a protocol setting out how SHFT will provide support to its service users, carers and family members. It should create specific roles to provide this support. SHFT recruitment processes should include good and effective communication skills	Work has been done and will continue to co-produce more effective communication channels with service users, carers and family members. The Trust has specific roles to support engagement and communication with service users, carers and families which includes carer peer support roles and Family Liaison Officers. The communications and patient engagement strategies have been reviewed to ensure alignment and this is regularly monitored. Communication skills training modules are already available. All existing training has been reviewed. There are existing training and development modules which incorporate effective communications and interpersonal skills. In addition, new training for line managers has

	criteria for all roles at every level of the organisation.	been developed and will be introduced in March 2022, a key aspect of which is communications skills. All recruitment processes have been reviewed to ensure that communications skills are clearly specified for all roles in person specifications and job descriptions, and that this is assessed at shortlisting and interview. Ensuring effective, compassionate communication in all contexts and between all audiences will always be an area for continuous improvement and development. As part of this the Communications Strategy for the Trust is due to be updated during 2022 and patients, carers, families and staff will be involved in this process.
R10	SHFT should develop a Carer's Strategy, in which the aims and actions are understood and are to be articulated by carers, working together with staff. As a minimum, these actions should be reviewed annually at a large-scale event with carers at the centre. In future, carers must have the opportunity to articulate their needs and the actions needed to address them. Part of this process should be the enhancement and wider use of the Carer's Communication Plan, which must be underpinned by relevant training.	Our carers action plan is aligned to the Hampshire Joint Strategy for Carers and the Southampton Strategy for Carers. Our plan was co-produced with a variety of stakeholders, particularly the Families Carers and Friends group who have oversight and monitor the plan. The action plan is a 'live' document and actions are added based on feedback and any issues highlighted to us by our carers. The use of Carers Communication Plans will be continuously monitored. We have a project underway looking specifically at engagement with lesser heard carers, e.g., military families, carers from rural areas, gypsy and traveller community, black and minority ethnic communities and young carers. We are also just starting a project to look at discharges and the effects on carers. We are strengthening our work with voluntary sector organisations to enable all of this work, and carers themselves are leading on aspects of the projects.
R11	SHFT should ensure all staff are all rapidly trained to understand the Triangle of Care and that these principles are clearly communicated across SHFT to all staff to ensure greater awareness. The Quality Improvement methodology should be used to measure the impact of the Triangle of Care.	The Triangle of Care is one of the approaches the Trust has for supporting carers. An increased number of Triangle of Care workshops have been offered and options for attending sessions out of hours and via webinar. 10 carers leads have been trained to deliver the training. An introduction module to give all staff an understanding of the principles and process is available online. The principles are included in local induction. The introduction of Esther coaching will further enhance and reinforce the Triangle of Care principles.

		Esther Improvement Coaches are specially trained dedicated members of staff who support the development of other staff to create a culture of continuous improvement to ensure person-centred care. User involvement is integral to the model, building a network around the patient including family, friends and key staff.
R12	SHFT should set up regular localised drop-in sessions and groups for carers and remote carers, which provides support and advice to meet local needs, to include ongoing peer support.	There are several groups already in existence and the new Carers and Patients Support Hub. The service will provide single point of contact for issues and concerns, with a hub and spoke model for outreach and drop-in sessions. The hub will include peer/ carer volunteer support and voluntary sector partners will be invited to run support sessions
R13	The Panel recommends that SHFT strengthens its links with the local Hampshire Healthwatch, to ensure that the voices of service users, family members and carers are heard locally. This relationship should be formalised and monitored through a quarterly feedback session between SHFT and Hampshire Healthwatch, with a written report that is publicly available.	The Trust has a good relationship with each of the Healthwatch groups. The Trust Chair and Chief Executive meet with Healthwatch groups. Formal feedback from Healthwatch will always be made available on the Trust's website.
R14	SHFT should pay due regard to the 7th principle and 8th principle of the UK Caldicott Guardian Council in recognising the importance of the duty to share information being as important as the duty to protect patient confidentiality. Through training, supervision and support, staff need to be empowered to apply these principles in everyday practice and SHFT should be transparent about how it does so.	The Trust already promotes the importance of both principles. There are mechanisms in place to hear directly from carers and family members about how the principles are applied in practice. We will continue expansion of the Triangle of Care training and the incorporation of this ethos into our services. The information governance training has been updated and therefore all staff will access this when they undertake their annual training. Identifying good practice or training opportunities will continue to be a key part of Learning from Events and feedback forums. In learning from events and the subsequent learning across the Trust we will look for evidence of the principle being upheld, highlight good practice and encourage a closer understanding where practices could be improved. We will continue to ensure Carers Forums are attended by senior clinical leaders and share learning from these events widely. This will form part of ongoing monitoring. This is a continuous area of development and improvement.

R15	SHFT should seek to improve both the quality of the handover and the sharing of information between clinicians involved in patient care, to include nursing, medical, therapy and pharmacy staff. This should extend, where relevant, to all care settings, including, SHFT and General Practices across its divisions.	This is an important aspect of the daily routines of all clinicians. We need excellent communications throughout a patient journey from community, through a crisis into hospital and then back home into the community again. This includes GPs, social services, pharmacy, acute hospitals, care homes etc. This is an area for continuous improvement. Internal communication is being improved through many workstreams, examples include: strengthening the multidisciplinary team meeting, better operability and access to RIO (our electronic clinical record system where we record clinical notes), ensuring dedicated time for handovers and an established methodology to make the handover process more productive, use of Rio mobile and Rio on our physical health wards, and prioritising the further development of Risk and Care plans. External communications are being improved, for example: a pharmacy review of all medications prior to discharge including direct communication with GPs; timely use of redesigned discharge summaries; and working with partners to improve the way different clinical systems across the health and care sector digitally exchange information in real time. (NHSX are leading on legislative work to accelerate this interoperability work nationally). All doctors have a required reflection and discussion each year in their appraisal about their communication skills. We will look to echo this approach to all our staff, both clinical and non-clinical. There are opportunities to listen to patients', families' and carers' views on communication via various surveys and direct requests for feedback.
R16	SHFT must make swifter progress in developing the Patient Experience Dashboard to ensure that it is able to triangulate data and information effectively. It should consider using the data from the Triangle of Care processes to inform this Dashboard. It should also implement specific audits of carer feedback at a local level.	The Patient Experience dashboard is in place and presented at the Quality and Safety Committee on a quarterly basis. The measures are regularly reviewed and will continue to be developed. This will include user defined standards for mental health and physical health inpatient and community services. The Carers survey is now part of our automated audits. We our currently surveying young carers in partnership with Hampshire Young Carers Alliance and also carrying out a survey with carers on discharge and the impact on carers.

R17	SHFT should adopt the Patient Safety Response Incident Framework and National Standards for Patient Safety Investigations (published by NHSE/me in March 2020) for reporting and monitoring processes, when they are introduced nationally.	Agreed. The framework has been released and NHS England are working with early adopter sites. The final framework and standards will be informed by the early adopter sites and released in Spring 2022 and organisations are then expected to transition to this. In advance of this we have been developing our own processes to prepare for readiness and recently (October 2021) gained accreditation from the Royal College of Psychiatrists' Serious Incident Review Accreditation Network (SIRAN)
R18	It is recommended that future NHS patient safety frameworks for Serious Incidents should acknowledge and incorporate the different needs of patient groups, such as physical health, mental health and learning disability and the unique context in which the incident took place.	The timing of the publication of the revised Patient Safety Response Incident Framework and National Standards has been delayed with the evaluation report on the pilots released at the end of January. Our investigation process enables the involvement of subject experts from services to incorporate the needs of different patient groups as well as reflecting the needs of individual patients and families in the way the investigation is carried out. Inequalities data is now recorded on Ulysses to identify themes.
R19	SHFT should provide a clear and transparent definition of 'independence' and an open and accessible explanation about its processes for ensuring its investigations are 'independent'. The definition and explanation should be available to service users, carers and family members and staff. SHFT should also set out criteria which indicate when an independent and external investigation in respect of a Serious Incident will be conducted and who, or which organisation, will commission it.	Patients and families are provided with a clear explanation of our approach to independence and a letter confirming this is sent to the family prior to investigation. Our patient and family leaflets have been updated to include a definition on the levels of independence and these will be signed off by the Patient Experience Group in March 2022.
R20	In the case of an enquiry into a Serious Incident that requires an external independent investigation, there should be a fully independent and experienced Chair, the background and qualities of whom should be specific to the facts of the case subject to investigation.	This is current practice. The Trust in conjunction with NHS England, will commission fully independent reviews where appropriate.
R21	Following a Serious Incident, SHFT should ensure that families, carers and service users, with limited resources, can access external legal advice, support, or advocacy services, as required. Due to potential conflicts of interests, SHFT should not	Signposting advice has been collated and is made available to people through the Carers and Patients Hub as well as through our processes for complaints and serious incident investigations. The Family Liaison Officer signposts families to 'Help At Hand' and 'Coroner's guides' for all deaths. Advice also given about how to make a medical negligence claim if the family ask how to do this.

	fund such support services directly, but should explore options with local solicitor firms and Third sector or not-for-profit organisations, to facilitate access or signpost their availability.	
R22	The job description for SHFT's Investigation Officer role should include specific qualities required for that post. The minimum qualities should include integrity, objectivity and honesty.	Job descriptions in Southern Health are clear on the skills, experience, qualities and values required for all roles. The Investigation Officer job description has been reviewed and amended.
R23	SHFT should develop a more extensive Investigation Officer training programme, which includes a shadowing and assessment process. Service users, family members, carers and clinical staff should be involved in the development of this programme. It should include, but is not limited to, regular refresher training, a structured process for appraisals, a continuous professional development plan and reflective practice. This will ensure continuous quality improvement in the centralised investigations team.	The Investigation Officer training package will be updated (June 2022) when PSIRF is launched and following completion of the Healthcare Safety Investigation Branch training (31.3.22). It will be co-produced with the support of the Family Liaison Officer. We will set up a continuous improvement network including patient and family feedback to support the development of the Investigating Officers. This will be collated quarterly and shared with the Learning from Events Group. The Trust already has a structured approach in place for appraisals and we ensure there is access to both reflective practice and a professional development plan.
R24	SHFT should urgently change and improve the Ulysses template for investigation reports to ensure that all completed investigation reports are accessible, readable, have SMART recommendations and demonstrate analysis of the contributory and Human Factors.	The Ulysses template has already been amended as part of the Serious Incident Review Accreditation Network (SIRAN) accreditation, which was successfully achieved in October 2021. An audit will be carried out after 6 months to support continuous improvement on these measures. During 2022 there are likely to be further changes as the Trust introduces the new national standards and also continues to develop the principles of Safety II where we proactively understand the practices and processes in place when things go well.
R25	All completed investigation reports in SHFT should explicitly and separately document the details of family and carer involvement in the investigation, in compliance with any data protection and confidentiality issues or laws.	We agree. This is current practice and is a requirement for the completion of investigation reports.
R26	SHFT must share learning more widely throughout the whole organisation and ensure that staff have ready access to it. The Trust should ensure staff attend learning events to inform their practice.	The Trust has a range of 'Learning from' programmes including Hot Spots, Learning Matters and Governance Snapshots which are available to all staff on intranet. Trust wide Learning from Events groups and specialty level groups are in place. We are currently working with the National Air Traffic Control Services (NATS) on translating lessons into learning, behaviour and culture change.

		This is an area that the Trust will always be working to continuously improve.
R27	SHFT should have in place, as a priority, a mechanism for capturing the views and feedback of the service user, family member and carer about the entire SI investigation process. This should be monitored at regular intervals for learning purposes and should be shared with the central investigations team and the Board.	The feedback form has been co-produced with families. A quarterly report will go to Quality &Safety Committee from quarter one 2022/23, detailing the feedback received. We will collate feedback on investigations from a number of sources including families and Coroners and report this to the Patient Experience and Caring Group. The membership and Terms of Reference of this group has been amended to include their role in hearing feedback about services. Thematic reviews of investigations, complaints and other learning will be shared at the Learning from Events group and Quality & Safety Committee at the end of Q1 (June 2022). There is a staff checklist in place to ensure regular involvement with families and carers which will be audited in April 2022, and we will use this to further develop family/ carer involvement in investigations as part of the PSIRF implementation.
R28	SHFT should improve the quality of the Initial Management Assessments (IMAs) that are provided to the 48-hour Review Panel to ensure that the decision-making process for the type of investigation required is robust, rigorous and timely. This should be done through a systematic training model and quality assurance mechanisms should be put in place	The review and redesign of the Trust's incident review panel processes are ongoing and will be completed by 31st March 2022. A working group involving staff is currently reviewing completion of incident forms and IMAs, the redesign of staff guidance and revised IMA template; and the separation of 48hour panels and mortality panels which will form part of the Medical Examiner review process implementation.
R29	SHFT should produce a quarterly and annual Serious Incidents Report, which should provide a mechanism for quality assurance. It should be presented to the Board and available to the general public, in compliance with data protection and laws.	This is current practice and reports are presented at the Trust Quality and Safety Committee and reported annually through the Trust Quality Account.
R30	The SHFT Board and the Quality and Safety Committee should receive more information on the degree of avoidable harm and the lessons learnt, through regular reporting. Thereafter, that information should be discussed by the Board and shared through the Quality Account and Annual	This is current practice with 'near misses' reported in our quarterly serious incident reports. This is an area for continuous improvement and learning. The Learning from Deaths quarterly report is scrutinised by the Quality and Safety Committee and discussed by the Board.

	Report and with the general public, in compliance with data protection and confidentiality laws. It should address not only the quantitative analysis of all incidents, but it should also reflect a thorough qualitative analysis to identify the relevant themes of current error and future themes for learning.	
R31	SHFT should recognise, implement and develop the role of the Medical Examiner, in line with forthcoming national legislation and guidance.	It has been agreed nationally that the next stage of the Medical Examiner roll out will extend to all deaths in community and mental health wards. The process for this is that the service into the acute hospitals will extend to cover our sites. We are supporting colleagues fully with this approach and will roll out in line with the requirements of the Medical Examiners at UHSFT, HHFT and PHU. The timeline for this is being determined by them and the national requirements.
R32	SHFT should examine the potential of expanding and bringing together the Patient Safety Specialists into a team, led by a Director of Patient Safety, from the Executive level.	The Trust has a group of Patient Safety Clinical Leads (introduced in 2019), embedded within our clinical divisions, who report into the Patient Safety Specialist and are led by the Director of Patient Safety.
R33	SHFT should develop a co-produced Patient Safety Plan, which includes a long-term strategy for the recruitment of Patient Safety Specialists and Patient Safety Partners and a commitment to continuous improvement.	We have a Patient Safety Commitment 2018-25 in place which was co-produced in 2018 and refreshed in April 2021 in consultation with service users and families. The national requirements for the Patient Safety Expert are relatively recent (October 2021) and the Trust is consistent with these. We will continue to review these arrangements in line with the Patient Safety Response Incident Framework and National Standards when they are published during 2022.
R36	All Action Plans that are created by SHFT, at any level of the organisation, should include a deadline and the name of an individual(s) and their role, who is responsible for taking forward the action indicated. They must be monitored to ensure they have been implemented and shared for learning.	This is current practice and action plans are monitored at the appropriate part of the organisation. This may be Divisional or at a Trust wide forum including Board Committees where appropriate. The Learning from Events forum facilitates Trust wide learning. Work is ongoing to streamline action plans and ensure they are outcome focused.
R37	SHFT should introduce a Board-level monitoring system for action plans and the implementation of recommendations made during investigations.	The Learning from Events Forum provides a key role in ensuring actions of improvement are undertaken and learning is shared widely across the organisation. This is attended by

	That process should require tangible evidence to be provided of actions of improvement and learning. That process should be documented and reported on regularly.	Patient Safety Leads. Themes from this and our serious incident reporting also are considered by the Quality and Safety Committee and the Board where appropriate.
R38	SHFT should adopt the NHS Just Culture Guide and put in place an implementation plan to ensure its uptake through its ongoing organisational development and staff training programme. It should ensure that it is well placed within the SHFT recruitment strategy and within all induction programmes for all staff, to particularly include substantive and locum medical staff.	We are developing A Just Culture Implementation Plan, in line with NHS Just Culture Guide, ensuring it is embedded in all our people processes. This will be an areas for continuous improvement.
R39	SHFT should work to ensure that the membership of its sub-committees and its Staff Governors is increased and diversified, so that it better represents the population it serves. It should work with its Governors to do so. This should form part of a long-term strategy and the impact of it should be measured, monitored and reported on through formalised structured processes.	The Board has made it very clear over a number of years that diversity and inclusion is a foundation on which we build our people and services. The Board recognises fully the challenges of workforce and health inequalities that exist with our society and the Trust is committed to addressing these. The Board set an aspiration to be representative of our diverse communities at all levels by 2024. Plans to deliver this have been progressing and reviewed with progress being made against the 2019 baseline. Work will continue with the appointment of a new Associate Director of Diversity and Inclusion (now in post) and a recent audit to inform our priorities for development. We will ensure that our Governors and membership are included as part of this work. We are also taking an active role in the Integrated Care System with the Chief People Officer taking on the Senior Responsible Officer role for Hampshire & Isle of Wight.
Learning Points		
L1	SHFT should avoid terms such as ‘upheld’ or ‘not upheld’ in all complaint investigation reports and response letters.	We ceased this practice in late 2019 / early 2020.
L2	SHFT should consider more effective mechanisms to respond to the immediate needs of carers. That could include a possible helpline or other technical aid in order to lead to a practical response	We are currently able to support carers who are directly involved in our carers’ groups. The Carers and Patients Support Hub is a new resource to support carers. The support hub provides multiple ways for people to get in touch, including online options, text messaging service as well as phone line.
L3	SHFT should work harder to ensure that compassion and respect is reflected in every verbal, written response and communication it has with service users, carers and family members.	We agree and believe we have already made significant steps of improvement. We are currently undertaking a pilot with the Parliamentary and Health Service Ombudsman (PHSO) which includes monitoring and evaluating quality of communication with services, families and carers regarding complaints and investigations. We will implement

		recommended changes following this work. The PHSO are presenting at Quality & Safety Committee in March/April 2022. The pilot will run until 21st October 2022.
L4	SHFT should take a 'team around the family' approach to providing support to families and carers and actively recognise that carers and families are often valuable sources of information and they may be involved in providing care and also in need of support.	We agree. We have several families and carers groups in place and the Carers and Patients Support Hub will provide specific support to individuals. Wider outreach sessions will be developed in the community. We will be able to gain feedback from patients and carers about the effectiveness of these arrangements and will also look to improve further.
L5	SHFT should consider the use of recognised mediation services to resolve outstanding issues with families who have disengaged within the last two years.	The Trust has appropriate mechanisms in place. The Trust will always consider independent support and encourage advocacy.
L6	SHFT should review its 'Being Open' Policy to ensure that it is fit for purpose and actively promote it to staff, service users, carers and family members, in digital and paper formats.	The Being Open policy has been reviewed by the SHFT Family Liaison Officer team. It has been refreshed using the feedback from the following committees. 1. Working in partnership Committee – Lay group with Voluntary sector 2. Carers, Family & Friends Group – Carers and service users 3. Patient Experience & Caring Group – Divisions, teams, carers and patient reps 4. Staff promotion in staff bulletin 5. Caldicott Guardian engagement & advice 6. Learning From Events Forum – Clinical staff Staff guidance is available on the Trust intranet with a printable easy to read leaflet for service users and families which will be available on the public website. The policy and supporting materials will continue to be developed and improved with engagement from staff, carers families and service users.
L7	SHFT should involve service users, family members and carers in the writing of action plans across all investigations. Where requested and the appropriate consent is in place, they should be provided with regular updates on the implementation of the action plan.	This is current practice. We offer this opportunity within our current processes.

L8	SHFT should ensure that staff members and volunteers across all levels of the organisation and a diverse range of service users, carers and family members are part of the Quality Improvement (QI) projects and SHFT's journey of improvement.	Agreed. Our Quality Improvement (QI) Programme has trained staff at all levels in the organisation who have worked alongside more than 150 patients, their families and carers on specific projects. We will continue with this approach as we re-energise our QI programme and move to the next stage of its development.
L9	SHFT should, overall, increase its annual and quarterly reporting by committees and divisions to be accessible to the public it serves.	A review of guidance and good practice is being undertaken.

Note: Recommendations 34 and 35 relate to the Clinical Commissioning Group and Integrated Care System so have not been included in this table.

2. Further information

2.1. The full report (including an Easy Read version) and the Trust's public statement (issued on the day of publication), can be found on the Trust website here: https://www.southernhealth.nhs.uk/about-us/news-and-views/second-stage-review-southern-health-published-today

2.2. Additional information, including the Terms of Reference for the review, can be found on the NHSE/I website here: https://www.england.nhs.uk/south-east/publications/ind-invest-reports/southern-health/

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10th February 2022

Dear colleague,

Publication of CQC report into Southern Health

In October 2021, our Regulator, the Care Quality Commission (CQC) inspected six of our core mental health services and their findings are published in a report today. You can read the full report here and view the ratings 'scorecard' for the Trust at the end of this letter.

The CQC found evidence of progress and good practice in a number of areas which is encouraging. However, the inspectors also highlighted the challenges that our teams have faced due to staffing pressures and in delivering services during the pandemic. As a result, the overall rating for the Trust has changed from 'Good' to 'Requires Improvement.'

We are of course disappointed by the change in rating. However, we are encouraged to see that the CQC praised our staff and culture, heard positive feedback from patients and found strong, supportive leadership actively addressing the challenges. The CQC found that the Trust was learning from the past and continuing to move forwards as an organisation. Inspectors also recognised the innovative way that the Trust has responded to the pandemic.

Our staff have worked tirelessly during the last two years, often in extraordinarily challenging circumstances, to deliver care to patients and their families and we are hugely grateful for everything they do. The CQC highlighted the sense of pride that staff had in their work, their drive to keep improving, and their commitment to supporting their patients. We are responding to our staffing pressures by continuing to prioritise the engagement, health and wellbeing of our people, and carrying out extensive recruitment and retention programmes.

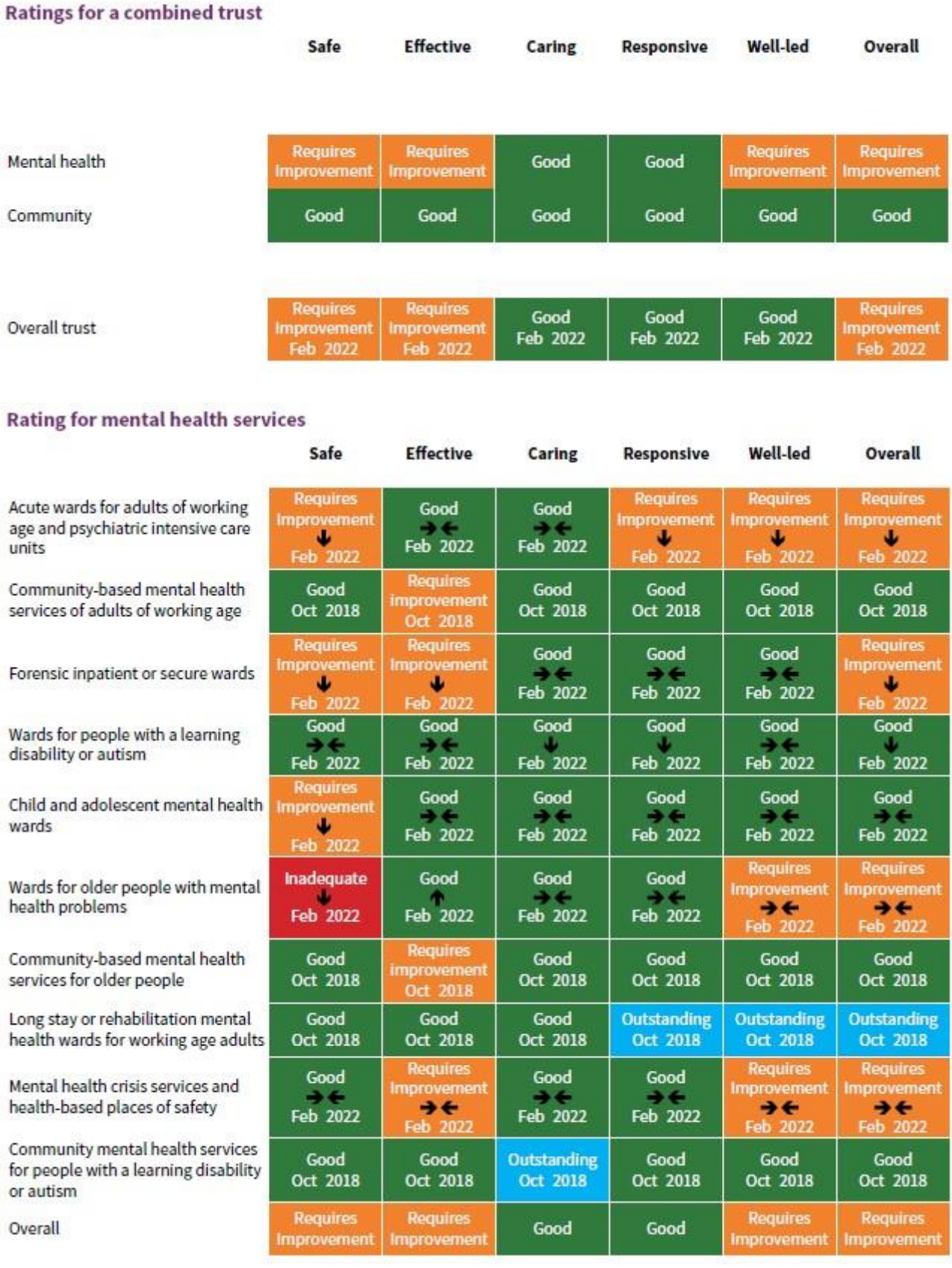
As can be seen in the report, the Trust has many good services and we will continue to improve in those areas identified by the CQC. We remain totally committed to providing the best possible care to our patients and communities.

If you would like to discuss the report and how we are responding, please get in touch via Helen Richmond (helen.richmond@southernhealth.nhs.uk).

With best wishes,

Ron Shields, Chief Executive and **Lynne Hunt, Chair**
Southern Health NHS Foundation Trust

CQC 'scorecard' for Southern Health:



Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Mental health	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Community	Good	Good	Good	Good	Good	Good
Overall trust	Requires Improvement Feb 2022	Requires Improvement Feb 2022	Good Feb 2022	Good Feb 2022	Good Feb 2022	Requires Improvement Feb 2022

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement ↓ Feb 2022	Good →← Feb 2022	Good →← Feb 2022	Requires Improvement ↓ Feb 2022	Requires Improvement ↓ Feb 2022	Requires Improvement ↓ Feb 2022
Community-based mental health services of adults of working age	Good Oct 2018	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Forensic inpatient or secure wards	Requires Improvement ↓ Feb 2022	Requires Improvement ↓ Feb 2022	Good →← Feb 2022	Good →← Feb 2022	Good →← Feb 2022	Requires Improvement ↓ Feb 2022
Wards for people with a learning disability or autism	Good →← Feb 2022	Good →← Feb 2022	Good ↓ Feb 2022	Good ↓ Feb 2022	Good →← Feb 2022	Good ↓ Feb 2022
Child and adolescent mental health wards	Requires Improvement ↓ Feb 2022	Good →← Feb 2022	Good →← Feb 2022	Good →← Feb 2022	Good →← Feb 2022	Good →← Feb 2022
Wards for older people with mental health problems	Inadequate ↓ Feb 2022	Good ↑ Feb 2022	Good →← Feb 2022	Good →← Feb 2022	Requires Improvement →← Feb 2022	Requires Improvement →← Feb 2022
Community-based mental health services for older people	Good Oct 2018	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Long stay or rehabilitation mental health wards for working age adults	Good Oct 2018	Good Oct 2018	Good Oct 2018	Outstanding Oct 2018	Outstanding Oct 2018	Outstanding Oct 2018
Mental health crisis services and health-based places of safety	Good →← Feb 2022	Requires Improvement →← Feb 2022	Good →← Feb 2022	Good →← Feb 2022	Requires Improvement →← Feb 2022	Requires Improvement →← Feb 2022
Community mental health services for people with a learning disability or autism	Good Oct 2018	Good Oct 2018	Outstanding Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Oct 2018	Good Oct 2018	Outstanding Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community health inpatient services	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community end of life care	Good Oct 2018	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community urgent care service	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community health services for children and young people	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Overall	Good	Good	Good	Good	Good	Good

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Southern Health NHS Foundation Trust

Inspection report

Headquarters
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Tel: 02380874036
www.southernhealth.nhs.uk

Date of inspection visit: 5 Oct to 3 Nov 2021
Date of publication: 10/02/2022

Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

We award the Use of Resources rating based on an assessment carried out by NHS Improvement. Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Overall summary

What we found

Overall trust

We carried out an unannounced comprehensive inspection of six of the mental health services provided by Southern Health NHS Foundation Trust as part of our continual checks on the safety and quality of healthcare services.

Following this inspection, we rated the trust 'requires improvement' overall. In addition, we rated each of the key questions – safe and effective as requires improvement and caring, responsive and well led as good overall. The rating of safe had reduced from good to requires improvement.

During this inspection we inspected six of the Trust's core services and rated two as good (wards for people with a learning disability or autism, child and adolescent mental health wards) and four as requires improvement (forensic inpatient/secure wards, wards for older people with mental health problems, crisis services and health based places of safety and acute wards for working age adults and psychiatric intensive care units).

The rating for acute wards for working age adults and psychiatric intensive care units and forensic inpatient/secure wards had reduced from good to requires improvement. The rating for mental health crisis services and health-based places of safety and wards for older people with mental health problems remained requires improvement. Additionally, wards for people with a learning disability and autism had reduced to good from outstanding.

We also undertook an inspection of how 'well-led' the trust was, and we rated this good. Southern Health NHS Foundation Trust is one of the largest providers of mental health, specialist mental health, learning disabilities and community health services in the UK with an annual income of approximately £316 million. The trust provides these services across Hampshire. It employs 5,927 staff who work from over 200 sites, including community hospitals, health centres and inpatient units as well as delivering care in the community. The trust has 634 inpatient beds. The trust

Our findings

received foundation status in April 2009 under the name Hampshire Partnership NHS Foundation Trust. Southern Health NHS Foundation Trust was formed on 1 April 2011 following the merger of Hampshire Partnership NHS Foundation Trust and Hampshire Community Healthcare NHS Trust. The trust has a well-publicised history of challenges and regulatory action, culminating in successful prosecutions by CQC and the Health and Safety Executive. The trust has taken action to address the issues that resulted in the prosecutions and have used these to learn and improve the services.

Southern Health NHS Foundation Trust provides community health, mental health and specialist mental health and learning disability services for people across the south of England. Covering Hampshire, the trust is one of the largest providers of these types of services in the UK.

Our last comprehensive inspection of the core services was in October 2019 when we inspected four mental health core services.

At our last inspection we rated the trust as good overall.

The core services inspected on this occasion were chosen due to intelligence that we held, with a decision to inspect made on the balance of risk to service users. This included consideration of the previous inspection and ratings.

The trust provides ten mental health core services

- Acute wards for adults of working age and psychiatric intensive care units (PICU's)
- Long stay/rehabilitation mental health wards for working age adults
- Forensic inpatient / secure wards
- Child and adolescent mental health wards
- Wards for older people with mental health problems
- Wards for people with a learning disability or autism
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Community-based mental health services for older people
- Community mental health services for people with a learning disability or autism

The trust also provides two specialist mental health services

- Perinatal service
- Eating disorder service

The trust provides five community health core services:

- Community health services for adults
- Community health services for children, young people and families
- Community health inpatient services
- End of life care

Our findings

- Urgent care

On this inspection we inspected six mental health core services:

- Acute wards for adults of working age and psychiatric intensive care units (PICU's)
- Child and adolescent mental health wards
- Forensic secure wards
- Wards for older people with mental health problems
- Wards for people with a learning disability or autism
- Mental health crisis services and health-based places of safety

Experts by experience (people who have experience of using services or caring for those who use services) and specialist advisors (senior practitioners with specialist knowledge and experience of working in the core services areas) were part of the inspection teams for each core service inspection and so helped us collect high quality evidence and make robust judgements.

We also looked at how well-led the trust was. In order to ensure we have appropriate expertise to make a robust judgement about how well-led the trust is, our inspection team comprised an executive reviewer (a board level leader from another organisation rated good or outstanding), a specialist advisor with expertise in governance and a senior leader from NHSI/E with financial expertise as well as CQC inspection team members.

Our rating of services went down. We rated them as requires improvement because:

We rated two of the key questions, ‘are services safe and effective’ as requires improvement. We rated three of the key questions, 'are services caring and responsive and well led' as good.

We rated two of the trust’s mental health services as good and four as requires improvement. In rating the trust, we considered the current ratings of the nine services we did not inspect this time which have retained the previous ratings.

We had serious concerns about the safety on one of the wards for older people with mental health problems. As a result of the significant concerns identified, we wrote to the trust to seek immediate assurances about the safety of the service. We advised them that if there was not significant improvement in the safety of care on the ward, we would take enforcement action to address the issues. The trust responded by reducing the bed numbers, improving the staffing ratio, reviewing risks and practices around safeguarding and falls. The trust submitted an action plan to CQC to demonstrate how the changes were to be implemented and embedded going forward. Following two further visits to the ward, the inspection team were satisfied that immediate risks to patient safety had been addressed to prevent immediate and significant enforcement action being taken. Leaders at all levels were not cited on and did not recognise the seriousness of the issues on Beaulieu Ward and the significant safeguarding concerns found in incidents were not picked up and acted upon.

The trust had difficulty attracting substantive staff. Staffing levels were not always being met. We identified concerns relating to staffing levels in four of the six services we inspected. Staff told us there were not always enough staff to effectively manage higher acuity patients at Ravenswood House Medium Secure Unit, leaving them and patients

unsupported. The crisis service at Parklands reported a high vacancy rate and had an over reliance on the use of agency staff and staff on the older persons and acute and PICU wards did not always have enough staff to keep patients safe. Staff on the acute and PICU wards told us that this meant they were not always able to provide the level of care to patients that the patient should expect. This included less leave and less time in therapy focused work.

Some staff in mental health services felt unsafe due to an increase in the acuity of illness of the people they were caring for and incidents of violence against staff. Staff told us that the number of injuries to staff and patients during incidents of aggression on the acute and PICU wards were increasing and they did not always respond to changes in risk. Staff felt pressured to admit patients onto wards when it was unsafe.

There were pockets of low morale across the trust, this was impacted by staffing pressures.

In three of the services inspected, we found gaps in the recording of National Early Warning Score 2 (NEWS2) records we reviewed. This included missed entries, missed signatures and totals not completed. In the absence of these records where a patient's deteriorating health should have been escalated in line with national guidance, this could have been missed and not escalated.

Several strategies had been put on hold during the COVID-19 pandemic and there was work to do to bring the clinical strategy and the wider trust strategy together into a comprehensive document that set out the direction clearly. There was a clear vision that was understood and articulated by a number of the senior leadership team around working in partnership and collaboration to deliver good quality services to meet the health needs of the local population – although there was a need to ensure this and what it meant is communicated effectively to a wider audience.

However:

One of the biggest risks in the organisation was staffing in the mental health inpatient wards, the trust had plans in place regarding recruitment and the board recognised this was an area which needed to be achieved at pace.

Staff were proud to work for the trust. There was a strong sense of staff at all levels putting patients at the heart of everything they do. All staff were respectful, compassionate and kind towards patients. Staff were also friendly, approachable and supportive. We saw positive interactions between staff and patients. Staff were highly motivated and provided care in a way that promoted patient's dignity.

The trust leadership was now stable and capable. Since the last inspection the board had appointed a new chief executive and a new medical director. Two new non-executive directors (NEDs) also joined the trust during the pandemic.

The trust had a Board Assurance Framework and a risk register which were regularly reviewed. The performance team delivered good quality reports for each division to have an overview of risk within the divisions.

We found that the trust now had a highly skilled, strong, stable and experienced senior team, including the chair and non-executive directors. Leaders had the skills, knowledge, integrity and experience to perform their roles and had a good understanding of the services they were responsible for delivering. They were visible in the service and approachable to patients and staff.

Our findings

There was a strong estate's, workforce, digital and safeguarding team, medical and financial leadership. Nursing and AHP leadership were strong and the team communicated well and knew the issues they faced and were clear about how they would address them. There was strong leadership of the Council of Governors with a clear view on working in partnership whilst challenging the board to ensure safe and effective service delivery on behalf of the public.

We met individuals and teams who were very proud of working at the trust; with lots of hope for the future. The trust was building on the past and getting to grips with the job of taking the organisation forward. The trust was coming through legacy issues and learning from these, building. Everyone we met spoke positively.

People accessing the learning disability ward were receiving safe and effective care. They were treated with dignity; risks were assessed, and the environment was safe. They received kind and compassionate care.

The trust engaged well with patients, staff, equality groups, the public and local organisations. Trade union representatives were very positive about how the trust leaders worked with them in an open and transparent way and had supported staff throughout the pandemic.

The trust had reviewed their disciplinary policy and made changes based on a Compassionate and Just Culture model.

There was good practice and innovation around IT and the digital focus. Digital development and information governance systems were strong with consistent clinical and service line engagement.

Learning from serious incidents had been strengthened and the trust had been rewarded accreditation through the Royal College of Psychiatrists' Serious Incident Review Accreditation Network (SIRAN). The trust used 'favourable event reporting' where they learned from things that had gone well in the same way they learned from things that had not gone so well. The aim was to replicate good practice and disseminate this across the trust. The trust had responded to serious incidents and investigated them. Following the inspection, a serious incident occurred at Parkland's hospital that resulted in the death of a patient. The trust had commissioned an independent investigation into this and worked closely with the police.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

We used CQC's interim methodology for monitoring services during the COVID-19 pandemic including on site and remote interviews by phone or online.

For the child and adolescent mental health wards inspection, the inspection team:

- visited all three sites, looked at the quality of all the ward environments and observed how staff were caring for patients,
- spoke with 14 young people who used the service and six family members,
- looked at 21 electronic and paper copies of care and treatment records,
- observed an assessment and admission meeting, a shift handover meeting, a daily team meeting and two ward round meetings,

Our findings

- spoke with 35 staff including a head of nursing, a head of operations, three modern matrons and three ward managers. We also spoke to members of the multidisciplinary team, social workers and a pharmacy technician,
- reviewed a range of documents relating to the running of the service,
- looked at medicine's management, including medicine charts.

For the adults of working age and psychiatric intensive care unit's inspection, the inspection team:

- visited eight wards at the three sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 22 patients who were using the service both in person and via telephone calls.
- spoke with five carers
- spoke with the ward managers or interim managers for each ward
- spoke with 37 other staff members; including doctors, nurses, occupational therapist, occupational therapy assistants, healthcare assistants, social workers, pharmacy technicians and a psychologist
- attended and observed multi-disciplinary meetings and safety huddles
- looked at 21 care and treatment records of patients
- carried out a specific check of the medicine management on all wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service

For the wards for people with a learning disability or autism inspection, the inspection team:

- visited Ashford and looked at the quality of the environment and observed how staff were caring for people
- spoke with head of operation and modern matron
- interviewed the ward manager
- checked the clinic room
- spoke with eight patients
- spoke with five staff including nursing staff, support workers and positive care and safety coordinator
- spoke with the forensic psychologist, occupational therapist, social worker
- reviewed five care records and 10 treatment records
- reviewed several meetings minutes and looked at a range of policies and procedures related to the running of the service

For the wards for older people with mental health problems inspection, the inspection team:

- visited four wards
- interviewed the four ward managers
- checked the clinic rooms and reviewed the medicines charts.

Our findings

- spoke with 17 patients
- spoke with five carers or relatives of patients
- spoke with 26 staff including doctors, nurses, occupational therapist, occupational therapy assistants, healthcare assistants, social workers
- reviewed 33 care and treatment records of patients
- reviewed several policies, meetings minutes, personnel records and supervision records
- observed staff meetings on the wards, including multidisciplinary team meetings, ward rounds, staff handover meetings, patient safety at a glance (PSAG) meetings

For the forensic inpatient/secure services inspection, the inspection team:

- visited six wards at the two sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 16 patients who were using the service both in person and via telephone calls.
- spoke with 3 carers
- spoke with five ward managers
- spoke to the modern matrons of the two sites
- spoke to 3 consultant psychiatrists and 5 junior doctors
- spoke with 28 other staff members; including a psychologist, an occupational therapist, a pharmacy lead, two pharmacist technicians, a social worker, nurses, health care assistants, a ward administrator and student nurse.
- attended and observed one handover meeting, a morning planning meeting, a Situation Report (sitrep) meeting and multidisciplinary care review meetings for three patients
- looked at 32 treatment records of patients
- reviewed 34 medicine prescription charts
- reviewed eight staff records
- looked at a range of policies, procedures and other documents relating to the running of the service.

For the mental health crisis and health-based place of safety inspection, the inspection team:

- Visited the crisis teams, also known the home treatment teams within Parklands and Antelope House. These teams are recognised within the Trust as Crisis Resolution and Home Treatment teams (CRHT).
- Visited the crisis team at Elmleigh, who acknowledge and process referrals, provide face to face assessments of patients before the case is handed over to the home treatment teams located in other areas of the region.
- Visited the Parklands health-based place of safety (HBPoS), the HBPoS at Antelope House and Elmleigh were being used during the time of our visits.
- Reviewed 11 care and treatment records of patients using the HBPoS.
- Reviewed nine care and treatment records of patients across the crisis and home treatment teams.

Our findings

- Attended two multi-disciplinary team meetings.
- Spoke to 22 staff members; including clinical team leaders for the home treatment team and health-based place of safety, qualified nurses, service managers, healthcare assistants, consultant psychiatrists, operational director, patient flow manager.
- Looked at a range of policies, procedures and other documents relating to the running of the service.
- Spoke with one patient who had used the health-based place of safety, and five patients who had been supported by the home treatment team.
- Spoke with one family member of a patient.

What people who use the service say

On the older persons ward except for one patient, all patients who were able to talk to us said they were happy with their care and positive about their experience. Patients were able to say the activities were good and there was a good choice of food. Patients said that staff took time to listen to them and staff are very caring. Patients said they knew who their named nurse was, and they could speak to them if they had a problem.

Within the crisis service patients told us staff were respectful and kind. Patients and their carers told us that staff were caring and supportive.

Within CAMHS, young people were largely positive about their experiences at the service. The young people we spoke with reported feeling safe and felt that the staff were kind and respectful and took a genuine interest in their care and wellbeing. Young people told us that they had the opportunity to maintain contact with their families, were involved in care and discharge planning and had copies of their care plans. Young people said that food was generally good, and they particularly enjoyed some BBQs during the pandemic. They also told us that they had access to doctors when needed.

We received mixed information from young people regarding activities. Whilst some young people in Austen House told us that activities were not cancelled and they had two activity coordinators, young people at Bluebird House told us that they were bored during weekends and there was not enough staff. Young people at Leigh House told us that there were issues with staff shortages and as a result walks were cancelled.

Some young people and relatives at Leigh House told us that they were unhappy that sometimes male staff were carrying out observations of young females. Some young people at Austen House raised some issues with us which we followed with staff and received explanations.

We also received positive feedback from the families we spoke with about the quality of care young people received from staff. Most of the relatives we spoke with felt that young people were safe and that visiting arrangements were good. Some relatives told us that that they participated in ward round meetings, kept informed and received ward round notes. However, some relatives were concerned about staff shortages and the arrangements for contact with families as sometimes they received too many calls in one day.

At Ashford people told us the staff were very kind, supportive and helped them to understand information. They praised the staff and said they were helpful and understood their needs. Although people said the ward was short staff at times, they gained attention from staff when they needed to discuss their needs and how they were going to be supported.

Our findings

On the Acute and PICU wards most of the feedback we received from patients and carers was positive. Patients told us that staff were polite and respectful and that they felt safe on the wards. Patients also told us that there were enough activities and regular leave. However, they also told us that the wards were often short staffed and that leave, and activities were sometimes cancelled because of this. Patients also said that that if there were incidents on the ward they did not feel as safe. Patients told us this was because the staff had to manage the incident.

The carers we spoke to told us that staff cared for their family member or friend and treated them well. Staff involved carers in the patients care. However, they also told us it was difficult to contact the ward at times and the quality of the information you received depended on who answered the phone.

Within the forensic ward's patients said staff treated them well and behaved kindly. Fourteen of the patients we spoke with told us staff were approachable and very supportive. However, they also commented that the quality for the food could be improved.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services in line with legal requirements. This action related to five services.

Location/core service

Wards for older people with mental health problems

- The trust must ensure there are enough suitable skilled and experienced staff on every shift at Beaulieu ward to keep patients safe. (Regulation 18).
- The trust must ensure that there are no same sex breaches on the wards and there is access to the female only designated lounge. (Regulation 12).
- The trust must ensure that safeguarding incidents are reported in line with local and national policy. (Regulation 13).
- The trust must ensure that the outside space on Beechwood ward is safe for patients. (Regulation 12).
- The trust must ensure that people's physical health following the administration of rapid tranquilisation medicines. (Regulation 12).
- The trust must ensure that patients are observed in line with their observation policy and that staff are not placed on constant observations for long periods of time. (Regulation 12).
- The trust must ensure that staff follow the NEWS 2 escalation process when indicated. (Regulation 12).
- The trust must ensure that the internal assurance processes work effectively to monitor and mitigate risks. (Regulation 17).

Our findings

Crisis & HBPOS

- The trust must review the S136 policy and consider how those detained under S136 are assessed in a more timely manner by a doctor in the first instance (Mental Health Act 1983 Code of Practice 10.31), and ensure that approved mental health professionals (AMHPs) attend the health based places of safety in a timely manner. The Mental Health Act 1983 Code of Practice 10.28 states that the 'Assessment by the doctor and AMHP should begin as soon as possible after the arrival of the individual at the place of safety'. (Regulation 9).

Forensic secure service

- The trust must ensure there are sufficient numbers of suitably qualified, skilled experienced staff deployed at all times to meet the patients care and treatment needs. (Regulation 18).
- The trust must ensure that NEWS2 are completed consistently across the service and results are escalated appropriately and action taken and documented. (Regulation 12).
- The trust must ensure all care plans are comprehensive, reflect patient involvement and are personalised and holistic and are recorded and updated consistently across the service. (Regulation 12).

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

- The trust must ensure there are sufficient numbers of appropriate skilled and qualified staff are deployed on all wards at all times to meet the patients' needs. Regulation 18: Staffing (1)
- The trust must ensure that staff report all incidents, and that sufficient detail is included in the reports to understand and manage the ongoing risk. Regulation 12: Safe care and treatment (1)(2)(a)(b)
- The trust must ensure that staff complete observation documentation correctly in line with policy and best practice and appropriate action is taken when indicated. Regulation 12: Safe care and treatment (1)(2)(a)(b)
- The trust must ensure that risk assessments are completed correctly, and care plans are updated following all risk events. Regulation 12: Safe care and treatment (1)(2)(a)(b)
- The trust must ensure staff take appropriate action to monitor patients' physical health care needs when indicated by NEWS charts. Regulation 12: Safe care and treatment (1)(2)(a)(b)
- The trust must ensure high dose anti-psychotic monitoring forms are completed when required, so that appropriate action can be taken if the medication is having a negative effect on the patient's physical health. Regulation 12: Safe care and treatment (1)(2)(g)
- The trust must ensure that staff follow the controlled drug policies. Regulation 12: Safe care and treatment (1)(2)(g)
- The trust must ensure that there is a clear admission and discharge pathway. The pathway must clearly demonstrate criteria for admission to PICU beds and ensure this is followed. Regulation 12: Safe care and treatment (1)
- The trust must ensure that they have systems in place that support the ward staff to ensure safe and effective admissions and discharges. Regulation 12: Safe care and treatment (1)
- The trust must ensure that all staff feel able to raise concerns about the service and demonstrate what actions they have taken and why. Regulation 12: Safe care and treatment (1)

Child and adolescent mental health wards

Our findings

- The trust must ensure that there are always enough skilled and experienced staff deployed in all units at all times to keep patients safe and meet their needs. (Regulation 18).

Action the trust SHOULD take to improve:

Location/core service

Wards for older people with mental health problems

- The trust should ensure that staff are listened to when they raise concerns.
- The trust should ensure that patients discharges are planned from the start of their admission.

Crisis & HBPOS

- The trust should ensure they take proactive steps to address the lack of substantive nursing and medical staff across the service.
- The trust should ensure they take steps to improve the quality of patient care plans and ensure all patients are offered copies of their care plans.
- The trust should ensure lessons learned are shared with all staff to support improvements in the provision of care.
- The trust should review working arrangements with external providers for staffing the health- based place of safety to ensure patient safety.

Wards for people with a learning disability or autism

- The trust should ensure that people are supported at all times by sufficient numbers of appropriately skilled staff at all times. The deployment of staff must be sufficient to ensure the staff can meet people's needs and enable them to achieve outcomes safely and in a timely manner.
- The trust should ensure that activities planners are reflective of the activities that are available to people.
- The trust should ensure that training targets are met, and staff have the skills required to meet people's needs
- The trust should ensure communication care plans are in place for people who require support with understanding information

Forensic secure service

- The trust should ensure the patient risk assessment and risk management plan are recorded consistently.
- The trust should review the provision of food on the wards and portion sizes.
- The trust should continue to address morale issues among staff.

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

- The trust should ensure clean stickers are placed on all appropriate equipment following cleaning.
- The trust should ensure all patients are given copies of their care plans.
- The trust should ensure no local restrictions are in place regarding bedroom or cup access.
- The trust should review all capacity assessments to ensure they all explain why the patient lacks capacity.

Our findings

Child and adolescent mental health wards

- The trust should ensure that ligature risk assessments include completion dates for actions, and control measures clearly indicate how risks are mitigated.
- The trust should ensure that there is a system in place for monitoring whether the company contracted to check the emergency medications in grab bags delivers the service appropriately, and staff always follow systems and processes when recording and storing medicines.
- The trust should ensure there are enough activities for young people throughout the week, including at weekends.
- The trust should ensure that all staff at Leigh House receive regular supervision.
- The trust should address the staff morale issues at Leigh House and should provide appropriate support and debriefs after incidents.
- The trust should ensure that the issues with the acoustics at Austen House are rectified

Is this organisation well-led?

Leadership

Since the last inspection in October 2019, there had been some changes to the trust board. The trust had appointed a new chief executive, medical director and two non-executive directors.

The non-executive directors (NEDs) had the appropriate range of skills, knowledge and experience. They all had experience as senior leaders in a range of organisations and brought skills such as a knowledge of finance, strategic development, legal, probation service, information technology, working in partnership and transforming services. All board members had lead areas including non-executive directors who chaired specific committees or were leads on areas of work.

The trust leadership was stable and capable. The trust had purposefully implemented the recommendations of the independent review of the well-led domain undertaken by the Good Governance Institute (GGI) in 2020 and was continuing to make good progress. Work continued to embed these improvements fully and to develop processes for assurance, quality, performance, innovation, and learning.

The trust leadership demonstrated a high level of awareness of the priorities and challenges facing the trust and how these were being addressed. The trust leadership had demonstrated an ability to adapt at a fast-changing pace during the COVID-19 national pandemic.

The trust leadership team had actively engaged with staff throughout the pandemic, reasonable adjustments were made for BME staff and clinically vulnerable staff early on into pandemic.

Fit and Proper Person checks were in place. The trust had an appropriate process for carrying out their duties in respect of the Fit and Proper Person Regulation. Files were fully compliant and there was a yearly check and update process in place.

A number of NEDs undertook hearings as Mental Health Act Review Managers.

Our findings

Vision and Strategy

The trust vision and objectives were consistent and credible. The trust recognised that the trust strategy and enabling strategies required refreshing and the trust had commenced work to ensure that this would be completed in 2022/23.

The trust were proactively working with other providers to facilitate the strategic development of mental health and community health services within the Integrated Care System (ICS). The trust was actively involved across a wide range of workstreams and in ensuring that mental health and learning disability services achieved a parity of esteem and equity in resources.

In 2019/20 the trust set out a five-year strategy, with four identified strategic priorities:

- Improve health and wellbeing through outstanding services
- Become the best employer
- Transform services through integration and sustainable partnerships
- Improve value

The trust also had a set of values which underpinned its work. These were:

- Patients and people first
- Partnership
- Respect

Culture

The newly appointed Equality and Diversity lead was passionate and committed. The trust was working to address the gaps in the trust approach and had identified the need for a Diversity and Inclusion steering group with executive membership.

Some staff expressed concern about speaking up and raising concerns. Senior leadership were aware and worked to address these concerns, arranging to make themselves available to groups of staff.

The Freedom to Speak up Guardian (FTSuG) had expanded their team since our last inspection. The substantive FTSuG had recently stepped down and there was an interim in post while recruitment was carried out, who was supported by an assistant FTSuG. Staff felt able to raise issues via the FTSuG mechanism. The trust were looking at the model of the Freedom to Speak up Guardian function and moving towards a team, rather than a single individual. They had recruited two more assistant guardians and the appointment of the new permanent guardian was pending. Most issues raised with the FTSuG were to do with staffing, staff safety and the need for support for staff.

The trust actively sought feedback from patients and carers to influence and develop service delivery. The trust had 194 carers leads across the organisation, in nearly all services, who act as advocates and champions of the triangle of care. This was co-produced with carers and patients. There was a carers network and carer support groups within services. The trust also employed more experts by experience and this team was embedded within the organisation. The trust also had a peer support programme in place. All Quality Improvement projects had patient experience representation.

Staff networks

Our findings

As part of the trust's work around equality, diversity and inclusion there were four established staff networks. The networks were focused on the promotion of diversity in the workplace. The networks were comprised of peer groups of staff who used the networks as a safe space for peer engagement and support as well as a forum for providing feedback to the trust senior leadership on areas and opportunities for improvement. The networks in the trust were:

- Black Minority Ethnic (BME) staff network
- LGBTQI+ staff network
- Disability staff network
- Spirituality staff network

The trust also had the Staff Carers Together group which had been developed in January 2021 for staff who were also carers, following feedback from the Carers Rights Day in November 2020. The purpose was to listen to staff, understand their experiences within the trust, offer opportunities for them to share and learn from each other through peer support, and tell the trust how they can support them better.

A number of NEDs and executives had undertaken Ally training and are part of the trust's Allies Network.

Governance

The Audit, Risk and Assurance Committee has identified some issues in the alignment of the Board Assurance Framework and Corporate Risk Register and had made recommendations to address this. Like many organisations, the COVID-19 pandemic had impacted responsiveness to independent recommendations from audit providers. Timely implementation of recommendations is, however, an indicator of a well-led organisational focus on the systems of internal control. Interviews and observation confirmed a good understanding of risks to achievement of strategic priorities and a clear understanding of the actions required to control and mitigate risks.

Digital development and information governance systems were strong with consistent clinical and service line engagement. The development of the Mobile RIO tool during the COVID-19 pandemic evidenced significant direct patient hour contact gains. Staff can use the tool in patient's own homes, work on care plans side by side and ensure the patient's voice is reflected in the care plan. This frees up clinical time to care.

The trust's Digital Strategy expires at the end of the financial year. It was felt to have become outdated, following new appointments to digital teams and developments due to COVID-19. The new strategy will be developed with stakeholder engagement which will start at board level, and will include input from NEDs, patients and service users.

Digital leads within each division who represent different specialities such as mental health and physical health have regular meetings with digital team and discuss technology projects.

Management of risk, issues and performance

The trust accountability and performance framework was robust, clear, and well executed. Management reporting supported clear financial oversight of service lines.

Our findings

The trust integrated performance report was clear and well structured. External benchmarking of services is developing and insights from patient level costing were also under development. The information presented for decision making was systematically reviewed to ensure completeness, accuracy, reliability, timeliness, and relevance.

There was a need to recruit a risk manager, but at the time of inspection, this work was sitting with the Company Secretary in addition to their substantive role.

The trust had reviewed their disciplinary policy and made changes to implement a 'Compassionate and Just Culture' model.

The trust leadership was clear that the biggest risk was the workforce, the ability to recruit and retain staff.

The trust had developed good crisis pathways and had adapted these during the COVID-19 pandemic to divert people from attending A&E. The trust operated the Safe Haven crisis café. This was opened in March 2020 as a drop-in service. During the COVID-19 pandemic this moved to a virtual model due to social distancing. The trust also had a mental health crisis car and ambulance car which was staffed by personnel with mental health training. The crisis pathways were well advertised and promoted on social media.

Information Management

The Integrated Performance Report was independently reviewed by NHSE/I and rated as 'Green'. The Trust remained committed to a process of continuous improvement for the report. The Integrated Performance Report contained a plan on a page summary that detailed the Trust Strategic priorities, described success and specified the outcomes that measure success.

Regulatory performance was presented graphically with summary supporting narrative and analysis of the chart. Strategic Priorities were reported as domains and the Board Assurance Risk relating to the domain was summarised showing the accountable lead, the sub-committee of the Trust Board providing oversight and assurance and the current risk score against the target risk.

The Integrated Performance Report for Month 3 (June) was presented to the Trust Board on 27 July 2021. Under Strategic Domain: Become the best employer, the Trust reported that the outcome measure SHFT is well-led and one of the best places to work in the NHS as Amber (At risk). This was attributed to recruitment challenges, a slowing down in improvements in Staff Survey results presented to the Trust Board in March 2021, and initial feedback from the Summer Cultural Insights Survey that showed stabilisation but no improvement in cultural indicators.

The trust reported a high level of confidence in the completeness, timeliness, relevance, and accuracy of information presented. Information Governance processes were reported to be strong and clinical engagement in digital and information governance development and controls was observed to be strong.

The trust had rolled out the electronic patient system onto staff mobile phones as an app. The trust had been runners up for a Healthwatch award for the work on this. The trust had also introduced video appointments during the COVID-19 pandemic and had been shortlisted for an HSJ award.

Engagement

Our findings

The trust utilised a number of communication methods such as the intranet, blogs and newsletters to ensure staff, patients and carers could access the most up to date information. There were opportunities for patients, carers and staff to feedback on services.

The engagement of younger people and employment of patients with lived experience in the development and planning of services was purposeful and innovative.

The trust Council of Governors are an effective and engaged body who contribute significantly to the work of the trust.

The trust had 194 carers leads in post, and all quality improvement projects have service user voice as part of the process. The trust have actively sought patient and carer feedback and involvement in service delivery.

During the pandemic, the trust had actively supported other organisations locally, offering financial support to voluntary groups.

Since our last inspection the trust had strengthened its family liaison service with the appointment of two additional family liaison support workers. The trusts family liaison officers had chaired the national forum and were leading on some national work. The FLO's function is to make contact with the family and explain the trust process for investigating the serious incident, offers a meeting & follows up with a letter. The FLO priority is supporting the family through the initial investigation or inquest, and they are guided by the family.

Learning, continuous improvement and innovation

NHS trusts can take part in accreditation schemes that recognise services' compliance with standards of best practice. Accreditation usually lasts for a fixed time, after which the service must be reviewed. The trust had been awarded Royal College of Psychiatrists' Serious Incident Review Accreditation Network (SIRAN). The services Lyndhurst, Malcolm Faulk and Mary Graham Wards at Ravenswood House & Cedar, Oak and Beech Wards at Southfield had received Quality Network for Forensic Mental Health Services (QNFMHS) accreditation.

The Trust Board of 25 May 2021 noted that Committee effectiveness reviews were now underway with outcomes due to be reported to upcoming Committee meetings.

Learning from serious incidents had been strengthened since the arrival of the new medical director. A 'Learning from deaths' report went to quality and safety committee and then to the board. Clinical teams were involved in the serious incident investigation process, so there was learning throughout, not only at the end of the process. The direct team, divisional lead and patient safety officer disseminated learning. An action plan was developed at the end of the serious incident investigation, the team came to an evidence improvement panel to look at actions and learning. Evidence of learning was disseminated through trust communication's; all learning went to a trust wide group.

The trust used 'favourable event reporting' where they learned from things that had gone well in the same way they learned from things that had not gone so well. The aim was to replicate good practice and disseminate this across the trust. The trust also had 'evidence of improvement' panels which met to ensure improvements had been made after a serious incident had been closed. Families and CCGs were invited to be involved in these panels.

Our findings

‘Triangle of Care’ involves putting the focus on the service user. Many staff had undertaken training and had been assessed and have won awards and accreditation for the way they have implemented this programme. It aims to ensure patients have a better experience and staff work around them.

The Expert by Experience Co-Ordinator worked trust wide to support people with lived experience, advocating for mental health and sat with the equality and improvement team. Educating clinical and non-clinical staff to support service users when doing clinical improvement work. The lived experience and advisory panel was attended by managers, as a way for them to seek a service user voice or opinion. The trust was offering part time posts for peer support roles, trying to reach all demographic groups.

The trust had funding from NHS ‘mind the gap’ for a project to support their work to reach out to black and minority ethnic groups. The trust were also looking at utilising social media to reach Black and minority ethnic groups.

A number of NEDs were involved in Star Awards judging panels and participated in Randomised Coffee Trials (Quality Improvement conversation initiative) which were implemented throughout the trust. NEDs followed up with individual discussions with staff, leading to ongoing engagement. The Star Awards was a recognition scheme, which was an opportunity to share good practice through monthly team briefings, delivering key messages, opportunity to share good news such as information about new therapeutic environments and celebrate success.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement Feb 2022	Requires Improvement Feb 2022	Good Feb 2022	Good Feb 2022	Good Feb 2022	Requires Improvement Feb 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Adult social	Requires Improvement	Good	Good	Good	Good	Good
Mental health	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Community	Good	Good	Good	Good	Good	Good
Primary medical	Good	Good	Good	Good	Good	Good
Overall trust	Requires Improvement Feb 2022	Requires Improvement Feb 2022	Good Feb 2022	Good Feb 2022	Good Feb 2022	Requires Improvement Feb 2022

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Crowlin House	Requires improvement Aug 2021	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Aug 2021	Good Aug 2021
Brune Medical Centre	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Overall trust	Requires Improvement Feb 2022	Requires Improvement Feb 2022	Good Feb 2022	Good Feb 2022	Good Feb 2022	Requires Improvement Feb 2022

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Crowlin House

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement Aug 2021	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Aug 2021	Good Aug 2021

Rating for Brune Medical Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
People with long term conditions	Not rated	Not rated	Not rated	Not rated	Not rated	Good Apr 2019
Families, children and young people	Not rated	Not rated	Not rated	Not rated	Not rated	Good Apr 2019
Older people	Not rated	Not rated	Not rated	Not rated	Not rated	Good Apr 2019
Working age people (including those recently retired and students)	Not rated	Not rated	Not rated	Not rated	Not rated	Good Apr 2019
People experiencing poor mental health (including people with dementia)	Not rated	Not rated	Not rated	Not rated	Not rated	Good Apr 2019
People whose circumstances may make them vulnerable	Not rated	Not rated	Not rated	Not rated	Not rated	Good Apr 2019
Overall	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement ↓ Feb 2022	Good →← Feb 2022	Good →← Feb 2022	Requires Improvement ↓ Feb 2022	Requires Improvement ↓ Feb 2022	Requires Improvement ↓ Feb 2022
Community-based mental health services of adults of working age	Good Oct 2018	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Forensic inpatient or secure wards	Requires Improvement ↓ Feb 2022	Requires Improvement ↓ Feb 2022	Good →← Feb 2022	Good →← Feb 2022	Good →← Feb 2022	Requires Improvement ↓ Feb 2022
Wards for people with a learning disability or autism	Good →← Feb 2022	Good →← Feb 2022	Good ↓ Feb 2022	Good ↓ Feb 2022	Good →← Feb 2022	Good ↓ Feb 2022
Child and adolescent mental health wards	Requires Improvement ↓ Feb 2022	Good →← Feb 2022	Good →← Feb 2022	Good →← Feb 2022	Good →← Feb 2022	Good →← Feb 2022
Wards for older people with mental health problems	Inadequate ↓ Feb 2022	Good ↑ Feb 2022	Good →← Feb 2022	Good →← Feb 2022	Requires Improvement →← Feb 2022	Requires Improvement →← Feb 2022
Community-based mental health services for older people	Good Oct 2018	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Long stay or rehabilitation mental health wards for working age adults	Good Oct 2018	Good Oct 2018	Good Oct 2018	Outstanding Oct 2018	Outstanding Oct 2018	Outstanding Oct 2018
Mental health crisis services and health-based places of safety	Good →← Feb 2022	Requires Improvement →← Feb 2022	Good →← Feb 2022	Good →← Feb 2022	Requires Improvement →← Feb 2022	Requires Improvement →← Feb 2022
Community mental health services for people with a learning disability or autism	Good Oct 2018	Good Oct 2018	Outstanding Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Oct 2018	Good Oct 2018	Outstanding Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community health inpatient services	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community end of life care	Good Oct 2018	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community urgent care service	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community health services for children and young people	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Overall	Good	Good	Good	Good	Good	Good

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Wards for older people with mental health problems

Requires Improvement ● ➔➔

Is the service safe?

Inadequate ● ↓

Safe and clean care environments

Safety of the ward layout

Staff did not always complete and regularly update risk assessments of all wards areas or remove or reduce any risks they identified.

Not all wards complied with same sex guidance. On Berrywood ward, there were multiple mixed sex breaches; male patients were sleeping in female areas and females were sleeping in male areas. However, leaders stated this was individually risk assessed in some cases. On Beechwood ward, there was a male patient sleeping in a female area, staff had risk assessed this and closely observed the area 24 hours a day. Male patients also used the female designated lounge and there was a therapy room at the end of the female corridor that males used. This meant that female patients had to walk past males to get to their bedrooms or to use the toilets as there was only one bedroom that had en-suite facilities. On Beaulieu ward there was a female patient sleeping in the male area; this had not been risk assessed and staff told us the area was only observed at night putting the female patient at risk from other male patients. Staff on Beaulieu ward used the female lounge for weekly ward round which meant that female patients did not have a designated female only lounge for up to four hours once per week. However, Rose ward did comply with same sex guidance, patients' bedrooms were single and ensuite and there were separate male and female lounges. These concerns were raised on the day of the inspection.

The outside space at Beechwood ward was not safe and was overgrown with stinging nettles, there was moss in between patio slabs, blind spots with no CCTV or convex mirrors and a low fence which staff told us a patient had previously tried to escape over. Staff told us that the garden was observed every 15 minutes but over the period of one hour we only observed staff check the garden on one occasion.

The risks associated with ligatures were well managed. Staff on Berrywood ward, Rose ward and Beechwood ward knew about any potential ligature anchor points and mitigated the risks to keep patients safe. They were knowledgeable about risks and were mindful of the risks in the ward. Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. We observed staff on all wards cleaning the environment regularly.

Staff followed infection control policies, including handwashing. There were hand sanitation points around all wards, and we observed staff following good hand hygiene routines.

Clinic room and equipment

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment. However, there was no examination room on Beechwood ward or Beaulieu ward and so patients were examined in their bedrooms. Rose ward had a full examination room where patients could be seen in private outside of their own personal space.

Safe staffing

The service did not always have enough nursing staff.

Nursing staff

The service did not always have enough nursing and support staff to keep patients safe. On Beaulieu ward, there were not enough staff to meet patients' needs and keep them safe from harm. On the day of inspection, there were 14 patients on the ward, four of whom were on a one to one which meant they required continuous close observation. There were six staff working on the early and late shift and so the shifts were running short by three staff. This meant that four staff were on one to ones with patients, one member of staff was completing intermittent observations and one member of staff was the nurse in charge running the shift and administering medicines. At one point there were three patients on a one to one in the lounge, there were only two staff observing them. On another occasion there were three staff on a one to one with patients but one of the staff was feeding a different patient with her back to the patient they were supposed to be closely observing. We reviewed the rotas and the shift allocation lists for Beaulieu ward and found the ward to be regularly understaffed. On Berrywood ward, Beechwood ward and Rose ward there were occasional staffing gaps, but the teams managed well to ensure patient safety.

Following the initial inspection, we returned to Beaulieu Ward twice. Due to the concerns raised around the staffing on the ward the trust had taken positive action to reduce the amount of beds on the ward to 10. This had meant that they could reduce the staffing levels down to seven on a day shift and six on a night shift to make the ward easier to staff safely.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Patients did not always have regular one-to-one sessions with their named nurse. At the time of the inspection there were four patients on a one to one and six staff, meaning patients on Beaulieu ward did not have regular one to one time with their named nurse due to staffing shortages. Patients on Berrywood ward, Rose ward and Beechwood ward did have one to one time with their named nurse.

Patients did not always have their escorted leave or activities as planned. On Beaulieu ward there were not enough staff to provide escorted leave or activities. On the day of the inspection the activities coordinator did not deliver any activities because the ward was so short staffed, and they were counted in the numbers to cover for the nursing team. On Beechwood ward there was no activities coordinator, this role had been vacant since Spring 2020, but the trust had recently appointed someone to this post. On Rose ward there were two activity coordinators and a third activity coordinator was due to be appointed. On Berrywood ward, there were activities throughout the day seven days per week.

Wards for older people with mental health problems

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. Managers could call locums when they needed additional medical cover. However, on Beaulieu ward there was no specialist old age consultant psychiatrist. The nurse consultant was specialised in older persons mental health care, supervised by a consultant psychiatrist with a specialism in dementia. They did not have responsible clinician status and so they were supported by a psychiatrist from another hospital in the trust who did not specialise in old age psychiatry. A responsible clinician is a person who has overall responsibility in terms of the Mental Health Act 1983.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up to date with most of their mandatory training. However, at Beaulieu Ward staff had completed patient handling training (62%) and basic life support (67%), was below the trust target of 95%. The trust had paused some essential training due to the risks with the CoOVID-19 pandemic.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well.

Assessment of patient risk

Staff did not always update and review risk assessments, including after any incident.

Management of patient risk

Staff were not always familiar with each patient's individual risks and did not act to prevent or reduce these risks. We reviewed 33 care records across the core service. Staff on Beaulieu ward did not update risk assessments following incidents such as violence, aggression or falls. One patient had sustained significant physical harm because their falls risk had not been re-assessed and mitigated effectively. Staff had not considered the safety risks associated with patients being situated on mixed sex bedroom corridors. Risk management plans in relation to ongoing safeguarding concerns between two patients had not been completed and the two patients' bedrooms remained near each other on the ward. However, on the other wards inspected, we found there to be thorough risk assessment and management of risk.

Staff could not always observe patients in all parts of the wards. There were insufficient staffing numbers on Beaulieu ward to observe patients in all parts of the ward. During the inspection a patient on 15-minute observation went missing and this was not identified for 45 minutes as staff had not been completing the observations in line with the trust observation and engagement policy. We noted from the shift allocation sheets that staff were allocated to observations for significant periods of time up to seven hours without a break. Staff on Rose ward, Berrywood and Beechwood ward could observe patients on all parts of the wards.

Wards for older people with mental health problems

Following the initial inspection, the trust responded to the concerns about patient risk assessments, mixed sex bedroom areas and staff being unable to safely observe all areas of the wards. The clinical leadership team had conducted a review of all patients risks and observation levels. The trust had also committed to reviewing patients and gradually discharging those appropriate until they were down to 10 beds where they were able to staff the ward more safely and manage patient risk. The trust had also started a daily safety huddle to review patient risk and whether they were able to safely manage the risk of the ward with the staff they had. The falls lead for the trust had been in to review the patients falls assessments and there was a plan in place to train staff in falls assessment and prevention.

Use of restrictive interventions

Staff only used restrictive interventions such as restraint and seclusion when absolutely necessary Levels of restrictive interventions were low on all wards.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff did not always follow National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. On Beechwood ward, staff did not always consistently follow post rapid tranquilisation physical health protocol. This meant that patients receiving fast acting medicines who might have had adverse reactions were not monitored by staff as closely as they should have been. On Rose ward and Beaulieu ward staff did follow the protocol.

Safeguarding

Staff did not always report safeguarding incidents when they occurred.

Staff on Beaulieu ward did not always raise safeguarding incidents of reported abuse. We identified two examples where patients had sustained fractures that had not been reported to the local authority safeguarding adults' team. We were also made aware of other incidents including physical altercations and a mixed sex breach that had not been reported to safeguarding.

Staff on Beechwood ward had not reported three safeguarding incidents which occurred with another provider but should have been raised by the trust when the patients transferred back to Beechwood ward.

Staff on Rose ward and Berrywood ward did raise safeguarding alerts in line with national and local policy. Staff could clearly describe what action they would take when an incident of potential abuse had been identified.

Following the initial inspection, we returned to Beaulieu ward on two further occasions and sought assurances about the approach to safeguarding vulnerable adults from abuse. The trust had responded to the initial concerns raised regarding safeguarding by reviewing progress notes and incident records to ensure that incidents that required a safeguarding alert had been raised.

Staff access to essential information

Staff had easy access to clinical information. However, they did not always maintain high quality clinical records.

Wards for older people with mental health problems

Patient notes on Beaulieu ward were not comprehensive. Nursing entries in patients' records on Berrywood ward, Beechwood ward and Rose ward were comprehensive. All staff had access to a secure electronic card log in to maintain confidentiality and promote accountability.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. However, rapid tranquilisation protocols were not always followed.

Staff on Beechwood ward did not always follow post rapid tranquilisation protocols to monitor patients' physical health following fast acting intramuscular injections. Three of the records we reviewed showed that staff had documented some non-contact observations, but these were inconsistent and not in line with the trust policy or national guidelines. Staff would not be able to identify significant physical health deterioration that could occur after this medicine is administered

However, staff on all wards followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff stored and managed medicines and prescribing documents in line with the provider's policy. Decision making processes were in place to ensure people's distressed behaviour was not controlled by excessive and inappropriate use of medicines.

Reporting incidents and learning from when things go wrong

The service did not always demonstrate learning from incidents.

The records on Beaulieu ward did not demonstrate that learning had taken place following all incidents. We reviewed incidents across the four wards. One patient had fallen three times which finally resulted in a serious injury. No learning had been taken from previous falling episodes. However, staff on all wards received weekly reflective practice meetings with the psychologist.

Staff did not always recognise incidents and report them appropriately.

Staff on Beaulieu ward did not always report incidents. Patients also described incidents that had occurred which were not documented in the electronic incident record system, for example assaults on other patients.

Staff on Berrywood ward, Beechwood ward and Rose ward reported incidents appropriately and in a timely way.

Managers on Berrywood ward, Beechwood ward and Rose ward debriefed and supported staff after any serious incident. Staff had access to psychology on all wards who supported them with regular reflective practice following incidents.

Is the service effective?

Good 

Assessment of needs and planning of care

Wards for older people with mental health problems

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Staff regularly reviewed and updated the National Early Warning Signs 2 (NEWS) tool on all wards regularly. However, on Beechwood ward, there was no evidence that when patients' vital signs deteriorated, the escalation process was followed. This meant that staff could not always guarantee that they could respond to deterioration in patient's health in good time.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff on some of the wards participated in several quality improvement initiatives. Staff on Beechwood ward were working on a reducing restrictive interventions programme. On Rose ward there were quality improvement projects relating to the use of Zopiclone and section 17 leave.

Staff on most wards identified patients' physical health needs and recorded them in their care plans. However, on Beaulieu ward, staff did not update care plans following incidents such as assaults from other patients and falls.

Staff on most wards made sure patients had access to physical health care, including specialists as required. There was evidence that the falls team had visited Rose ward, Beechwood ward and Berrywood ward. However, on Beaulieu ward the falls team had not always been involved with patients that were at high risk of falling. On Rose ward, records demonstrated positive input from the mobility and exercise advisor.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff on all wards completed food and fluid charts as appropriate and escalated and concerns about poor food and fluid intake as necessary.

Staff used technology to support patients. Patients on all wards had access to electronic tablets to video call friends and relatives.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Wards for older people with mental health problems

The service had access to a full range of specialists to meet the needs of the patients on the ward. Both Rose ward and Beaulieu ward had a dedicated nurse consultant and staff on Rose ward told us this had been very beneficial. However, on Beaulieu ward there was no psychiatrist with a specialist interest in old age psychiatry dedicated to the ward.

Managers made sure staff attended regular team meetings and had supervision and a yearly appraisal. However, on Beaulieu ward, staff told us that when they raised concerns at team meetings such as lack of staffing or high patient acuity, these concerns were not addressed. Staff received supervision and yearly appraisal.

Multi-disciplinary and interagency teamwork

Staff from different disciplines did not always work together as a team to benefit patients.

On Beechwood ward, there was lack of multidisciplinary working evident in the care records; patients told us that the multidisciplinary team were not visible on the wards. On Beaulieu ward, one patient told us they had not seen their doctor at all. On Beaulieu ward, ward rounds did not involve patients or carers unless they made a specific request and so patients and carers did not benefit from the input of a multidisciplinary team. However, on Rose ward and Berrywood ward, the multidisciplinary staff team did work well together, and this benefited the patients. Staff and patients on Rose ward spoke positively about the multidisciplinary team on the ward, in particular the role of the nurse consultant.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. However, on Beaulieu ward, staff had to leave the handover we observed before it was completed due to staff shortages on the ward, this meant that they may have not been briefed on all aspects of patient care.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and with the Ministry of Justice when necessary.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Wards for older people with mental health problems

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff clearly recorded that the principles and assessment under the MCA were adhered to.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve.

Is the service caring?

Good 

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Wards for older people with mental health problems

Staff were discreet, respectful, and responsive when caring for patients. We observed staff on all wards treating patients with care and kindness. Patients on all wards said staff treated them well and behaved kindly.

Staff gave patients help, emotional support and advice when they needed it. They supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff did not always involve patients in care planning and risk assessment or actively seek their feedback on the quality of care provided. However, staff ensured that patients had easy access to independent advocates.

Involvement of patients

On Rose ward, Beechwood ward and Berrywood ward, patients told us they felt involved in their care and their care planning. Patients and relatives on Beaulieu ward were not routinely invited to their ward round and feedback was only given to relatives after decisions had already been made. On Beaulieu ward, records did not demonstrate that patients or carers were involved in their care. For example, a relative was not informed that their loved one had gone missing from the ward until they were contacted hours later by a member of the public.

Staff ensured patients understood the arrangements for their care and treatment and communicated this with patients in a way they could understand, especially where patients had particular communication needs. Staff involved patients in decisions about the service, when appropriate. For example, on Rose ward, patients and carers past and present had been actively involved in the development and refurbishment of the ward.

Patients on Rose ward, Beechwood ward and Berrywood ward could give feedback on the service and their treatment and staff supported them to do this.

Staff on all wards made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff on Rose ward, Beechwood ward and Berrywood ward supported, informed and involved families or carers. On Beechwood ward, there was a carer's liaison officer who contacted families seven days after the patient was admitted. Their role was to build trust with families to support the admission process and plan effectively for discharge.

Wards for older people with mental health problems

Staff helped families to give feedback on the service.

Is the service responsive?

Good

Access and discharge

Staff managed bed occupancy well. Discharge was not always well planned.

Bed management

Managers and staff did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interest of the patient. Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

Staff on most wards carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. On Berrywood ward, there was a recovery nurse who was involved in ward-based activities but also sought appropriate resources and potential services/groups available in the community that benefited the patients currently awaiting discharge. There was also a 'hospital to home worker' role funded by age concern; this person visited patients in their place of residence following discharge. However, on Beechwood ward only four out of six patients' records had discharge plans in them. Staff told us they did not always plan patients discharge from the point of admission and waited until the first Care Programme Approach meeting which was two to three weeks after admission.

Managers monitored the number of patients whose discharge were delayed. The only reasons for patients experiencing a delay in their discharge from the service were clinical. Staff supported patients when they were referred or transferred between services. The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient on all wards had their own bedroom, which they could personalise. Staff used a full range of rooms and equipment to support treatment and care. The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private. All wards had a cordless phone that patients could use to make private calls. Ipads were also available for video calls.

Patients on Berrywood and Beechwood ward could make their own drinks and snacks and were not dependent on staff. Patients on Rose ward and Beaulieu ward needed to ask staff for drinks and snacks due to the choking risks of leaving these items unattended.

The service offered a variety of good quality food.

Patients' engagement with the wider community

Staff on most wards supported patients with activities outside the service, such as family relationships.

Staff helped patients to stay in contact with families and carers. Carers told us they could visit the wards to see their relatives and where appropriate patients went home to visit relatives.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, and cultural and spiritual support.

The service could support and adjust for disabled people and those with communication needs or other specific needs.

Wards were dementia friendly and supported disabled patients. Rose ward had undergone a significant refurbishment to make it a dementia friendly environment. The environment had been developed with patients, staff and the community. Meetings were held on a weekly basis over a period several months to ensure that all stakeholders were fully involved in the design of the environment. Signs and colour schemes had been in a dementia friendly way. The outside space had also been completely refurbished. Hazards on the ground had been removed and the ground material was soft to reduce the risk of injuries during falls. The sensory garden was also under development and the team had worked with the local garden centre to ensure the plants used were nontoxic to patients.

The environment on Beechwood ward and Beaulieu ward also had a dementia friendly focus; consideration had been given to the colour scheme and the effect different colours have on a patient with dementia. There was a large dining room and a large conservatory and space for patients to move around freely.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients told us the food was good.

Patients had access to spiritual, religious and cultural support. Patients could access material to meet their spiritual needs and access spiritual leaders where necessary.

Wards for older people with mental health problems

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Staff protected patients who raised concerns or complaints from discrimination and harassment.

The complaints we reviewed had all been handled appropriately and feedback was given to the complainant and learning shared with staff.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Requires Improvement 

Leadership

Leaders did not always have the skills, knowledge and experience to perform their roles. They did not always have a good understanding of the services they managed and were not always visible in the service and approachable for patients and staff.

Beaulieu ward did not have an effective leadership team in place during the inspection. The ward manager was new to the role and therefore needed support from other leaders to settle into the job and the matron was on long term sick leave. Following the inspection, the trust had put in extra support for Beaulieu ward through increased focus from the leadership team who had based themselves on the ward and supported staff with the care.

However, on Berrywood ward, Rose ward and Beechwood ward local leaders were experienced and effective. Leaders were clear about their roles and had a good understanding of quality performance, risks and regulatory requirements. The staff told us the ward managers were supportive and the team was working well together.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Staff were aware of the values of the organisation and worked within them. There was a commitment from all staff to do a good job. However, staff on some wards felt under a lot of pressure from the challenges of being short staffed.

Culture

Staff on most wards felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Wards for older people with mental health problems

Staff on three of the four wards we inspected were positive about the culture of the service. They felt supported by their immediate line manager and by the trust. We spoke with some passionate and dedicated staff on the older persons inpatient wards. Some support workers were hopeful of securing some formal training to help with their career progression. However, due to ongoing staffing shortages on Beaulieu ward, staff had found working on the ward over the last few months very challenging.

Following the initial inspection, we returned to Beaulieu ward on two further occasions to re-inspect and follow up on assurances provided by the trust. On the third visit, we were able to talk to staff who had said that since the ward had reduced their beds and there was extra support and focus on staffing it had been a nicer place to work. The staff on the ward spoke fondly of the care they provided but had not had a voice when concerns were raised to the management team of the ward. Staff said they felt more listened to by the trust over the two-week period following the initial visit.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

Following the initial inspection, we escalated the concerns with Beaulieu ward to the Chief Executive and the Director of Nursing. We advised them that if there was not significant improvement in the safety of care on the ward, we would take enforcement action to address the issues. The trust responded by reducing the bed numbers, improving the staffing ratio, reviewing risks and practices around safeguarding and falls. The trust submitted an action plan to CQC to demonstrate how the changes were to be implemented and embedded going forward. Following two further visits to the ward, the inspection team were satisfied that immediate risks to patient safety had been addressed to prevent immediate and significant enforcement action being taken.

Managers could access information from a variety of sources that allowed them to understand their team's performance against their identified key performance indicators. There were clinical governance meetings to review incidents and the care provided and ensure any learning was shared both within the wards and outside across the core service. However, the number of concerns raised regarding the care on Beaulieu ward showed that the processes in place were not being used effectively to highlight and escalate risks to ensure they were managed. For example, issues around the assessments of risk, learning from incidents and the checking of essential safety measures such as post rapid tranquilisation physical health checks. These had not been picked up through internal assurance processes.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The trust used a digital reporting tool to record and identify issues with performance and compliance. Managers used this to monitor compliance with essential aspects of patient care and staffing. For example, training and supervision levels and compliance with targets around care record completion.

Information management

Staff had access to sufficient equipment and information technology in order to do their work. The secure record keeping system was easily available to staff to update patient care records and to review when needed.

Wards for older people with mental health problems

Learning, continuous improvement and innovation

Staff engaged actively in local and national quality improvement activities. Staff on some of the wards participated in several quality improvement initiatives. Staff on Beechwood ward were working on a reducing restrictive interventions programme. On Rose ward there were quality improvement projects relating to the use of Zopiclone and section 17 leave.

Wards for people with a learning disability or autism

Good

Is the service safe?

Good

Safe and clean care environments

The ward was safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. The layout of the ward allowed all parts to be observed and, where appropriate, mirrors were used in corridors to remove blind spots.

. Staff knew about any potential ligature anchor points and mitigated the risks to keep people safe. The staff undertook risk assessments to ensure there were no potential ligature points.

Staff had easy access to alarms and people had access to nurse call systems in their bedrooms and communal space.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. Staff followed infection control policy, including handwashing.

People told us they were responsible for keeping their bedrooms tidy with support from housekeeping staff.

Seclusion room

The seclusion room met the requirements of the Mental Health Act (1983) Code of Practice. The seclusion room was connected to the de-escalation room which had access to an enclosed garden with staff supervision. There was clear observation into the seclusion room, two-way communication with staff and facilities for personal care including toilet and bathing facilities. Staff were able to obscure their view from the observation area, where possible, while people were showering to ensure their privacy was respected.

The staff confirmed the bedding in the seclusion room was to be upgraded to meet current good practice guidelines.

Clinic room and equipment

The clinic room was clean, well-organised and records clearly marked and available. It was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. All emergency equipment was in working order with portable appliance testing (PAT) completed.

Safe staffing

We spoke with eight people who told us staffing levels were not always maintained. People told us some staff were leaving which meant the frequency of some activities had reduced. For example, the occupational therapist was leaving which reduced the time spent on activities.

One person told us staffing numbers on duty were not consistent with the staff board which detailed the set number of staff for the ward. Another person told us there were high numbers of agency staff on night duty. They said that at night, the staff on duty were not always familiar due to the numbers of agency staff covering vacant shifts. Managers told us that 25% of night staff cover was from agency staff.

The set staffing levels were met with permanent and with agency staff. The staffing levels during the day were two nurses and three support workers with two additional staff mid shifts from10am to 6pm and at night one nurse and four support workers were on duty.

Staff said minimum staffing numbers were deployed to work on the ward and they felt this needed to increase to allow them to deliver the standard of care that they believed people required and deserved. They said that although managers responded to cover vacant shifts there were occasions when shifts were cancelled and not covered. Managers told us there were two full time equivalent band 2 nurse vacancies. They told us there had been an uplift of staffing levels due to the size of the building and a further review of skill mix was to take place in future. However, there was no date set for this review.

People rarely had their escorted leave cancelled although it was delayed when the service was short staffed.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. Managers could call locums when they needed additional medical cover.

Mandatory training

The content of the mandatory training programme met the needs of people and staff. The Learning Disabilities community team delivered learning disabilities and autism awareness training to staff.

There was an expectation that staff attend mandatory training determined essential by the trust for the safe and efficient delivery of services. The training attended included safeguarding adults from abuse, Health and Safety. The ward manager told us the trust supported the staff to undertake specialist training. However, Ashford House was not meeting their own target of 95% of mandatory training. For example, 88% of staff had attended resuscitation – basic life support and 88% Mental Health Act.

Assessing and managing risk to people

Staff assessed and managed risks to people and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support people's recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of risk

Staff completed risk assessments for each person on admission using a recognised tool, and reviewed this regularly, including after any incident. Admission assessments which covered areas such as people's individual risks and how to manage them were completed following an admission to the ward.

People told us there were times when they used behaviours to express their emotions. One person told us how they expressed their frustrations which placed others at risk of harm. They told us how staff managed these situations and recognised input from the psychiatrist team was needed.

Wards for people with a learning disability or autism

Management of people's risks

People's Individual assessments, risk assessments and care plans were reviewed at Multidisciplinary Team (MDT) meetings over a two-week period. Risk assessments were detailed, and strategies on how to achieve the desired outcomes were shared with the team. Staff were knowledgeable about people's individual risks and took appropriate action to prevent or reduce these risks.

Staff were able to observe people in all areas.

Staff followed trust policies and procedures when they needed to search people or their bedrooms to keep them safe from harm. People returning from unescorted leave were searched in a designated room using a handheld device. Where people refused to be searched the staff instigated one to one support until they agreed to be searched.

Use of restrictive interventions

Positive behaviour plans were devised for people whose behaviours at times placed them and others at risk of harm. Levels of restrictive interventions were low. Staff made every attempt to avoid using restraint by using de-escalation techniques. They said verbal de-escalation was the main method of reducing situations from escalating. For example, people were offered time alone with staff in a low stimulation environment.

Staff were trained to manage behaviours such as signs of frustration and anxiety which placed the person and others at risk of harm. They had attended Supporting Safer Services (SSS) training, however this was to be replaced with Prevention and Management of Violence and Aggression (PMVA).

The trust had a trust wide policy on restrictive practice. The staff participated in the provider's restrictive interventions reduction programme which ensured minimal use of seclusion and segregation was used. However, the policy was trust wide and needed to be more specific to learning disabilities and autism. For example, the policy only reflected the Mental Health Act Code of Practice and did not reflect the trust's provision of care and treatment to people with learning disabilities or/and autism.

Safeguarding

Staff understood how to protect people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The trust safeguarding policy was in place and a flowchart on display for staff's reference. Staff received training on how to recognise and report abuse, appropriate for their role. They knew the types of abuse and how to make a safeguarding referral and who to inform if they had concerns.

People told us they mainly felt safe in the ward and two people told us how staff managed situations when others made them feel anxious. For example, around confrontation between people.

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records

Electronic and paper-based care record were accessible to staff. Staff said current and essential information about people was shared during handovers which occurred when shifts changed.

Wards for people with a learning disability or autism

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health. They knew about and worked towards achieving the aims of Stopping Over-Medication of People with a learning disability, autism or both (STOMP).

Staff stored, managed medicines and prescribing documents in line with the provider's policy. Records of medicines administered were up to date with no omissions. Staff followed systems and processes for safe administering, recording and storing medicines. Individual protocols were in place for people prescribed with medicines to be taken when required (PRN).

Medication was minimal and only that essential to current health needs was prescribed. Staff were aware of The Stopping Over Medication of People (STOMP) a national project to help prevent the overuse of medications for people with a Learning disability and or autistic people. Consent to treatment forms were present where required.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed safety incidents well.Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff reported accidents and incidents through an online system. Incidents were discussed at multidisciplinary meetings. De-briefs took place following incidents and outcomes were shared in the form of memos and emails. Staff said there was feedback on areas for improvement from debriefs which prevent a re-occurrence of the same incident. For example, the actions they managed correctly and how to manage the same situation using other approaches.

Is the service effective?

Good

Assessment of needs and planning of care

People told us they involved in their care planning and had copies of their care plan. Care plans reflected people's assessed needs, were personalised, holistic and strengths based.

A care programme approach (CPA) was used to assess people's needs either on admission or soon after. CPA's were structured on the principles of Good Lives Model, a framework used to ensure people's needs were met around taking responsibility, staying healthy, getting along with others and keeping busy. CPA meetings were held every 12 weeks to review the plans in place and detailed people's views along with the input from the multidisciplinary. For example, each section detailed the person's current need and the actions needed to achieve the outcomes identified.

Physical health was assessed soon after admission and regularly reviewed during their time on the ward. "National Early Warning Score 2" (NEWS 2) scoring/recording document was used to identify health changes rapidly when the scores change. These were completed daily or as often as required depending on the individuals needs at the time.

Wards for people with a learning disability or autism

Positive behaviour support plans (PBS) were present and supported by a comprehensive assessment.

Best practice in treatment and care

Staff provided a range of treatment and care for people based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives.

Staff used recognised rating scales to assess and record severity and outcomes.

People had access to a range of care and treatment suitable for the people in the service. There were a range of therapies available from psychologists, psychiatrists, occupational therapists (OT), speech and language therapists (SaLT) and access to the social work team to facilitate discharge. For example, SaLT therapist developed training in the use of talking mats, Makaton and Picture Exchange Communication System (PECS).

Staff were aware individual positive behaviour support (PBS) plans were in place and detailed how to approach people when they used behaviours to express their frustrations and anxieties. They said PBS plans described the most effective approach to de-escalate situations

People's dietary needs were catered for and staff assessed those needing specialist care for nutrition and hydration.

Skilled staff to deliver care

The ward team(s) included or had access to the full range of specialists required to meet the needs of patients on the ward(s). Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the people on the ward.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. Staff told us the induction had prepared them for the role when they were employed.

All staff had an annual appraisal of their work and regular supervision was used to monitor any professional developmental goals arising from their appraisal.

Individual supervision meetings were with the line manager and where discussions of performance, concerns and training needs took place. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with staff from services that would provide aftercare following the patient's discharge.

Multidisciplinary meetings (MDT) were held weekly, they were open to all disciplines such as psychiatrists, psychologists allied health care professionals where people's care was reviewed with them. Clinicians worked across forensic learning disabilities and community teams. Ward teams had effective working relationships with community teams and commissioners. They liaised with external providers to increase people's opportunities and to engage in meaningful occupation.

The staff who attended the MDT meetings described these forums as platforms for gaining guidance on how to support people's specific needs. For example, solutions on how to achieve outcomes. Staff shared clear information during handovers about people and any changes in their care.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain people's rights to them.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Staff attended Mental Health Act training and were knowledgeable on the principles of the Mental Health Act and its Code of Practice.

Easy read information leaflets were available about independent mental health advocacy. Staff explained to each person their Section 132 rights under the Mental Health Act in a way they were able to understand every three months after admission.

Staff ensured people had their Section 17 leave as agreed with the Responsible Clinician and/or with the Ministry of Justice. Records were well maintained and kept in care files.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Good practice in applying the Mental Capacity Act

Staff supported people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for people who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. They told us how people were supported to make decisions and choices. For example, information was presented in a way it could be understood and checked people's understanding.

Staff assessed and recorded capacity to consent clearly each time a person needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of person and the decision makers considered their wishes, feelings, culture and history.

Wards for people with a learning disability or autism

Is the service caring?

Good

Kindness, privacy, dignity, respect, compassion and support

People told us the staff were very kind, supportive and helped them to understand information. They praised the staff and said they were helpful and understood their needs. Although people said the ward was short staff at times, they gained attention from staff when they needed to discuss their needs and how they were going to be supported.

We noted a calm atmosphere during the inspection, and we saw staff use a kind approach and were knowledgeable about people in the ward.

People said the staff respected their rights to privacy. They were able to approach staff with concerns and there were easy discussions on how they were to be resolved.

Staff described their approach which demonstrated a respectful and compassionate approach. For example, they responded when people sought their attention, spent time with individuals and groups on activities. They maintained professional boundaries, and treated people as they would like to be cared for.

Visual signs were used for people to find their way around and with their orientation of the ward. People had a choice of communal areas such as a dining area where people gathered and a pool table. There were other different rooms for people to spend quiet time away from others or to watch the television. There was a continuous flow of activities with staff including ball games in the courtyard.

People told us about the therapy garden and how they were reminded of local places of interest. They said the staff supported them to prepare meals and refreshments which helped them develop independent living skills.

Involvement in care

People were involved in their care planning and risk assessment and staff actively sought their feedback on the quality of care provided. Staff ensured that people had easy access to independent advocates.

Involvement of patients

People had access to their care plans and risk assessments and staff helped them understand their care and treatment.

There were weekly community meetings on Fridays where people made decisions about the service, when appropriate. People told us their views were gathered during the meetings and taken seriously. For example, local visits.

People knew how to make contact with advocacy services. They said the advocacy service contact details were on display in the unit.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

People were supported to maintain relationships. They said visits were arranged in advance and a family room was available to have visits.

Wards for people with a learning disability or autism

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Good

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare. One of the eight people we spoke with said their discharge was not as prompt as they expected.

Bed management

The staff followed the ward's admission process which included gathering information about the person before their arrival. They told us assessments and care plans helped them prepare for people's admission.

Managers told us referrals for admission and discharges were from the community or other hospitals. Discharge and future plans were discussed with the individuals MDT meetings. The ward manager told us two people were due for discharge, the staff were liaising with the establishment and updating them regularly to promote successful discharges.

Regular meetings regarding Section 117 aftercare were taking place with commissioners to support effective discharges. The process included developing transition plans, offering training to external providers before admission into the community and contact with ward teams for six weeks after discharge.

Discharge and transfers of care

Plans for discharge were discussed with the person during MDT meetings and care managers and coordinators worked well towards effective discharges.

People were referred for transfer following the assessment period when staff were not able to meet the identified needs. Staff supported people when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported people's treatment, privacy and dignity. Each person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

The ward was bright and decorated to a good standard. Bedrooms were single with en-suites and people were able to personalise their bedroom with equipment such as televisions and play stations.

People were able to store personal possessions in a secure space. There was a property store for people to store additional belongings.

Wards for people with a learning disability or autism

People had access to a full range of rooms and equipment to support treatment and care. There was a pool table in the communal space and separate rooms for private call, television room and quiet room.

People were able to access the garden with staff support between 7am and 12 midnight and during the inspection we saw people playing ball games with staff.

People were able to make refreshments including hot and cold drinks in their designated kitchen between 7am and 12 midnight. There was water available between these times.

People said food was good and we saw a range of fruit available around the ward.

Staff supported people with activities outside the service.

People we spoke with told us about the internal and community activities. They told us about the support they received with gaining independent living skills.

People had access to a therapy corridor with staff support and where they were able use the sensory, art and music rooms and the fully stocked activity kitchen for people to develop their independent living skills. Other facilities included a gym and climbing wall.

The occupational therapist told us they followed the Creative Ability model where people's skills and abilities were assessed to develop outcome goals. There were **i**nternal and community activities which were organised daily. For example, museum visits and shopping trips. A timetable of activities with pictures and words was on display in the communal space. However, we understood the gardening club was not taking place although it was listed as an activity." Since the inspection the activities board was updated to accurately reflect the activities taking place.

Meeting the needs of all people who use the service

The service met the needs of all people – including those with a protected characteristic. Staff helped people with communication, advocacy and cultural and spiritual support.

Accessible Information Standard (AIS) were mostly followed. AIS aims to make sure people with a disability or sensory loss are given information they can understand. Staff supported people to understand information being shared, however, communication care plans or passports on the person's preferred communication method was not always detailed. For example, the communication care plan for one patient was dated 2018 and care records were not specific on the patients preferred communication method such as large print and audio.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

The complaints procedure was displayed about how to raise concerns. Staff understood the policy on complaints and knew how to handle them.

Wards for people with a learning disability or autism

Managers investigated complaints and identified themes. There had been no complaints about care provided on the ward. The ward manager was knowledgeable on how to manage complaints and how to escalate them if needed.

People were aware they had a voice and were comfortable talking and addressing any concerns to staff.

Is the service well-led?

Good 

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

The ward manager had been recently appointed, and had a good understanding of quality performance, risks and regulatory requirements. The staff said the ward manager was new, visible on the ward, knew patients well and was approachable.

The staff told us the ward manager was supportive and the team was working well together. They felt empowered as individuals, able to share their ideas and make suggestions on improvements.

There were systems in place for staff to receive feedback from the ward manager with the sharing of information and updates on policy changes. There were systems in place for staff to have individual supervision with their line manager. Team building was planned with an away day for staff.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

The staff were aware of the trust values and worked within them. They said there was support from the ward manager and they had job satisfaction and they felt confident within the team.

Culture

Generally, staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression.

Staff told us they felt valued. They said information was shared through staff meetings, discussions during supervision and the training attended.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Wards for people with a learning disability or autism

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

An audit system to assess and monitor the standards of care was in place and action was taken where shortfalls were identified. For example, restrictive interventions, risk assessment and care plans.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

A range of audits were used to assess and monitor standards of care and safety. The ward manager sought guidance and advice at the Quality Assurance meetings where shortfalls from the audits were identified. Individual assessments, risk assessments and care plans were reviewed during Multidisciplinary (MDT) meetings.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Learning, continuous improvement and innovation

The ward was working on developing the ethos of the unit post COVID. There were four workstream reviewing areas of culture and values, model of care, referral and wider community.

Robust model spanning in-patient and community. Training was offered to provider before people were admitted to community services. Social workers were retaining contact with providers six weeks from discharge.

The service was not fully meeting the principles of Right support, right care, right culture guidance. People and staff told us staffing levels were not sufficient to support independence and choice.

Child and adolescent mental health wards

Good

Is the service safe?

Requires Improvement

Safe and clean care environments

All wards were clean, well equipped, well furnished, well maintained and fit for purpose. Vacancy rates were high for nursing staff.

Safety of the ward layout

Staff completed risk assessments of all ward's areas. However, it was unclear whether actions for reducing and removing any identified risks were promptly followed up. For example, when an issue was identified there were no clear dates identified for when the action should be completed. In addition, it was unclear how some of the control measures included on the ligature risk assessments helped staff to mitigate the identified risks and staff were not always able to explain clear rationales for these. For example, a control measure for ligature risks identified in young people's bedrooms at Leigh House, stated that doors were kept unlocked so young people had access, but there were no further explanations of how this helped to mitigate risks and staff were also unable to explain.

Staff could observe patients in all parts of the wards. We saw that any blind spots were mitigated by mirrors and there were staff allocated to observe ward areas where needed.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff were issued with personal alarms. Nurse call alarms were available throughout the wards, including in young people's bedrooms.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. We observed staff on all sites cleaning regularly and saw completed cleaning checklists.

Staff followed infection control policy, including handwashing. There were hand sanitisation points around all wards and we observed staff following good hand hygiene routines.

Seclusion rooms

Seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock. Most of the seclusion rooms were in good condition and staff told us that they were rarely used. However, a mattress in Bluebird House seclusion room was torn and in need of replacement.

Clinic rooms and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs. However, these were not always checked regularly. Medication included in the emergency bags on all three sites was out of date. Senior staff told us that the trust was aware of this and had discussed with the contractors to rectify.

Safe staffing

The service did not always have enough nursing staff, who knew the patients. Staff received basic training to keep people safe from avoidable harm.

Nursing staff

The service had high vacancy rates and high rates of agency nurses mainly at Bluebird House and Leigh House, although most shifts were covered by bank and agency staff. The trust had recruitment plans in place to recruit nurses, including initiatives to recruit international nurses, but vacancy rates remained high. For example, Leigh House had 3.4 full time equivalent substantive band six registered nurses employed, although it had an establishment of 9.8 band six staff.

Staff at Bluebird House and Leigh House told us that issues with staff shortages and skill mix was the main concern for the units. They told us that they were exhausted and found it hard to feel safe because there were so many agency and new staff who did not know the young people well. Sometimes members of the multidisciplinary teams were asked to support nursing staff on the wards.

Staff shortages and issues with skill mix at Leigh House had affected staff morale and wellbeing and this reflected on the unit's sickness record and staff turnover. We saw staff rotas at Leigh House showing high number of staff being off sick.

Senior staff described considerable challenges with staffing, including difficulties with retention, recruitment and maintaining the appropriate skill mix. However, there were no significant issues with staffing levels at Austen House, and senior staff told us that they were aiming to achieve the same at Bluebird House and Leigh House. Staff at Austen House also told us that recent recruitment has been successful and the unit was not experiencing any staffing shortages.

Staff shortages impacted on activities at Bluebird House and Leigh House. Both staff and young people told us that activities were often cancelled. Sometimes escorted leave was also cancelled, however, staff managed to keep cancellations at a low level.

Medical staff

The service had enough daytime and night time medical cover and there was a doctor available to go to the ward quickly in an emergency. All units had dedicated speciality doctors and consultant psychiatrists who spoke to us about their roles and the specialist care and treatment they were offering to the young people.

Managers could call locums when they needed additional medical cover.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. The mandatory training programme was comprehensive and met the needs of the young people and staff. Managers monitored mandatory training and alerted staff when they needed to update their training.

Overall, 93% of staff had completed mandatory training at Bluebird House and 93% of staff had completed mandatory training at Austen House. The rate at Leigh House was lower, 82.6%. Managers at Leigh House told us that they were aiming for 95%, which is the trust's target, but staff shortages and high ward acuity impacted on the unit's ability to release staff to promptly complete training. Staff at Leigh House were also attending specialist training for eating disorders. The trust had paused some essential training due to the risks with the COVID-19 pandemic.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. **Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.**

Assessment of patient risk

Staff completed risk assessments for each young person on admission and reviewed these regularly. At Bluebird House, for example, we saw very detailed risk assessments for the young people, which were part of their electronic care records. All managers and staff we spoke with, described how they were making sure that risk assessments were comprehensive and regularly reviewed.

Medical staff at Austen House described how they used an in house risk rating tool which captured the state of the unit and informed decisions about whether it was safe to admit more young people, or what support was required by staff.

Management of patient risk

Staff knew about any risks to each young person and acted to prevent or reduce risks. They identified and responded to any changes in risks. For example, at Austen House there was a bathroom that had soft padded walls and flooring which was specially designed to accommodate the needs of a young person in a distressed state and helped to mitigate the risks of them harming themselves.

We observed that management of risks were thoroughly discussed during various meetings, such as handovers, ward rounds and assessment and admissions meetings.

Staff could observe patients in all areas of the wards and we saw completed patient observation records.

Staff followed trust policies and procedures when they needed to search patients to keep them safe from harm. At Austen House, we saw facilities allocated for this purpose and there were posters which guided and reminded staff of the relevant procedures.

In both secure units, Austen House and Bluebird House, there were staff responsible for security who were assisting young people when appropriate and provided general security for the buildings.

However, staff at Leigh House told us that sometimes managing risks was a challenge because the service had become more specialist and the acuity of young people on the ward area had increased significantly due to the number of young people who required tube feeding to support their eating disorder. This had also impacted on staff shortages and skill mix and staff sometimes felt unsafe. Staff also told us that there were often no debriefs after incidents. Senior staff acknowledged that the service needed to respond to the changing acuity levels and the difficulties staff were facing.

Use of restrictive interventions

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained young people only when these failed and when necessary to keep young people or others safe.

Levels of restrictive interventions were reducing at Bluebird House and Austen House. At Bluebird House, de-escalation techniques were used to good affect and there was a very low use of when needed (PRN) medications. Managers spoke very highly of the staff team's ability to effectively use de-escalation methods, resulting in low numbers of restraints and usage of rapid tranquilisations. Staff had devised colour coded monthly summaries of rapid tranquilisations, restraints, seclusions and other restrictive care, called 'safety crosses', which highlighted the reduction in restrictive practices at the unit.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. At Austen House, there was an ongoing least restrictive practices project which had resulted in the reduction of incidents and restrictive practices. There were clear graphs displayed demonstrating this. The unit has also adopted a model of intervention which encouraged staff to support young people who attempted to use ligatures without making physical contact with them.

There were a high number of physical restraints at Leigh House because of the need to restrain some young people in order to ensure they could be tube fed to support their care. These young people have complex needs and the service provided highly specialised care to meet the needs of the local population. However, staff told us that they needed more support from managers and better communication with doctors and members of the multidisciplinary team, to clearly understand the rationale for the prescribed interventions for the young people with eating disorders.

When a patient was placed in seclusion, staff kept records and followed best practice guidelines. Managers told us that there were identified senior staff who reviewed seclusion packs to identify areas of improvement and to monitor implementation.

Safeguarding

Staff understood how to protect young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The teams had a safeguarding lead.

Staff received training on how to recognise and report abuse appropriate for their role and kept up-to-date with their safeguarding training.

There were social workers as safeguarding leads who maintained up to date safeguarding records and were liaising with the Local Authorities safeguarding teams when needed.

Staff knew how to make a safeguarding referral and who to inform if they had any concerns. We observed that safeguarding concerns were discussed and actioned in multidisciplinary meetings and handovers. Staff told us that they knew how to report safeguarding incidents and social workers confirmed that staff understood safeguarding and reported any concerns.

Staff access to essential information

Child and adolescent mental health wards

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Young people's care notes were comprehensive and all staff could access them easily. Records were stored securely, and staff had individual log in details to maintain confidentiality and promote accountability. Paper copies of young people's care plans were also kept on the wards.

Medicines management

The service used systems and processes to safely prescribe and administer medicines. However, sometimes record keeping and auditing was inconsistent.

Decision making processes were in place to ensure young people's behaviour was not controlled by excessive and inappropriate use of medicines. There was low usage of antipsychotic and when needed medications.

We found that staff had introduced forms and practices to assist with medication management. For example, staff at Bluebird House had conducted medication and clinic room audits and developed a medication reconciliation form to be used on the wards.

However, staff did not always follow systems and processes when recording and storing medicines. There were some inconsistencies and errors with recording and some lack of auditing for new medicines received or destroyed. For example, some signatures were missing on the control drug books and there was no signature sheet for staff who administered medication. Also, emergency medication in grab bags was out of date. The trust contracted with a company to check these. When we raised this with senior leaders at the trust they took action to ensure the company took immediate action to correct this.

Track record on safety

Reporting incidents and learning from when things go wrong. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff reported incidents clearly and in line with trust policy. They knew what incidents to report and how to report them. Incidents were logged on an online risk management system and reviewed by staff. Any trends and themes were discussed during staff meetings.

Managers investigated incidents, checked for themes and shared learning with all staff. At Bluebird House there were learning from incidents meetings in place, where themes were identified and a relevant report was produced. Learning was then cascaded to staff through staff meetings. At Leigh House, any learning form incidents meetings fed into clinical governance meetings.

Is the service effective?

Good 

Assessment of needs and planning of care

Staff assessed the physical and mental health of all young people on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the young people's assessed needs, and were holistic and recovery-oriented.

Care plans were personalised, holistic and recovery-orientated. Staff developed a comprehensive care plan for each young person that met their mental and physical health needs. Staff regularly reviewed and updated care plans when young people's needs changed. Each young person had an identified core staff team and these teams had core team days where they had the opportunity to review and update care plans.

Care plans for young people at Bluebird House and Austen House were very detailed and included information around how young people would like to be supported when at risk or in crisis. Staff at Austen House had also developed 'at a glance' care plans mainly for new and agency staff to have quick access to important information about how to best support the young people. However, the young people's care plans in Leigh House were not always personalised. Some of them were very similar with standard wording used.

Best practice in treatment and care

Staff provided a range of treatment and care for young people based on national guidance and best practice. They ensured that young people had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the young people in the service. They made sure young people had access to physical health care, including specialists when required. We observed that physical health needs were discussed during a daily multidisciplinary meeting in Austen House. Staff at Leigh House were liaising with external clinicians and services, such as phlebotomy for blood tests, to ensure that young people's physical health needs were met.

Staff helped young people live healthier lives by encouraging them to take part in programmes or by giving advice. Staff ran monthly wellbeing clinics at Bluebird House, in addition to the regular monitoring of physical health. Young people had the opportunity to receive advice and support for different topics, such as sexual health and oral hygiene.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Medical staff told us that they were proactive in developing post care pathways for young people.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Occupational therapists at Leigh House used the Activity Participation Outcome Measure (APOM) to assess ability and outcomes for young people. Staff were also monitoring information from the quality network for inpatient child and adolescents services and oversaw quality improvement tasks cascaded by the trust.

Skilled staff to deliver care

Child and adolescent mental health wards

The ward teams included or had access to the full range of specialists required to meet the needs of the young people on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals and supervision. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the young people. Each unit had access to multidisciplinary teams which included psychiatrists, psychologists, occupational therapists, social workers, family therapists and speech and language therapists.

Managers gave each new member of staff a full induction to the service before they started work. Staff at Bluebird House told us that they found induction very good and had completed competencies such as patient observations and security. They also told us that they had the opportunity to shadow shifts before starting to support young people on the wards. Agency staff received security and ward inductions. Most staff at Austen House told us that they received good inductions.

Managers supported staff through regular, constructive appraisals of their work.

Staff received regular supervisions by their managers. Staff at Austen House were complimentary about the support they received from managers through supervisions and reflective practice sessions. They all said that they received regular managerial and clinical supervisions, weekly reflective practice and ward supervisions.

However, supervision sessions for staff at Leigh House were not regularly completed, with only 55% having received supervision. This was due to staff shortages and the high acuity of young people on the ward area. Managers told us that they were organising for someone external to provide reflective practice sessions to staff fortnightly and monthly.

Staff had the right skills, and experience to meet the needs of the patients in their care. We observed some very skilled staff dealing with some complex issues. We attended some handover meetings and observed that staff were very knowledgeable of young people's needs, especially around eating disorders at Leigh House. Staff at Leigh House were also attending specialist eating disorders training. Staff were completing competencies and we saw that staff at Austen House had completed patient observation competencies.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit the young people. They supported each other to make sure young people had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss young people and improve their care. They made sure they shared clear information about young people and any changes in their care. We observed some well attended multidisciplinary and handover meeting in all units. Staff discussed follow up actions, education attendance and progress, treatment goals, risks, physical health and updates to care plans. Staff were completing comprehensive documentation following each meeting, such as handover and ward rounds documents.

Ward teams had effective working relationships with external teams and organisations. For example, staff at Leigh House had liaised with the Police about young people who were absent without leave.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Child and adolescent mental health wards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to young people.

Staff made sure that young people could take section 17 leave (permission to leave the hospital) when this was agreed with the responsible clinician or with the Ministry of Justice. However, leave had been cancelled sometimes because of staff shortages. Staff at Bluebird House told us that a new process was being introduced where young people could request leave after ward round meetings and then some allocated staff considered diaries and other commitments to spread leave equally and avoid cancellations. We observed staff discussing arrangements for section 17 leave with young people during ward round meetings.

Staff stored copies of young people's detention papers and associated records correctly and they could access them when needed. Staff explained to each young person their rights under the Mental Health Act and recorded it in their care notes.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. For example, we saw that at Austen House staff completed weekly Mental Health Act audits.

Good practice in applying the Mental Capacity Act

Staff supported young people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to patients under 16. Staff assessed and recorded consent and capacity or competence clearly for young people who might have impaired mental capacity or competence.

Staff assessed and recorded capacity to consent clearly each time a young person needed to make an important decision. We saw information about consent kept on young people's care records.

Staff knew how to apply the Mental Capacity Act to patients 16 to 18 and where to get information and support on this. Staff understood how to support children under 16 wishing to make their own decisions under Gillick competency regulations. For example, we saw that staff at Austen House had access to information about capacity and competence to consent, best interest principle and Gillick competency.

Is the service caring?

Good ➔➔

Kindness, privacy, dignity, respect, compassion and support

Staff treated young people with compassion and kindness. They respected young people's privacy and dignity. They understood the individual needs of young people and supported them to understand and manage their care and treatment.

Staff were respectful and responsive when caring for young people and gave them help and advice when they needed it. They knew the young people well and were kind whilst engaging with them. Most of the young people we spoke with told us that staff treated them well and behaved kindly.

The service had responded to feedback received from young people and our previous inspections. For example, we saw that staff at Austen House had placed 'please knock' signs on the young people's bedroom doors to remind staff about privacy.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour towards the young people.

Involvement in care

Staff involved young people in care planning and risk assessment and actively sought their feedback on the quality of care provided. **They ensured that young people had easy access to independent advocates and to child helplines.**

Involvement of young people

Staff involved young people and gave them access to their care planning and risk assessments. In Bluebird House for example, we saw that there were agreements in young people's care records that they were happy with their care plans.

Staff made sure that young people understood their care and treatment. Staff at Austen House described how they met monthly with young people to review their care plans.

Staff supported young people to make decisions on their care. Community meetings were taking place regularly, feedback from previous meetings was given and more complex issues were escalated to other meetings and forums. We observed young people being encouraged to share their opinions and wishes during ward round meetings. There was a board at Austen House displaying information regarding requests made by young people during community meetings. Young people and staff could see all requests categorised as either being actioned, or being reviewed, or unable to change currently and will be reviewed again.

Staff made sure young people could access advocacy services. Advocates were attending weekly during community meetings. Relevant posters about advocacy were displayed on wards.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. At Bluebird House, members of the multidisciplinary team liaised with families from admission to ensure that they had all the necessary information. During the Covid-19 pandemic, staff tried to maintain visits and there were also video calls in place.

In Leigh House, psychology were offering family sessions to help families understand how to support young people and how to deal with eating disorders at home. Feedback to families was sent after each ward round meeting. Some family members told us that family therapy was excellent and that they participated in ward rounds.

Child and adolescent mental health wards

Staff at Austen House told us that families were involved when they meet with young people to review care plans; contact with families was care planned. The service had leaflets available for families with information about what to expect from the service.

Is the service responsive?

Good

Access and discharge

Staff managed beds well. A bed was available when needed and young people were not moved between wards unless this was for their benefit.

Managers made sure bed occupancy did not go above 85%. Managers regularly reviewed length of stay for young people to ensure they did not stay longer than they needed to. We observed staff discussing a delay in discharge for a young person during an admissions and assessments meeting and there were weekly recorded updates regarding progress. We also observed staff discussing two new admissions.

Managers and staff worked to make sure they did not discharge young people before they were ready. When young people went on leave there was always a bed available when they returned. Staff at Bluebird House and Austen House told us that preparing young people to move on to the community was a strength of the service and they found it very rewarding when young people were successfully discharged.

Discharge and transfers of care

Managers monitored the number of young people who experienced a delayed discharge. The reasons young people experienced a delay to their discharge was mainly because of issues sourcing appropriate community placements. Staff told us that there was a lack of facilities to discharge young people to if they couldn't go back to live with their parent or guardian and lack of community support.

Staff carefully planned young people's discharges and worked with care managers and coordinators to make sure this went well. Staff supported young people when they were referred or transferred between services. We saw a good transition plan at Bluebird House.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the wards supported young people's treatment, privacy and dignity. Each young person had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and young people could make drinks and snacks.

Each young person had their own bedroom, which they could personalise. We saw that some young people had used craft works they created to personalise their bedrooms.

Staff used a full range of rooms and equipment to support treatment and care. All three units had quiet areas and rooms where young people could meet with visitors in private. Young people could make phone calls in private. All units had an outside space that young people could access easily.

The service offered a variety of good quality food. Most of the young people we spoke with said that food was good. There were menus devised by dieticians, a choice of meals and alternative menus.

However, at Austen House there were issues with the acoustics of the building, especially in larger areas and rooms. Sometimes voices and noises were loudly echoed, making the environment unpleasantly noisy especially for people with sensory issues. The trust had tried to address this by placing some sound absorbing panels in the unit, but the issue was not fully rectified. Senior staff told us that the service had been accepted to be part of a project about sensory interventions and therefore assessments would be done to identify what building work and/or interventions were needed at all three units.

Young people's engagement with the wider community

Staff made sure young people had access to high quality education throughout their time on the ward.

Staff made sure young people had access to education and supported them. Education to young people was provided through Hampshire County Council. Leigh House had its own purpose-built education unit. At Austen House there was a very good board displaying young people's educational progress so nursing staff were aware and worked together with education staff for better outcomes.

Staff helped young people to stay in contact with families and carers. Both the young people and their family members we spoke with, told us that they had the opportunity to maintain contact and visiting arrangements were good.

Meeting the needs of all people who use the service

The service met the needs of all young people – including those with a protected characteristic. Staff helped the young people with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. There were some very good sensory rooms at all the units equipped with a range of sensory equipment for young people to use. A sensory garden was being developed at Austen House and the environment was suitable for wheelchair users.

Occupational therapists at Leigh House were carrying out sensory assessments for the young people and staff at Austen House had created 'sensory grab bags' for each young person. Staff at Bluebird House told us they were planning to bring in an expert to advise them on young people having more access to multimedia safely. There was a good display at Leigh House raising awareness about the LGBT community.

The service had information leaflets available for families and young people. At Leigh House there were a number of information leaflets available at the reception area.

The service provided a variety of food to meet the dietary and cultural needs of the young people, who also had access to spiritual, religious and cultural support. All units had a multi faith room, and managers informed us that any denomination pastoral support could be arranged as needed.

However, some young people told us that sometimes they were bored because of lack of activities, especially on weekends. Staff told us that activity coordinators were due to start at Leigh House and Bluebird House and felt that putting in place activity plans would be beneficial for the young people.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Young people and their relatives knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in communal areas.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. We saw that complaints were included on managers' check lists, had completed action plans and gave feedback.

Is the service well-led?

Good 

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for young people and staff.

Most of the staff members we spoke with felt supported and spoke positively about support received from managers Some staff were very complimentary about initiatives in place for staff wellbeing including supervisions and reflective practice sessions. However, staff at Leigh House told us that they did not always felt supported by managers and senior staff.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

Staff were aware of the values of the organisation and worked within them. There was a commitment from all staff to do a good job. However, staff on some units felt under a lot of pressure from the challenges of being short staffed.

Culture

Most of staff felt respected, supported and valued. They said the trust provided opportunities for development and career progression. They could raise any concerns without fear.

Some staff spoke highly of the positive dynamics within the teams. Staff from Bluebird House and Austen House told us that they felt valued and supported by managers and the multidisciplinary teams. Staff at Austen House told us that good staff incentives had contributed to good staffing levels for the unit. Staff at Bluebird House told us that there were nursing team away days for team building.

Managers at Bluebird House said that they had an open door policy and they always tried to give feedback to staff for any issues they raised and discussed outcomes. Members of the multidisciplinary team told us that staff went above and beyond, and the needs of the young people were always at the centre of all they do.

However, staff at Leigh House told us that staff shortages and issues with skill mix had affected their morale. They felt exhausted and unsupported from managers and sometimes management did not promptly respond to issues and concerns raised.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were mostly managed well.

'Safety huddle' multidisciplinary meetings were held daily and they were well attended by a range of professional and clinicians. We observed that issues and risks were discussed and action was agreed. Staff handover meetings were detailed, covered a range of information related to young people's care and information shared was well documented.

Senior staff regularly organised calls across the service to discuss staffing levels and any skill mix adjustments needed for the day, and shared with staff if possible between the units when needed.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff teams had access to the information they needed to provide safe and effective care and used that information to good effect. The trust had ensured that staff had log-in details to access electronic care records and there were also paper copies of care plans kept on wards.

Managers had systems and dashboards in place to support them in their role. We observed that managers had checklists in place which included weekly and fortnightly checks for paperwork, inductions, supervisions and there were action plans in place. Senior staff told us that they had a risk register and knew what the top risks were.

Information management

Staff had access to sufficient equipment and information technology in order to do their work. The secure record keeping system was easily available to staff to update patient care records and to review when needed.

Learning, continuous improvement and innovation

Staff engaged actively in local and national quality improvement activities.

Mental health crisis services and health-based places of safety

Requires Improvement 

Is the service safe?

Good 

Safe and clean environments

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose

The physical environment of the health-based places of safety (HBPoS) were clean and safe for patients.

Interview rooms were available for patients when required. However, we saw that due to ongoing building works at Parklands, this had recently impacted on the availability of rooms available to see patients for assessments. Staff told us they were able to utilise other unused rooms in the hospital if the usual meeting rooms were not available.

Staff followed infection control guidelines, including handwashing.

Where necessary staff made sure equipment was well maintained, clean and in working order. Clinic rooms had up to date cleaning rotas.

Safe staffing

The number of patients on the caseload of the mental health crisis teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

Nursing staff

Managers used a recognised tool to calculate safe staffing levels. Managers told us the service was short of permanent registered nursing staff, and the service was using NHSP bank and agency staff to cover shifts. This shortage varied across the locations we visited.

We saw the vacancy rate across the services was high, this was not evenly dispersed across the locations we visited. At the time of our inspection, Parklands had 10 band 6 vacancies and five band 5 vacancies. This was due to recently acquiring additional geographical areas of responsibility which required more staff to effectively provide care and treatment to patients, qualified bank and agency staff provided cover for these vacancies. Staff told us if the caseload continued to grow they were close to being unsafe.

The team based at Antelope House had few vacancies and were in the process of recruiting into those roles, registered bank staff provided cover for these vacancies.

Elmleigh had a vacancy for a band 6 practitioner for the home treatment team at the time of our visit. There was no use of bank or agency staff and staff from the home treatment team would occasionally provide cover for the crisis team. However, there were times when the crisis team were short of staff accepting and triaging patients which means there were sometimes longer call waiting times for people accessing the service.

Parklands staff provided a staff member to assist with cover for the health-based place of safety during the night. A contracted company facilitated this, and the night shift crisis team staff member would visit the HBPoS on hourly visits.

Managers made sure all bank and agency sufficiently covered shortages and staff had a full induction and understood the service before starting their shift.

Medical staff

The services we visited had enough medical staff and patients were able to access a psychiatrist when required. However, doctors were not requested by staff to attend the health-based places of safety for early determination of the presence of a mental disorder for people using that service.

Antelope House employed a pharmacy technician within their crisis service (CRHT). During our visit we saw initiatives being put into practice regarding clozapine community titration management and clozapine initiation care plans. Further initiatives included training for staff, information packs and a whole service audit on the medicating of patients. The outcome of this audit led to improved medicating practices. Medical staff and service leaders told us that these initiatives have improved practice, streamlined processes and improved outcomes for patients.

Mandatory training

Managers monitored mandatory training and alerted staff when they needed to complete their training. The training programme was comprehensive and met the needs of patients and staff. Some of the mandatory training units included safeguarding children and adults, medicines management and suicide awareness. Data we reviewed showed that 97% of staff had completed mandatory training which was higher than the trust target of 95%. The trust had paused some essential training due to the risks with the COVID-19 pandemic.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool. However, we saw risk assessments were not always personalised. We saw generalised statements relating to patients needs in the nine care records we reviewed across the crisis teams. This could mean that patients' risks were not accurately captured, and management of risk was not always appropriate to their needs.

Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need.

The service used different systems for personal safety protocols across the locations we visited. The lone working protocols kept their colleagues informed when they were out for visits. Devices used by the teams tracked their whereabouts and also had functions to record and alert the crisis team to an emergency. However, staff at Elmleigh told us they did not always feel safe when being expected to visit patients presenting a physical risk of harm and felt managers recommendations to attend with an extra staff member did not alleviate the risk or take this seriously.

Mental health crisis services and health-based places of safety

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. However, during an incident within the health-based place of safety (HBPoS) at Parklands the externally contracted staff acted quickly to remove the risk but were unaware of the need to ensure the patient received a physical health assessment or provide enhanced observations. This meant that the patient was at risk of their health deteriorating. When a member of the crisis team became aware during the following hourly check, they acted appropriately and carried out all required examinations on the patient.

The service did not have a waiting list and organisational timelines for admission, triage and assessment were within trust targets.

Staff followed clear personal safety protocols, including for lone working.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training. Staff undertook the safeguarding children and adults level two training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff we spoke to gave examples of when to escalate concerns when they identified abuse.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

Staff working for the mental health crisis teams could access patient records on the electronic records system. However, patient records were not always detailed, up-to-date and changes were not always recorded regularly.

When patients transferred to a new team, there were no delays in staff accessing their records. Patient records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff working for the mental health crisis teams regularly reviewed the effects of medications on each patient's mental and physical health.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patients told us that staff asked at every visit how they were getting on with medication and if any changes needed to be made.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses in line with trust policy.

Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. One patient told us an investigation was done really well, organised and timely.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. Staff at Elmleigh told us they were not always kept informed of any further details regarding safeguarding referrals they have raised

Staff met to discuss the feedback and looked at improvements to patient care. We saw meeting minutes at Antelope House and Parklands showing specific incident outcomes as discussion points.

Is the service effective?

Requires Improvement 

Assessment of needs and planning of care

Staff made sure that patients had a full physical health assessment. Physical health clinics were available for patients on certain days of the week and the teams discussed patients' physical health in multi-disciplinary team meetings. However, care records we reviewed across the crisis teams did not always clearly show when physical health checks had taken place.

Although all patients had a care plan in place, they varied in quality. Of the nine care and treatment records we reviewed across the three crisis teams we visited, there was a lack of personalisation, and they did not capture patients' views. Management plans for identified risks were not always comprehensive or evident, this meant that patients were not always having their needs met in a person-centred and holistic way.

Staff did not always update care plans when patients' needs changed. Staff were knowledgeable about the patients they cared for and their needs, however, recording of this information was not always completed.

Mental health crisis services and health-based places of safety

Best practice in treatment and care

We reviewed nine care records; only one record showed evidence of the Glasgow Anti-psychotic Side-Effect Scale (GASS) or any other recognised rating scale to assess the severity of patient conditions.

Staff at Antelope House took part in clinical audits, benchmarking and quality improvement initiatives. Managers at this location used results from audits to make improvements.

Antelope House had taken part in a Core Fidelity review (a programme organised by the University College London), this involved using a self-mapping tool, assessment of the service, scoring highlighted differences and actions and medial time against caseload. Managers and medical staff told us that as a result of this review, the service has been able to alter its practice and approach to best meet the needs of the patients in a more effective manner. We saw evidence of improvements following this review process in documentation we looked at.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. This included advice on smoking cessation, substance misuse and healthy eating.

Staff used technology to support patients, the service often used digital platforms to provide support to patients when appropriate. This meant staff were able to be more effective with appointments and responsive to patient's needs.

Staff spoke with patients at assessment stage to ascertain their needs and provide care and treatment suitable for the patients in the service. Staff told us if other treatment options were identified as a need, they would often signpost patients to the relevant professionals or agencies.

Skilled staff to deliver care

The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients under their care. We saw that access to psychology and medical professionals was evident across the service.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

They supported staff with opportunities to update and further develop their skills. Staff members had access to the 'ACE' academy, which was funded by the trust and provided staff with opportunities to further improve their skillset and qualifications. At the time of our inspection, supervision compliance across the four crisis and home treatment teams was 78%for the year to date.

Managers provided an induction programme for new permanent and agency staff. However, the induction process varied in quality across the locations we visited. For example, the induction pack at Antelope House explained everything a staff member would need to know regarding their employment within Southern Health NHS Foundation Trust and specifically within Antelope House. It also included comprehensive information on what they could expect within their day-to-day life in their role and support structures. Elmleigh induction pack included information relating to employment within the Trust and procedural information on working at Elmleigh, such as fire drill procedures and security.

Managers supported medical staff through regular, constructive clinical supervision of their work. We saw quality improvement initiatives undertaken by the pharmacy technician, which received appropriate oversight and approval from the medication management committee.

Managers at Antelope house and Parklands made sure staff attended regular team meetings or gave information from those they could not attend. We reviewed meeting minutes that included topics discussed and shared learning from incidents. Topics included in meetings included 48 hour follow ups, performance, triage referrals, staff updates, crisis plans, risk assessments and incident communication/feedback.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients.

The teams had effective working relationships with services outside the organisation including the police, local authorities and community mental health teams (CMHT). However, the crisis teams across the four locations did not have a mechanism in place to share concerns or lessons learned with each other.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients, changes in their care were not always recorded within care records we reviewed even though staff we spoke to were confident in discussing patients' up-to-date needs.

We saw documentation about transfer of care that was comprehensive and fully considered the patients' needs. However, this level of detail was not consistent across the three locations we visited.

Ward teams had effective working relationships with other teams in the organisation, we saw this in Parklands where the night-time crisis team staff member would provide cover for regular observations to the health-based place of safety (HBPoS). Other locations did not have a requirement to provide cover for the HBPoS due to ward-based staff undertaking this responsibility.

The service had care navigators. The role of the care navigator was to liaise with the relevant inpatient wards, part of this role was to ensure patients have a timely discharge back into the community setting with support provided by the home treatment teams.

Relevant agencies/personnel such as the police, approved mental health professional (AMHP) service, service lead, service user lead and Securecare attended the trustwide Heath based place of safety (HBPoS) meeting, this was also known as the S136 meeting.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff in the crisis teams understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. However, in the HBPoS, we saw evidence that staff did not request a doctor to examine a person using the place of safety as soon after arrival as possible to make an early determination about the presence of a mental disorder. Staff at all three locations we visited

told us, they did not request a doctor to come out, the practice was to automatically refer straight to a Mental Health Act assessment. The Mental Health Act Code of Practice states that should no mental disorder be present there is no authority to continue to detain the person further and they must be immediately released (Code 10.31). This meant patients were being detained for longer periods than necessary whilst waiting for a full mental health assessment to take place and was determined by the availability of approved mental health professionals (AMHP).

The HBPoS at Elmleigh did not provide patients with access to fresh air. During our visit, staff were not clear about the process for escorting patients to access fresh air.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. They knew who their Mental Health Act administrators were and when to ask them for support. The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy.

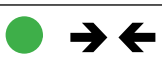
Staff did not always explain to each patient their rights under the Mental Health Act. We reviewed 11 records of people who had used the HBPoS, three of those records showed no evidence of patients being informed of their rights when the 24-hour detention period had been reached, which meant these patients were not informed of their rights to leave or given an opportunity to make an informed decision following advice from health professionals.

Good practice in applying the Mental Capacity Act

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. Staff knew where to get accurate advice on Mental Capacity Act.

In the HBPoS, staff did not always give patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. In three records we reviewed, we saw no record of any discussion with patients to see if they were willing to stay, or if they weren't, any discussion about the risks of letting them go versus unlawful detention. Or of making a decision to unlawfully detain in someone's best interests if they had been assessed as lacking capacity to consent or otherwise to staying.

Is the service caring?

Good 

Kindness, privacy, dignity, respect, compassion and support

Staff in the crisis teams were discreet, respectful, and responsive when caring for patients. Patients told us they felt cared for, and family members were given support to help provide appropriate support. Staff used private rooms to speak to patients when assessments are carried out at the hospitals to maintain privacy and dignity.

However, staff told us that an external agency contracted to provide care services for the health-based place of safety at Parklands were inconsistent in their approach to providing care to people who use the facility. Staff at Parklands told us

they feel that some external staff saw themselves as 'security' rather than a role to provide care to vulnerable people. Topics relating to the HBPoS are raised in the multi-agency 136 meetings which are attended by senior leaders of the external provider, debrief of recent events and shared learning are noted within these meetings. We reviewed the previous six months of meeting minutes and saw no concerns regarding the conduct of external provider staff at Parklands had been escalated to leaders of the service.

Staff understood and respected the individual needs of each patient. However, these individual needs were not always accurately recorded on patients' records.

Staff in the crisis teams gave patients help, emotional support and advice when they needed it. Patients we spoke to, spoke of feeling looked after and supported.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help. We saw evidence that staff in the crisis teams had supported people to access other services such as 'Mind'. Patients told us they had been helped to set up a mobile phone app called 'Calm' that helps with meditation, sleep stories and helps them to go to sleep and get into good hygiene patterns.

Involvement in care

Staff in the mental health crisis teams did not always document accurately patients' involvement in care planning and risk assessment, we saw care records lacking in patient input. However, four patients we spoke to told us they felt involved in decisions made about their care planning and one carer spoke very highly of the care their relative received and insisted that prior to using the crisis service, all other options of treatment had failed.

Staff informed and involved families and carers appropriately, patients told us they often had family members and loved ones involved in their care.

Involvement of patients

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. This included having access to interpreters to help communicate with people who spoke a different language.

Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. We saw positive compliments sent in by people who had used the service and one said the service had saved their life.

Involvement of families and carers

Staff supported, informed and involved families or carers. Staff helped families to give feedback on the service.

Mental health crisis services and health-based places of safety

Is the service responsive?

Good

Access and discharge

The mental health crisis service was available 24-hours a day and was easy to access, including through dedicated crisis telephone lines individual to each locality. During the night-time, assessments would be carried out within the hospital setting Staff assessed and treated people promptly. Staff followed up people who missed appointments.

The service varied in criteria to which patients they would offer services to. The crisis teams at Parklands and Antelope House accepted self-referrals. However, the service at Elmleigh did not accept self-referrals, this excluded people who would benefit from care. Staff told us that referrals could only be accepted by professional agencies and were unaware why the referral criteria for other crisis teams were different.

Staff assessed and treated people promptly. Staff saw urgent referrals quickly and non-urgent referrals within the trust target time. The team tried to contact people who did not attend appointments. They followed up people who regularly missed appointments and offered support. For example, during our visit, we saw members of staff attempting contact with people who had missed appointments so they could reschedule planned visits.

The team tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. During our visit, we saw that some patients were being offered opportunities to undertake virtual engagement to negate the need to be seen in person due to specific anxieties and other social barriers.

Patients had some flexibility and choice in the appointment times available.

Patient visits were planned and there had been no missed appointments, staff told us that when there needed to be changes in the arrangements due a patient's own schedule, they would discuss alternative arrangements with them. This included calling patients to inform them if they were running late.

Staff supported patients when they were referred and transferred between services as part of their discharge plans.

Facilities that promote comfort, dignity and privacy

There was a range of rooms and equipment available to the crisis and home treatment teams to support treatment and care. However, the design and layout of the health-based place of safety at Parklands and Elmleigh did not promote comfort, dignity and privacy for patients.

Patients' engagement with the wider community

Staff supported patients to access opportunities for education, patients told us they had access to the recovery college which gives an educational approach to equip patients with the knowledge and skills to progress with life despite mental health issues. Patients also told us they had been helped with claiming benefits.

Meeting the needs of all people who use the service

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. There was a translation and interpretation service available via an external provider for people who needed them.

Staff provided patients information on treatment, local service, their rights and how to complain.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, however, these were not always shared with the whole team and wider service. Staff at Elmleigh told us they are not informed of lessons learned by leaders and were not always informed of why changes to the service were made.

Patients, relatives and carers knew how to complain or raise concerns. Patients told us they were aware of how to make a complaint and if they became unsure they would look on the trust website.

Staff understood the policy on complaints and knew how to handle them. Staff told us they tried to address any patient concern in first instance and if their concerns cannot be resolved, they would support them to make a formal complaint.

One patient told us that they had raised a complaint, they stated that the investigation was done really well, organised and timely.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Requires Improvement

Leadership

Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed. However, they were not always visible in the service and approachable for patients and staff. Staff at Elmleigh told us they rarely saw managers to speak to.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team. The trusts' vision included providing compassionate, safe care and listening to each other. The general feedback from patients and carers was that staff complimented the trusts' vision in these areas.

Culture

Staff felt respected, supported and valued. They said the trust provided opportunities for development and career progression and they could raise any concerns without fear of retribution. Managers at Antelope house and Parklands interacted well with their teams and had an open-door policy. However, at Elmleigh, staff told us they do not often see managers and often felt unsupported, supervision compliance at this location was an average of 67% for the year to date.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. The teams had daily handover meetings where they discussed patients and their care. Service locations varied in reviewing risk for patients, all patients considered high risk were discussed in detail daily. This meant patients deemed least at risk were not always discussed in daily meetings but were discussed at least once weekly.

A new standard operating procedure for the crisis resolution home treatment team had been drafted in collaboration from team leads across the four crisis team locations. However, service leads told us that discussions across the four service locations had not happened for many months and were unsure why this was the case. This meant themes and practices across the core service were not shared among service leads.

The service held crisis resolution home treatment (CRHT) business meetings monthly at each crisis location to discuss agenda items such as: staffing, incidents, triage referrals and other areas relating to the care and treatment of patients. However, there was not effective oversight above the service leads to ensure the different locations were operating with equity of resources, efficiency of operating models and equal access to crisis services across the region for people who need it.

Information we reviewed from the S136 multi-agency meeting minutes showed leaders reviewed themes, concerns and shared learning. Review of activity within the health-based places of safety detailed the number admissions and details surrounding admissions where 24-hour breaches had occurred. Further discussion provided evidence of a multi-agency approach to make improvements where possible and practicable.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The trust used a visual analytics platform to record and identify issues with performance and compliance. Other data we saw held on the platform, included caseload size, documentation completion compliance and assessment stage compliance across the trust.

Information management

Staff collected and analysed data about outcomes and performance and engaged actively in local and quality improvement activities. The CORE fidelity review of services provided from the crisis team at Antelope House led to improved processes and outcomes for patients.

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

Requires Improvement

Is the service safe?

Requires Improvement

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated risk assessments of all ward areas and removed or reduced any risks they identified.

Staff could observe patients in all parts of the wards. Where there were blind spots, the trust had mitigated the risk by installing mirrors, CCTV and by staff observation of patients.

Staff knew about any potential ligature anchor points and took action to mitigate the risks to keep patients safe. There were regular ligature assessments completed on all the ward areas we inspected. Ligature anchor points were removed, and plans put in place for any risks that could not be moved. For example, new risks had been identified around curtain rails and patients' personal lockers and these had been immediately removed by the trust. Staff had ligature maps in the office to advise them of the high-risk areas. However, Staff at Antelope House felt that the trust did not take action to remove ligature points fast enough. The trust told us that all estates work to remove ligature points is overseen by the Ligature Management Group and are prioritised according to risk. There was work planned at Antelope House in January 2022.

There was no mixed sex accommodation. Although the ward at Melbury Lodge was mixed gender, the trust had divided into male and female areas, separated by a therapy corridor. There was a dedicated female only lounge in line with government guidance. Parklands had separate male and female bedroom areas. The other locations had separate male and female wards.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff were issued with alarms when they arrived at work and these were regularly tested. There were nurse call alarms for patients to use.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. All premises we visited were clean and tidy. We saw that housekeeping staff were employed on all the wards and they completed daily records of cleaning.

Staff followed infection control policy, including handwashing. Staff wore facemasks and cleaned their hands regularly. There were antiseptic hand gels at the entrance to each ward and we saw that staff used them, hand gels were also in

offices and treatment rooms. The services conducted regular infection control audits. For example, wards completed monthly hand hygiene audits where the lead member of staff would observe staff hand hygiene practice for a variety of care activities and identify any improvements that were then communicated back to the staff team. Following infection control procedures was a requirement from our last inspection and this was now being met by the trust.

Seclusion room

The Seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock. The seclusion rooms at Parklands hospital were newly built and did not include any blind spots which was a requirement of our last inspection.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. We saw that checks took place regularly and staff had photographs of what was in each bag to help them review it. Bags were sealed so that staff knew the bag had all the items needed in an emergency.

Staff checked, maintained, and cleaned equipment. All equipment we saw was clean and stored tidily. However, at Elmleigh and Antelope House equipment did not have clean sticker to say when it had last been cleaned.

Safe staffing

The service did not always have enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not always have enough nursing and support staff to keep patients safe. There were thirty-eight vacancies across the hospitals for nurses and support workers. Staff told us that this meant they were not always able to provide the level of care to patients that the patient should expect. This included less leave and less time in therapy focused work.

Managers calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. Staff told us that they were able to increase the number of staff needed on the wards to enable them to cover additional support needs of patients. However, staff told us that they could not always find staff to fill these shifts.

Turnover rates were increasing in the staff teams. The use of bank and agency staff was increasing. Manager and staff told us that this changed the skill mix of team and they were not always able to offer the same type of interventions. For example, the ward had less staff on duty trained in Dialectical behavioural therapy (DBT). DBT is a type of cognitive behavioural therapy. Cognitive behavioural therapy tries to find and change negative thinking patterns and pushes for positive behavioural changes. The trust had tried to address staff shortages by offering incentives to work for the trust. For example, they had offered qualified nurses two days a week to work on projects of their choice to develop patient care. However, managers told us this had not increased the number of staff applying for posts.

Ward managers could adjust staffing levels according to the needs of the patients. All ward managers told us they could increase the number of staff but felt that it was unlikely they could find extra staff as bank or agency staff had already been used to meeting their core staffing numbers.

Managers were not able to limit their use of bank and agency staff because of the number of vacancies throughout the trust. However, where possible, long term agency staff were used and managers requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Longer term agency received a full trust induction and could access trust training. Agency staff that covered shifts less often received an induction to the area they were working. The induction included tasks such as completing observations.

Managers supported staff who needed time off for ill health.

Patients had regular one to one sessions with their named nurse.

Patients regularly had their escorted leave or activities cancelled. When we spoke to staff, they told us this was due to staff shortages, patients told us leave was cancelled due to staff shortages and when there were incidents on the ward. Staff and patients told us that, where possible, staff rearranged cancelled leave, as soon as possible. Managers told us that they did not keep a record of when staff had needed to cancel leave so were not aware of how severe this issue was.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others.

However, the trust met the safer staffing number as identified in national guidance. The trust has a daily safer staffing panel and have increased ward managers access to bank and agency staff. The have recruited administration staff to support clinical teams and have an international recruitment programme. They have recruited above the agreed establishment on wards where possible and are looking at skill mixes to improve clinical care and have increased the number of senior nurses throughout the trust.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover. However, locum consultants were being used at Melbury Lodge. However, the locum consultants knew the patients and staff well and were able to offer good support to the multidisciplinary team.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up to date with their mandatory training. However, the trust was changing its physical intervention training programme. Managers and staff told us they were not sure how long it would take to retrain their team and were unsure when the change would occur. This meant that staff were coming to their renewal time and could not book on to a course.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers had access to information relating to mandatory training compliance rates and could encourage staff to book on to shift when they were need to. The trust had paused some essential training due to the risks with the COVID-19 pandemic.

Assessing and managing risk to patients and staff

Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, but not always after incidents. We reviewed 21 patient records and saw that all patients had a risk assessment. However, staff had not reviewed eight of the risk assessments as often as they should or had as much detail as was needed. For example, one risk assessment had not been updated following an incident that required seclusion and one had identified aggression towards other patients as a risk but did not have a plan in place to manage this.

Staff used the risk assessment on the electronic records system and could access more specific risk assessments if needed. For example, The Historical, Clinical and Risk Management – 20 (HCR -20) is a structured tool to assess the risk of violence.

Management of patient risk

Staff told us that the number of injuries to staff and patients during incidents of aggression were increasing. We were aware that staff had been injured and required hospital treatment during our visit. There were 75 reported incidents of assaults on staff during the last two months prior to our visit, this included two incidents of the most serve rating of major, permanent/long term harm.

Staff did not always respond to changes in risks to, or posed by, patients. We reviewed four incidents involving patients tying ligatures at Elmleigh in the week before the inspection and saw that the incident reports lacked details including what the patient had used to tie as a ligature. This meant staff may not be aware of what items would be a risk for certain patients. The clinical team had not increased the observation levels of the patient despite the increase in risk behaviour.

Staff could observe patients in all areas of the wards or staff followed procedures to minimise risks where they could not easily observe patients. However, we saw that observation records lack detail. For example, at Elmleigh staff had only ticked patients' observation records to identify they had seen them but not recorded when they were seen. We also saw that some records had not been recorded, these included patients identified as being at a high risk of ligaturing. This meant that the trust could not be assured that staff always followed local and trust wide policies when checking patients.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were reducing. Following peaks in December 2020 and May 2021 there has been a general down trend in the number and severity of incidents.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The team at Melbury lodge had conducted a number of quality improvement initiatives to reduce the number of restrictive practices on the ward. For example, reducing the amount of times staff checked people on general observations and unlocking the laundry cupboard. Staff told us about restrictive practices such as patients not being able to access their bedrooms during the day at Antelope House. We raised this with managers on the day of the inspection and they told us that they were unaware of this and would address it. Staff at Melbury Lodge told us they were concerned that senior managers did not agree with some of the changes and wanted them to put some of the restrictions back in place.

Staff at Elmleigh told us that patients had to ask staff to get a drink and could not use china crockery, we raised this with managers who told us this was not true. However, staff showed us a sign dated 20/09/2021, put up by managers, that said patients in red bay could only have paper or plastic crockery. Staff told us the sign had been removed the day before our visit.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed the National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. Following post rapid tranquilisation monitoring physical health was a requirement at our last inspection and the trust was now compliant with this.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff told us that they considered any known risk between patients when considering admissions and would make plans to protect patients when needed.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. There were family visiting rooms that could be used to facilitate children visiting relatives in the hospitals. Managers also told us that they would make special arrangements for patients that were bedridden at the time of the visit and always encouraged visits in the community.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke to could explain how to report a safeguarding concern. There was support provided by the trust if staff wanted to discuss possible safeguarding concerns.

Staff told us that senior managers did not always consider safeguarding concerns when requesting admissions. Staff at Antelope House told us that senior managers had told them to admit a patient despite raising concerns that there was a known safeguarding risk with a patient already admitted to the ward.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. Staff had easy access to the electronic record system. The trust had procedures in place for planned and unplanned shutdowns of the system.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. The electronic system was password protected and used an ID card for access. Staff stored paper records in a locked room when not being used.

Medicines management

The service generally used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. This included monitoring and responding when need to the temperature medications were stored at. This was a requirement of our last inspection and trust was now complaint with this. All wards we visited had a pharmacy technician who was the lead for medication processes on the ward. During the week they would administer daytime medication and were responsible for removing out of date medication and ordering.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. However, at Melbury lodge we found that there were several old controlled drug books that should have been archived and the weekly controlled drugs stock check had not been completed. We checked the controlled drugs level with the staff and found that they were all correct.

Staff followed current national practice to check patients had the correct medicines. The pharmacy technician checked all medication and reviewed this with a pharmacist and the consultant to ensure the ward followed national guidance.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. There were regular reviews of patient's medication by the multi-disciplinary team

Staff reviewed the effects of each patient's medication on their physical health in accordance with NICE guidance. We saw that staff reviewed patient's physical health needs and put plans in place to address any identified concerns. There was a system in place to review the use of high doses of anti-psychotic medication. However, at Elmleigh we found that staff had not completed the high dose anti-psychotic monitoring forms for one patient and at Antelope House we found that staff had not completed high dose three anti-psychotic monitoring forms for three patients. This meant that staff would not be aware if the medications were having a negative effect on the patient's physical health.

Track record on safety

Reporting incidents and learning from when things go wrong

Staff reported serious incidents in line with the trusts policy. When things went wrong, staff apologised and gave patients honest information and suitable support.

The incident reports we reviewed in Antelope house and Elmleigh lacked detail and the identified actions were the same for multiple incidents. For example, patients had used clothes to tie ligatures and self-harmed by swallowing items. Identified actions simply stated 'patient aware of risk, do not increase observation levels'; this did not clearly identify that how the risks were being managed.

Staff told us that they reported serious incidents in line with trust's policy, but they did not report all other incidents. This would mean that the trust may not be aware of patterns and trends of incidents that were occurring, and managers would not be able to take appropriate action to address them.

Following the inspection, a serious incident occurred at Parkland's hospital that resulted in the death of a patient. This was responded to by the trust with an external investigation being commissioned to look at the causes, while also working closely with the police for their investigation.

Managers did not always de-brief and support staff following an incident. Staff told us there was not always time to do debriefs correctly as they were often short staffed.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Managers were able to tell us about when they had apologised to patients and families.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers told staff about learning from incidents in team meetings and supervision. Staff also shared learning from incidents at handovers. For example, staff were aware that patient's safes and anti-ligature curtain rails had needed to be removed because of incidents in trust even when these had not happened at their place of work.

Staff met to discuss the feedback and look at improvements to patient care. However, at Antelope, Elmleigh and Melbury Lodge staff told us that they were not always listened to and that senior managers would make decisions without involving ward staff. For example, patients risk level remained unchanged after incidents and approaches to their treatment and management of risk did not change.

Staff at Elmleigh told us that the trust had not made any improvements following our inspection in April 2021, but some improvements had been made following a recent serious incident.

Is the service effective?

Good 

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Records we reviewed show that patients' mental health needs were reviewed on admission and that staff continued to assess them throughout their stay.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Doctors worked with patients to assess their physical health needs and it they could not be assessed on admission would work with the patient at their pace to ensure it was completed. However, we found that staff at Elmleigh, Antelope House and Parklands did not always follow up National Early Warning Scores (NEWS) correctly. Staff should repeat physical health observations sooner or seek medical assistance depending on the NEWS score calculated. We found five examples where staff did not repeat patients' physical health observations within the advised timeframe. This meant that staff would not recognise that patient's physical health had deteriorating and be able to seek assistance.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Staff regularly reviewed and updated care plans when patients' needs changed.

We reviewed 21 care records across the four sites and saw that although the quality of care plans varied, they were personalised, reflected the patient's views, were holistic and recovery orientated. However, staff had not recorded whether they had offered copies of the care plans to patients.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Staff told us that the lack of staffing was having an impact on the quality of treatment they offered. For example, the agency staff did not always have the skills needed to support the treatment being offered by other members of the MDT. For example, skills in DBT to support the patients with the skills they were learning in groups. However, the staff teams were working to address this by offering training and different working patterns to the permeant staff. Patients and carers we spoke to told us that they were receiving the treatment they needed.

Staff delivered care in line with best practice and national guidance. We saw evidence in patients records that staff followed latest guidance when planning care for patients.

Staff identified patients' physical health needs and recorded them in their care plans. We saw that staff had developed care plans for patients that had physical health needs.

Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. We saw care plans around meeting physical health needs that included support around healthier lifestyles. For example, we saw care plans around diet, exercise and to improve sleep.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. The electronic notes system had recognised outcome measures embedded that ward managers could use to audit patients progress.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Ward managers told us that they reviewed and audited clinical outcomes monthly. Melbury Lodge told us that they had completed a number of quality improvement reviews that had led to positive changes on the ward, this included the linen cupboard being open so that patients could get fresh sheets and towels themselves. Elmleigh had changed how they carried out observations, staff physically handed over observation charts to the next member of staff and discussed the patient. There was a 'snapshot of a patient' developed at Parklands that meant staff could quickly get relevant information about a patient.

Managers used results from audits to make improvements.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had a full range of specialists to meet the needs of the patients on the ward. The wards we visited had access to psychiatrists, occupational therapists, registered nurses and psychologists. When there were vacancies the trust approved the use of locum and agency staff to address this.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. However, ward managers were concerned that as staff left they could not always find agency staff who had the same skills to deliver care on the ward

Managers gave each new member of staff a full induction to the service before they started work. All staff had an induction before starting on the wards. Locum and long-term agency staff received the trust induction and could access trust training. Ad-hoc agency staff would get a local induction to the ward and the current patients.

Managers supported staff through regular, constructive appraisals of their work. Appraisal were used to identify training needs and career development.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. However, ward managers we spoke to told us that staff supervision was missed when the ward was busy. Staff also told us that the amount of supervision staff received was affected if the ward managers were off work. Staff we spoke to felt well supported by their local managers.

Managers supported medical staff through regular, constructive clinical supervision of their work.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. There were regular team meeting and daily safety huddles where staff could raise concerns and solutions agreed.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us that the pandemic had affected training opportunities, but more training was available to staff.

Managers made sure staff received any specialist training for their role. For example, staff had training in DBT so that they could provide groups to patients in line with national best practice guidance.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers told us that human resources would provide support to manage staffing issues.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff told us the teams worked well together. We attended MDT meetings and saw good multidisciplinary working.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation. We saw that local community teams were invited to ward rounds and discharge planning meetings and we offered the opportunity to attend in person or by a video call.

Ward teams had effective working relationships with external teams and organisations.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. At Melbury Lodge 97% of staff had completed training and 100% of staff at Elmleigh had completed training in the MHA and Code of Practice.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. We saw posters on the ward advertising advocacy and staff told us that they would visit and speak to patients.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. We saw that this was recorded in patients' records.

Staff were not always able to facilitate patient's section 17 leave (permission to leave the hospital) agreed with the Responsible Clinician and/or with the Ministry of Justice. Staff and patients told us that section 17 leave was cancelled due to wards being short staffed and due to incidents. We asked the trust how often staff cancelled section 17 leave and managers told us that the trust did not collect this information. Staff at Elmleigh told us patients sometimes had to wait for a registered nurse from a different ward to sign their paperwork before they could access leave, as the qualified nurse on duty had not completed the trust internal course to do this yet.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

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

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 (MCA) and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff did not receive training in the MCA as part of the mandatory training programme run by the trust. However, staff we spoke with had a good understanding of the five principles of the Mental Capacity Act.

There was a clear policy on MCA and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. Staff told us they could speak to the MHA administrators for advice.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. However, not all decisions about capacity were clearly documented, we saw one decision at Antelope House where staff had just recorded “no” in the section for does the person have capacity.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient’s wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications. Ward managers advised us that it was rare for them to make applications for a Deprivation of Liberty Safeguards order as most patients were detained under the MHA.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve. Ward managers told us that the trust audited the use of the MCA but could not advise us of any findings from this.

Is the service caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients’ privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. All interactions we saw between staff and patients was respectful and supportive. Patients we spoke to told us staff treated them with respect. For example,

knocking doors before coming into bedrooms. All staff spoke to us positively about the patients they were caring for. When staff were concerned that a patient had been placed inappropriately in their service, they recognised this as a service issue. For example, at the time of the inspection there were no female PICU beds available in Southern Health NHS Trust.

Staff gave patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition. Staff could access leaflets that explained treatments and medication in different languages and as easy read versions.

Staff directed patients to other services and supported them to access those services if they needed help. However, some carers we spoke to felt there should be more educational activities.

Patients said staff treated them well and behaved kindly. Patients and carers, we spoke to said that staff were respectful towards them.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff told us they were confident to raise concerns.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Staff would show patients around the ward and introduce them to the staff and other patients.

Staff involved patients and gave them access to their care planning and risk assessments. We saw evidence in risk assessments and care plans that the staff has included patient's opinions in their care plans. However, none of the 21 records we reviewed had evidence that patients had been given a copy of their care plan.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties.

Staff involved patients in decisions about the service, when appropriate. For example, staff encouraged patients to take part in recruitment by coming up with questions and meeting candidates prior to interviews.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services. Patients told us they had access to advocacy and that staff would help them if they wanted to access it.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Patients told us they could choose who was involved in their care and staff respected these decisions.

Staff helped families to give feedback on the service. There was a carers forum that allowed carers to share their experiences and give feedback to the trust.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Requires Improvement  

Access and discharge

A bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

Bed management

Most wards were continuously full and there was continuous pressure on staff to admit patients.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

Staff told us that senior managers only considered out-of-area placements for patients as a last choice. This meant that staff had to admit patients who were inappropriate for their service. Staff gave us examples of patients that senior managers insisted they had to admit after qualified nurses had screened the patient as unsuitable for admission. Once admitted the patients required high levels of restrictive interventions including multiple staff working with them, physical restraint, rapid tranquilisation and seclusion. Staff also gave us examples of when managers at the hospitals agreed that patients were not suitable for admission during usual working hours only for senior on-call managers to insist staff admit the patient out of hours.

Managers and staff worked to make sure they did not discharge patients before they were ready. However, staff told us that the bed management team would encourage them to discharge patients that were not ready to free up beds for admissions.

Staff and managers told us that if a patient went on extended leave, they would be under pressure to fill their bed. This meant that the patient would not have a bed to return to if they were unwell, however, the trust would always aim to provide them with another bed.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff told us that there was a shortage of psychiatric intensive care unit (PICU) beds across the trust. Ward managers told us that the PICU beds were limited and regardless of clinical need they were instructed not to keep referring patients to the PICU as there were no available beds despite clinical need. Currently the trust had a service level agreement with a provider outside Hampshire to provide female PICU beds and were in the process of opening a female PICU ward at Antelope House. Staff told that this meant patients who needed a PICU bed were being cared for in an acute bed. We had told the trust to continue the quality improvement work that they were doing in relation to PICU admissions. However, ward Managers told us the trust was no longer following this process.

The trust told us that they had more PICU beds than the national average and were planning to open more beds. They were following a bed model that placed patients where they would receive the best care, where their risks could be best managed and as close as possible to their home. They have and continue to make improvements to the wards to improve the quality of care provided. For example, reducing the size of the wards, improving gender segregation and improving seclusion facilities.

Discharge and transfers of care

Managers told us that a lack of suitable support in the community caused most delays to patients' discharge.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. However, staff told us that the trust bed management team would put pressure on ward staff to discharge patients before they were fully ready, as there was always a high demand for beds. Staff told us that members of the bed management team had visited wards to assess patients when ward staff had already assessed them as needing to remain in hospital.

The rates of re-admission were high across the trust. In the six months before our inspection 71 patients had been readmitted to the acute and PICU wards across the trust. Antelope House had the most readmission followed by Parklands. When we inspected the trust in 2019 there had been 115 readmissions in the previous 12 months. This showed that patients were either being discharged before they were ready to leave hospital or before an appropriate support package was ready in the community.

Staff supported patients when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment. Each patient had their own bedroom with an en-suite bathroom. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. However, the trust had removed all curtains from bedrooms. Staff did not know what the plan was to provide patients with appropriate curtains but told us the screening on the windows prevented people from seeing in.

Patients had a secure place to store personal possessions. However, since the trust had removed all locker from the bedrooms, patients had to ask staff to access personal belongings they wanted securely stored.

Staff used a full range of rooms and equipment to support treatment and care. All areas we visited had access to enough rooms to provide care and treatment to patients.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private. Patients had access to mobile phones and staff could facilitate private calls if a patient did not have their own phone.

The service had an outside space that patients could access easily.

Patients could make their own hot drinks and snacks and were not dependent on staff. However, we were told that patients needed to ask staff in Red Bay at Elmleigh for a cup to make a drink. Senior staff told us that cups were currently restricted due to patients breaking the cups and using them to self-injure. They told us that once more durable cups had been purchased the restriction would be lifted.

The service offered a variety of good quality food. Patients told us that the food was good and that the wards could cater for special diets.

Patients' engagement with the wider community

Staff supported patients with activities outside the service and family relationships.

Patients told us that there were activities on the wards but they were not always supported off the ward due to staff shortages. This meant work and education opportunities in the community were limited.

Staff helped patients to stay in contact with families and carers. Staff supported patients to visit relatives and they could use video call technology.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. There were accessible bathrooms available to patients and wards were on a single level.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Staff gave patients information when they were admitted to ward and there where posters on the notice boards that gave patients up to date information.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support. The wards all had chaplains who visited, and staff could arrange for spiritual leaders from different faiths to visit the ward when needed. There were multi-faith rooms available at each site.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Patients and carers told us they would be happy to raise a concern.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff could explain how they would handle a complaint and told us that they could get support from the trust's complaints team.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Requires Improvement 

Leadership

Ward Managers and local hospital leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Staff morale was very low due to the high level of incidents they had to manage each shift and the high level of vacancies in the service. Most staff told us that local management at all the sites we visited was supportive of the teams and understood and tried to help them manage the current challenges faced by the service. Staff told us that local managers were prepared to help out on the wards when they were short and supported the wards when they asked to suspend admissions to make sure they could keep all the patients safe.

However, staff told us that trust managers at divisional level did not understand the current pressures faced by the wards and only considered cost when staff raised concerns about admissions.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

Staff we spoke with understood the trust's values and said that they felt the teams they worked in lived up to them. Staff told us they formed part of the trusts appraisal process and were used for setting team objectives. However, they also said that due to staff shortages and the high levels of acuity currently faced by the staff teams it was harder to apply these values in their work. For example, managers told us it was harder to provide quality care because of the staff shortages and lack of PICU beds.

Staff felt that senior divisional leadership did not follow the values of the trust. For example, staff told us that ward managers decisions were ignored when considering admissions.

Culture

Staff felt respected, supported and valued by their local managers but not by the senior divisional managers in the trust.

Staff told us that senior divisional managers did not trust their clinical decision making about admissions and would ignore them and insist staff admit patients, whose needs could not be met by the service. They told us that senior divisional managers felt that adding more staff to a ward would solve issues, without recognising that services were struggling to find good quality staff.

Not all staff felt able to raise concerns with senior divisional managers without the fear of the managers bullying them afterwards. Staff that felt happy to raise concerns told us that they did not believe any action would be taken to address their concerns.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Managers could access information from a variety of sources that allowed them to understand their team's performance against their identified key performance indicators. Managers used this information to find areas for improvement and work with the staff teams to address this. For example, managers told us they had completed a deep dive into the use of physical interventions at Antelope House so that they could reduce them.

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

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Ward managers could access information easily about their service and could compare their ward to similar services in the trust. Ward managers told us they could submit items to the trust risk register.

Local hospital leaders told us there were strategies to address risks. For example, to address staffing issues they were deploying more long line agency staff, recruiting from overseas, they were being creative with posts offering built in time for career development opportunities and offering additional pay incentives to work extra shifts. However, they told us that this had not had a sufficient effect on the number of vacancies at the time of the inspection.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff told us that systems in place to collect and analyse data were efficient and did not add to their workload. The information collected was easily available to staff so they could understand their team's performance.

Staff told us that the current workload due staff shortages was reducing the time they had available to develop quality improvement initiatives.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Ward managers engaged with other teams. Ward managers encouraged staff from community teams and other health and social care to join relevant meetings and they could do this via video conferencing. However, managers told us that other services had the same issues with staff and level of acuity. For example, community teams did not have enough staff so this put pressure on the wards to admit patients into hospital who should be managed in the community.

Learning, continuous improvement and innovation

The wards at Parklands and Melbury lodge had the Accreditation for Inpatient Mental Health Services (AIMS) which recognises high standards of organisation and care. For a service to be given an AIMS, teams must meet national requirements from NICE and the Department of Health.

The trust has signed up to the national Mental Health Safety Improvement Programme (MHSIP) which has three aims, improving sexual safety, reducing restrictive practices and reducing self-harm and suicide.

The wards had engaged in quality improvement plans around reducing restrictive practices and putting information about patient preferences on their doors so that staff know how to complete observation.

Forensic inpatient or secure wards

Requires Improvement

Is the service safe?

Requires Improvement

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

The ward layouts did not allow staff to observe all parts of the wards. To mitigate the risk, cameras and convex mirrors had been installed to enable staff to observe blind spots. Environmental risks were also mitigated by patient engagement, risk assessment, staff awareness of potential ligature risks, staff presence in communal areas and the observation of patients.

The ward complied with guidance and there was no mixed sex accommodation.

There were potential ligature anchor points in the service. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Staff completed daily security checks and ligature risk assessments to identify and mitigate environmental risks. Allocated security leads for the wards were responsible for the security checks which we observed being completed during the inspection.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. We observed cleaning staff maintaining the cleanliness of the ward. Staff also supported and maintained the cleanliness of the ward after patient contact. Staff followed infection control policy, including handwashing.

Seclusion room (if present)

The seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock.

The trust had an up to date seclusion policy which provided guidance for staff to follow.

During the inspection there were no patients identified as being at risk of disturbed or violent behaviour placed in seclusion. Staff told us that if a patient was in the seclusion suite; a care management plan would be on display in the nurses' office; this would outline the reintegration pathway of the patient back to the main ward via long term segregation using the extra care area (ECA).

Forensic inpatient or secure wards

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff locked the clinic rooms when not in use and keys were always kept in a secure place. Clinic rooms were clean and tidy. Staff checked, maintained, and cleaned equipment. Staff conducted a weekly audit to ensure equipment was checked and the cleanliness of clinic rooms.

Safe staffing

The service had enough medical staff however did not have enough nursing staff who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

Ward managers told us the wards had low vacancy rates. Figures we received from the trust showed vacancy rates at Ravenswood Medium Secure Unit for the period between April and October were between 2.55% and 6.95%. However, vacancy rates for the same period at Southfield Low Secure Unit were higher; between 16.27% and 9.97%. The ward managers we spoke with told us that unfilled shifts were offered to substantive staff as overtime before these shift were made available to agency staff from outside the trust. The service did not use bank staff. However, shifts were available to NHS Professional staff. Managers ensured NHS Professional (NHSP) staff and agency staff were familiar with the wards. Managers made sure all NHSP and agency staff had a full induction and understood the service before starting their shift.

We attended an afternoon situation report (SITREP) meeting which confirmed the minimum number of staff required on each ward. This meeting allowed managers to monitor staffing number across the units for the next 72 hours. This often involved the redeployment of staff from other wards as well as therapists and security staff who supported staff in the day to day running of the wards. This happened when NHSP staff and agency staff were unable to fill shifts or when levels of acuity increased on a ward and the staffing requirement increased to keep the ward safe. The ward managers we spoke with told us that staff shortages were mostly related to long term sickness, career breaks, maternity or last-minute sickness and cancellation of NHSP or agencies staff.

However, some staff we spoke with told us there were not enough staff on the wards whilst others told us the staff did not have the right skills and training to manage and make the ward environment safe. At Southfield the vacancy rates for the months of April to October were between 16.27 % to 9.97%.The staff turnover rates for the same period were 16.20% to 12.27%.At Ravenwood sickness rates for the period of April to October were 8.52% to 10.08%. Staff turnover for the same period were between 18.15% and 14.53%. In the month of August at Ravenswood, Malcolm Faulk had a fill rate 78.5% for qualified nurses during the day shift and on Mary Graham ward the fill rate for qualified nurse on night shift was 75.7%. In July 2021 across both Ravenswood Medium Secure Unit and Southfield Low Secure Unit there were 11 incidents where staff numbers did not match to patients` need due to sickness and short notice cancellations resulting in delay of care and observations, on these occasions staff were moved around to support with shortages. Out of these 11 incidents two of these was staff skills did not match to patient need and were not trained in Supporting Safer Service which resulted in delay of care and observations.

Managers on the wards did not always have protected time for managerial duties and this was observed on Lyndhurst ward during the inspection when they were included in the staff numbers to support the daily running of the ward.

Forensic inpatient or secure wards

Staff at Southfield Low Secure Unit (Cedar, Beech and Oak ward) reported they were often redeployed to fill shifts on the medium secure wards at Ravenswood House Medium Secure Unit. This was often at very short notice at the beginning or during a shift on a low secure ward. Redeployment of staff between the wards was required to keep the medium secure wards safe, however, this left gaps on the low secure wards. Staff reported low morale due to frequent redeployments. Senior managers confirmed that the trust had a recruitment and retention strategy and they had been involved in encouraging new employees to the service. The matron at Ravenswood House Medium Secure Unit told us that recruitment had been difficult during the COVID-19 pandemic as the service could not invite candidates to the unit to show them around and talk to them about the service. Some new appointments of staff from outside of the UK had been delayed due to travel restrictions. Most of the staff we spoke with felt they did not have enough one-to-one time with patients to support their individual needs. Patients sometimes had their leave cancelled due to short staffing; however, these were re-arranged for a later date.

Medical staff

The service had enough daytime and night-time medical cover and a doctor was available to go to the ward quickly in an emergency. The service had a full complement of consultant and medical staff at the time of our inspection.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had not always completed and kept up to date with their mandatory training. The overall target for staff completing mandatory training was 95%. However, data we received from the trust suggested that some mandatory training were not met, for example Infection Prevention and Control was at 88.6%, Patient Handling level 2 was at 69.4%, Resuscitation Basic Life Support was at 74.55 and Supporting Safer Services was at 82.1% at Ravenswood Medium Secure Unit. Supporting Safer Services training was at 76.2% and Patient handling Level 2 was at 77.8%at Southfield Low Secure Unit as well. At the time of this inspection senior managers told us the service was replacing Supporting Safer Services training with Prevention and Management of Violence and Aggression. We were also told that the roll out of this training had been delayed as this was face to face training and it was difficult to adhere to social distancing and these training had recommenced. Managers monitored mandatory training and alerted staff when they needed to update their training.

The mandatory training programme was comprehensive and met the needs of patients and staff. However, due to COVID-19 pandemic, key training such as Supporting Safer Services training, basic life support , Patient Handling level 2 which were delivered in person had not been delivered. The managers told us as restriction has been eased these training had resume and staff were able to attend.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well although they did not record this effectively. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Some staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Forensic inpatient or secure wards

Assessment of patient risk

The trust had an observation and engagement policy. Following an incident in winter 2020 the service reviewed the observation policy and enhanced competency-based training was developed and delivered to staff. We saw this was embedded in staff practice on the wards we visited. Staff discussed risk and observation levels in daily zoning meetings. These meetings reviewed the individual patients' risk levels for the previous 24 hours and revised the management of the risk for the next 24 hours if appropriate.

Staff used a recognised risk assessment tool. Wards at both Ravenswood House Medium Secure Unit and Southfield Low Secure Unit completed the Historical Clinical Risk Management-20 (HCR20) with patients which is a structured tool for assessing patient's risk to others. These HCR20 risk assessments were not completed for all patients in the care records we reviewed.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Daily zoning meetings discussed and reviewed each patient. Risks were identified. However; the documentation of these risks was inconsistent across the wards both at Ravenswood House Medium Secure Unit and Southfield Low Secure Unit. For example, in some records we reviewed, risk information was recorded in the risk summary, others were recorded in the risk assessment while others were recorded in progress notes. This meant that patients ` risk information and information on how to manage these risks could be difficult to access. Staff shared information about patients' risks in the daily zoning and handover meetings. In some care records we reviewed historical and current risks were detailed and warning signs about deteriorating mental health were documented.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff on the wards increased or decreased the frequency of patient observations in response to changes in a patient's risk. However, in some care records we reviewed we could not evidence where staff updated risk assessments following each incident.

Staff completed observations of patients at levels determined by individual patients' assessed level of risk. The patient observation recording tool was recently reviewed and staff physically handed over the records to the next staff assigned to observe patients. This helped staff to indicate an observation had taken place. The tool included a place to record the patient's mental state, behaviour and interaction with staff and patients. We saw completed copies of the forms.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. However, due to a ligature incident within the trust and subsequent findings from that incident, access to self-administration of medicines lockers on step down wards across the trust had been removed. This was a blanket approach that impacted the individual needs of patients who were appropriate to manage some of their own medicines in preparation for discharge.

Use of restrictive interventions

Levels of restrictive interventions were low and/or reducing. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. For example, on Malcolm Faulk ward we saw the use of 'when required' (PRN) medicines to manage

agitation and aggression. Staff were able to describe whenever possible de-escalation would be used to avoid using a PRN medicine. If a medicine was used, it was usually at the lowest available dose. However, we did see some individuals at Ravenswood who had PRN medicines for agitation and aggression administered more frequently. Discussions with staff showed that this had been identified and was the least restrictive practice for the individuals concerned.

Staff at Malcolm Faulk and Cedar ward participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff did not always follow National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. At Ravenswood Medium Secure Unit on Malcolm Faulk ward we reviewed records for two instances of where rapid tranquilisation were used. Each had incomplete physical health monitoring in place. One instance had no records at all and the other only began monitoring after 45 minutes had passed.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff received annual safeguarding adults and children training. Staff could also access safeguarding supervision and all staff were invited to attend. The social worker at Ravenswood House Medium Secure Unit delivered additional training to staff to develop confidence and competence in reporting safeguarding alerts.

Staff kept up to date with their safeguarding training. Managers reviewed compliance against safeguarding training and reminded staff when training was required to be renewed.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff were responsible for making safeguarding referrals. These were reviewed by the ward managers and the social worker. The service also had a safeguarding lead who provided support and guidance.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had easy access to clinical information however did not maintain high quality clinical records – whether paper-based or electronic.

All staff, including NHSP and agency staff, had access to the patient's clinical care records to ensure they delivered effective patient care.

When patients transferred to a different ward or new team such as Forensic Community team, there were no delays in staff accessing their records and these records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The wards used paper prescription charts and an electronic system (RIO) for patients notes which supported them to safely prescribe, administer and record the use of medicines. The service had recruited pharmacy technicians to support staff in administering medicine when there were staff nurse shortages. We saw this in practice on Lyndhurst ward at Ravenswood House Medium Secure Unit . A pharmacist attended the wards at least once a week to provide clinical checks and give feedback to the wards on any errors or omissions.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patient's medicines were reviewed regularly and there was daily access to pharmacy input through the pharmacy technicians on the wards.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were stored securely in line with the provider's policy and national guidance and access was limited to authorised staff.

Staff followed current national practice to check patients had the correct medicines. Medicines reconciliation, the process of accurately listing patient's current medicines, was carried out by staff on admission. There was a dedicated pharmacy technician who completed a full daily medicines reconciliation on each ward.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff used an incident reporting system to record incidents and medicine safety concerns. Staff told us they received updates about errors and incidents that had occurred locally and on other sites across the trust.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

Forensic inpatient or secure wards

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff used Ulysses Incident Reporting System for recording accidents and incident reports. Incidents were reviewed by the ward manager.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff could describe concerns and incidents which needed to be reported and the process they followed. Staff reported serious incidents clearly and in line with trust policy and ward managers told us the service had no never events on the wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Ward managers debriefed and supported staff after any serious incident. Following any serious incident staff were offered a debrief. The service also offered reflective practice sessions for staff to attend. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. The trust circulated quality and safety briefings, learning from experience bulletins and quality improvement safety bulletins to managers. These were shared to all staff and discussed in team meetings by ward managers.

Staff met to discuss the feedback and look at improvements to patient care. Feedback and learning from incidents were discussed in team meetings. Staff confirmed they received feedback from investigation of incidents. Learning from incidents was shared at the directorate operational management meeting. These meetings were attended by consultants, ward managers, senior managers, community teams (if appropriate), prison managers, psychologists, medicines management team and social workers.

There was evidence that changes had been made as a result of feedback. All staff at Ravenswood House Medium Secure Unit and Southfield Low Secure Unit had completed an observation competency to improve knowledge and competence when undertaking patient observations. The observation competency had been developed following a serious incident in winter 2020 and rolled out to all staff. Managers shared learning with their staff about never events that happened elsewhere.

Is the service effective?

Requires Improvement 

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed care plans which were reviewed regularly through multidisciplinary discussion however were not always updated as needed. Care plans generally reflected patients' assessed needs and were holistic and recovery oriented. They included safety and security arrangements.

Forensic inpatient or secure wards

Staff completed a mental health assessment which included physical healthcare screening for every patient either on admission or soon after. The hospital used the Care Programme Approach (CPA) which is a package of care for patients that is used by secondary mental health services and reviewed annually. This approach meant staff formulated a care and crisis plan for each patient. A named care coordinator was assigned to each patient to coordinate their care.

Staff developed a care plan for each patient with regard to their needs. The care plans varied in quality. Most of the care records we reviewed, had care plans which were not personalised. These care plans did not always reflect the patient's involvement. Care plans were mainly a series of standard statements that were repetitive and lacked detail on how to achieve the outcomes identified.

Staff reviewed and updated care plans when patients' needs changed. However, staff did not update the whole care plan but added an addendum to the original care plan. This meant that it was difficult for staff who did not know the patients well; such as NHSP staff or agency staff to follow all the amendments linked to the original care plan or were following the correct plan.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. The care records we reviewed showed that staff provided a range of care and physical health activities suitable for the patient group. These included supporting patients with their daily living skills. For example, patients at Southfield Low Secure Unit had created a weekly walking club and we observed patients engaging in this.

Staff delivered care in line with best practice and national guidance from relevant bodies such as the National Institute for Health and Care Excellence (NICE). Staff told us they followed up-to-date policies and delivered high quality care according to best practice and national guidance issued by NICE.

Staff used the National Emergency Warning Score 2 (NEWS2), a nationally recognised tool developed by the Royal College of Physicians. NEWS2 is used to improve detection and response to deterioration in a patient's physical health. However, we found gaps in the recording of 10 NEWS2 records we reviewed. This included missed entries, missed signatures and totals not completed. In the absence of these records where a patient's deteriorating health should have been escalated in line with national guidance, could have been missed and not escalated.

There was a lack of processes for escalating patients who declined NEWS2 observations. For example, if patient declined physical health monitoring, these were not attempted again, and it was not included in the patient's care or medical records.

There was a lack of NEWS2 documentation audit at ward level. This meant we could not be assured that there were processes in place to ensure NEWS2 were being monitored effectively.

The trust was in the process of introducing an electronic record for the observation of a patient's physical health needs. Senior managers told us the trust intended on providing iPads to staff to record physical health monitoring. At the time of this inspection this was not implemented.

Forensic inpatient or secure wards

Staff made sure patients had access to physical health care, including specialists as required. Ravenswood House Medium Secure Unit had an onsite GP, dentist and physical health nurse. At Southfield Low Secure Unit staff told us patients were encouraged to access physical health care in the community as part of the recovery journey.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Specialist support from staff such as dieticians were available for patients when required.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Patients were encouraged to access healthy lifestyle options such as smoking cessation programmes, nutritionally balanced meals and physical exercise.

Staff used recognised rating scales such as Health of the Nation Outcome Scales (HoNOS) to assess and record the severity of patients' conditions and care and treatment outcomes. HoNOS is a method of measuring the health and social functioning of people with severe mental illness. Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward. This included social workers, occupational therapists, pharmacists, physiotherapists, psychologists, physical health nurse and speech and language therapists.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. An induction checklist was completed with new staff members before they began working on the wards. Managers ensured all NHSP and agency staff had an induction and understood the service. Areas covered in ward induction training included understanding observations and knowledge of emergency procedures such as the location of ligature cutters and the emergency bag.

Managers supported staff through regular, constructive appraisals of their work. However, staff told us they did not receive monthly supervision from their manager due to staff shortages and high acuity at Ravenswood House Medium Secure Unit. During this inspection the eight staff records we reviewed showed supervisions were not up to date.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Team meeting minutes were recorded and stored electronically, and a paper copy was stored in file for staff who could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers recognised poor performance, could identify the reasons and dealt with these.

Forensic inpatient or secure wards

Managers made sure staff received any specialist training for their role. During the COVID-19 pandemic, some training could not be delivered to prevent the risk of infection and to maintain social distancing. However, this training was now available, and staff were able to enrol.

Multi-disciplinary and interagency teamwork

Staff from different disciplines in most instances worked together as a team to benefit patients with the exception of Southfield Low Secure Unit. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation and engaged with them early on in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Staff on all wards held regular multidisciplinary meetings and daily zoning meetings to discuss patients and improve their care. We attended morning zoning meeting and a weekly multidisciplinary meeting at Ravenswood House Medium Secure Unit . These meetings involved an overview and discussion of all the patients including any presenting risks. We observed good interaction between staff and the consultants at Ravenswood House Medium Secure Unit. Staff were given the opportunity to share information about patients and any changes in their care. However, staff we spoke with at Southfield Low Secure Unit reported that the consultant and staff from some disciplines did not work as a multidisciplinary team. Some nursing staff told us they felt undermined and not listened to by the doctors.

Ward teams had effective working relationships with other teams in the organisation. Ward teams had effective working relationships with external teams and organisations. We observed staff working well together including their interaction with both internal and external agencies such as the community mental health team, police, and ministry of justice.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received, and kept up to date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff were able to describe and had a good understanding of the different sections of the Mental Health Act.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. We saw information on display in the wards regarding access to independent mental health advocacy (IMHA) services. An advocate from Voiceability visited the wards on a weekly basis. Patients were aware of the IMHA services and knew how to access the service.

Forensic inpatient or secure wards

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Patients told us staff explained their section to them. The Mental Health Administrator audited Section 132 rights to ensure they were in date.

Staff told us they tried to ensure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. However; they also told us us that there were occasions when leaves had been cancelled due staff shortages or high patient acuity. Staff told us when these leaves were cancelled patient were made aware and staff re-arranged these leave. Following this inspection, a data request was made to the trust regarding number of occasions when patients` leave were cancelled due to staff shortages or high patient acuity. The Trust currently did not capture or audited this information although this information would be recorded in the patient's notes.

The trust clinical digital transformation team was currently working on upgrading and improving the clinical implementation of Section 17 leave and had identified the need to record the reason for denied leave.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. We saw examples where a SOAD had been requested to review patient's treatment plans.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. MHA documentation was available for all patients detained under the MHA.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received, and were consistently up to date, with training in the Mental Capacity Act and had a good understanding of at least the five principles. Staff demonstrated a varied understanding of how the Mental Capacity Act was used in their practice. Some staff could give examples of where they would consider capacity using the "best interest" term. Staff told us that supported patients to make decisions on their care for themselves but if they were unsure, they would seek support from the doctors.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. Staff told us they knew who to contact for advice and support if required.

Forensic inpatient or secure wards

Is the service caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. We observed staff taking time to interact with patients in a respectful and considerate way both at Ravenswood House Medium Secure Unit and Southfield Low Secure Unit. There was good interaction between staff and patients. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgemental attitude when caring for or discussing patients.

Staff gave patients help, emotional support and advice when they needed it. We observed staff providing support and encouragement to patients who had become anxious on Malcolm Faulk ward and Lyndhurst ward.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly. Fourteen patient of the patients we spoke with told us staff were approachable and very supportive.

Staff understood and respected the individual needs of each patient. Patient records we reviewed showed that staff recognised the personal, cultural, social and religious needs of patients and how they may relate to their care needs.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff described how they would raise concerns about attitudes toward patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Each patient was given information about the ward, mealtimes, restricted items, details of the Mental Health Act and the running of the ward on admission.

Forensic inpatient or secure wards

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Staff told us they would find ways to communicate with patients with communication needs. This included the use of symbols or sign language and interpreter. The ward manager on Malcolm Faulk ward told us how staff used Google translate to facilitate communication with patient of foreign language during the COVID-19 pandemic.

Staff involved patients in decisions about the service, when appropriate. The service appointed patients` representative. The patient's representative took part in the interview process of new staff. On Beech ward we saw how patients were able to enhance the ward environment by painting wall mural and sensory equipment such as fish tanks to help patients to de-escalate and relax when needed.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients were invited to a weekly patient forum meeting where they could provide feedback on the service. The meetings had a standardised agenda. We saw a copy of the minutes and they included a review of the identified actions and an update from the ward manager.

Staff supported patients to make advanced decisions on their care. In some of the care record we reviewed we saw some examples of patients advance decisions/ statements; however, this was not consistent across all the wards and the two units.

Staff made sure patients could access advocacy services. Information about accessing advocacy services was available on the wards.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We observed staff supporting families by telephone and providing them with an update on their relative's wellbeing and progress. Patients could contact their friends and family by telephone, mobile phone or internet connection. At Southfield Low Secure Unit patient could have access to their smart phone at certain times of the day. Managers told us the restriction on access to smart phone was so this did not impact on attendance with therapeutic activities.

Is the service responsive?

Good 

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.

Bed management

Beds on most wards were fully occupied. The service accepted referrals for patients from out of area although staff said this was not normal practice. We observed staff liaising with the patient's local teams and involving care coordinators in decision making.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Bed management calls were held weekly and patient assessments and moves between wards were discussed. Staff monitored the number of patients who experienced delayed discharges. Staff at Southfield Low Secure Unit told us there were occasions when there were delays in a patients discharge. These extended lengths of stays were due to the lack of appropriate community packages of care and placements for patients.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave, there was always a bed available when they returned.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

Managers monitored the number of patients who had their discharge delayed. The only reasons for a patient experiencing a delay in their discharge from the service were clinical. Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. During the weekly bed management calls, out of area placements and assessments for patients moving on to other trusts or providers within the forensic care network were discussed. Each case was discussed in detail and actions reviewed to ensure discharges were progressing. All patients were triaged to ensure they were appropriately placed on the ward. There were clear pathways for staff to follow for discharging patients to community services or to low secure services.

Staff supported patients when they were referred or transferred between services. Staff discussed discharge with patients. Social workers facilitated and booked accommodation and trial visits at onward placements. The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. Every patient had their own bedroom and somewhere to securely store their possessions. Patients were able to personalise their bedrooms and were involved in decorating decisions for communal ward areas at Southfield Low Secure Unit. Patients at both units displayed posters on their bedroom wall detailing their preference on how they would like to be observed by staff during the night. Preferences included using a torch instead of switching on the light and whether to knock to inform the patient that they were about to be observed. Patients did not have access to en-suite facilities in their bedrooms, however there were adequate communal toilets and shower rooms to meet the needs of the patients on the wards.

Forensic inpatient or secure wards

The service had a full range of rooms and equipment to support treatment and care. Staff and patients could access the rooms. Patients were encouraged to actively participate in activities of daily living such as eating, bathing and getting dressed. The hospital had a range of rooms such as computer rooms, an onsite gym, an outdoor sports area, kitchen and occupational therapy rooms. The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private.

The service had an outside space that patients could access easily. All wards had direct access to garden areas. Patients on Lyndhurst ward had planted flower beds and grew vegetables and herbs with the support of occupational therapy staff in the summer. All patients could enjoy outside facilities at designated times under staff supervision at Ravenswood House Medium Secure Unit and Southfield Low Secure Unit. We received mixed feedback from patients at Ravenswood House Medium Secure Unit about the frequency of their access to the courtyard. We were told by some patients that the courtyard was not always opened at designated times due to staff not being available to supervise their access.

Patients could make their own hot drinks and snacks and were not dependent on staff. The service offered a variety of good quality food. Patients could make hot drinks and access snacks 24 hours a day, seven days a week. Patients told us the food available at the hospital was of good quality. However, patients told us food options were very repetitive and the portion sizes were small.

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work and supported patients. Patients at Southfield Low Secure Unit were complimentary of the support from the occupational therapy team in supporting them with education and CV writing and employment. Patients were also able to have paid jobs in the hospital at both units, such as acting as patients` representative. The occupational therapist at Southfield Low Secure unit told us the service was very focused on triangle of care. Triangle of Care is working collaboratively between patients, professional and carer which promotes safety, supports recovery and sustains well-being., Occupational therapy staff also held a service user and carer engagement group on the first Tuesday of every month whereby carers and department leads came together to discuss care and service development.

A support worker on Ravenswood was working as a carer champion, and this work involved to engage with carers, however there was no dedicated hours for staff to be able to do this work.

The occupational therapy staff gave example of a recent festival at Ravenswood – organised by the occupational therapy assistants. This festival included live music, patients singing and playing instruments, an external farm visit and carers and family visits.

Staff helped patients to stay in contact with families and carers. Patients could keep in contact with their families and carers by telephone, mobile phone or video call. Staff facilitated patients to contact family and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Staff told us they held a patients and carer evening at Ravenswood Medium Secure Unit on the weekend before this inspection. At this event other voluntary services were able to attend. Patients from Southfield Low Secure Unit were also able to attend the event at Ravenswood House Medium Secure Unit. Patients we spoke we were complimentary of this initiative.

Meeting the needs of all people who use the service

Forensic inpatient or secure wards

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support. For example, a patient on Lyndhurst ward told us how staff had been supporting them to observe Ramadan with alternative times for food and medicine administration. There was also a chaplain who visited the hospital.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Leaflets were available describing the process for a patient, relative and/or carer to make a complaint or raise concerns. Patients and relative we spoke to knew how to raise a concern or make a complaint.

The service clearly displayed information about how to raise a concern in patient areas. Information leaflets and posters about how to raise a concern or a complaint were displayed on information boards and available on the wards.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke to could describe the process they would follow if a patient or relative raised a concern or a complaint.

Managers investigated complaints and identified themes. Ward managers investigated complaints and identified themes and shared learning at team meetings. Team meeting minutes demonstrated learning was shared at meetings.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff dealt with informal complaints locally in the first instance and offered verbal responses. Formal complaints were referred to the patient advice and liaison service. Staff knew how to record complaints. Staff shared learning from complaints in staff meetings.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us they received feedback on the outcome of complaint investigations and acted on the findings to improve the service.

Forensic inpatient or secure wards

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Good 

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

The service had a clear management structure with defining lines of responsibility and accountability. Ward managers were supported by a senior leadership team who had the autonomy to lead the service towards the shared vision and goals of the trust.

Staff confirmed the ward managers were visible, approachable and provided good support.

Leadership development opportunities were available, including opportunities for staff below team manager level.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

The trust had clear visions and values. Staff were aware of the trust's vision and values.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression.

Staff we met with were welcoming, friendly and very passionate about their work. Staff cared about the service they provided and told us they were proud to work at the hospitals. Staff were committed to providing the best possible care for their patients. However, staff morale was very low with staff feeling stressed, exhausted and burnt out following the demands of COVID-19 pandemic. The short notice redeployment of staff to other wards at Ravenswood House Medium Secure Unit, from Southfield Low Secure Unit and staffing issues contributed to low morale. Some staff we spoke with said they were reluctant to speak about their concerns because of fears of reprisals.

Staff felt the culture at Ravenswood House Medium Secure Unit was improving, but still needed further work. The new ward managers had improved staff confidence. Staff said they felt the new managers enabled them to be open and transparent and they were more confident in confiding in them.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. Staff followed a trust speak up policy. Staff confirmed they were aware of how to contact the Freedom to Speak Up Guardian and how to access the service.

Staff we spoke with told us that the service provided opportunity for career progression. Some support workers we spoke to told us they were part of the nurse apprenticeship program. Ward managers and seniors nurses had opportunity to enrol on specific leadership modules at Winchester and the Open University.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. There were a range of meetings held regularly at the hospital to ensure essential information was discussed. There were regular directorate operational management meetings, bed management meetings, ward manager meetings, multi-disciplinary meetings and ward level meetings such as team meetings, daily zoning meetings and handovers. There were systems and procedures to ensure that wards were safe and clean. Ward managers attended directorate operational management meetings weekly. The meetings covered staffing, restraint, training, incidents, violence and aggression. The minutes of these meetings showed managers were engaged in understanding the pressures across all the wards in the service. The minutes of the directorate operational management meetings were made available to senior managers, the ward consultant psychiatrists and managers on call. The ward managers attended monthly inpatient and safeguarding governance meetings. Managers cascaded relevant information at team meetings.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. We saw how actions and learning had been implemented across the service following a serious incident in winter 2020.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff maintained and had access to the risk register at ward and directorate level. Staff at ward level could escalate concerns when required. Managers reviewed the risk register annually but could add items as required. Managers had access to the risk register and all identified risks. Staff could access the risk register on the trust's shared drive. Staff said they could escalate concerns when required.

The service had plans for emergencies - for example, adverse weather or a flu outbreak. There had been effective contingency planning during the COVID-19 pandemic and adjustments made to the operation of the service as a result. For example, we saw procedures had been put in place to manage social distancing such as meetings with high number of attendees were held virtually.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. The service used electronic care records. The trust was in the process of installing an electronic system for physical health records, the roll out of this had been delayed to the COVID-19 pandemic.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

Information governance systems included confidentiality of patient records. Patient records were stored securely, and staff required login details to access information. Computer access was password protected and we observed staff logging out of computer systems when they had finished.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Managers had access to performance dashboards which were used to monitor service delivery.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed. Safeguarding alerts were recorded on the trust's risk management system and notified the relevant lead who raised the alert with the local authority.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used for example, through the intranet, bulletins, newsletters and so on. Staff could access the hospitals intranet system and showed us how they accessed policies and documents.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Patients had opportunities to give feedback on the service they received through patient forum groups. Managers provided feedback to patients to ensure they were kept up to date with any concerns raised. There was information available about how to contact the patient advice and liaison service (PALS).

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. Staff and patients on Malcolm Faulk ward and Cedar ward were two wards participating in the Reducing restrictive practice programme. The aim of this program was to emphasize reducing use of restrictive practices in inpatient mental health services.

Primary care update

Context

1. This report summarises Hampshire, Southampton and Isle of Wight Clinical Commissioning Group's (CCG) work programmes relating to delegated primary care commissioning functions in Hampshire. It includes a brief summary of some key achievements, how commissioning of services currently work, information about practice mergers and an update on workforce.

Appointments

2. Practices continue to offer face-to-face, online, video and telephone urgent and routine appointments for patients. Whereas nationally rules have now been relaxed relating to COVID-19, the NHS in England continues to follow the UK Health Security Agency's (UKHSA) infection prevention and control guidelines.

3. Currently this means NHS guidance remains in place across all health services including hospitals, urgent treatment centre, minor injuries clinics, GP practices, dental practices, optometrists and pharmacies to ensure patients and staff are as protected as possible from the virus. Staff, patients and visitors are expected to continue to follow social distancing rules when visiting any care setting as well as use face coverings, mask and other personal protection equipment.

4. The latest available appointment data for our GP practices is as below, split to show current levels for December 2021 (the most recent available data) and the comparison to pre-COVID levels for December 2019:

	Dec 2021	**%**	**Dec 2019**	**%**
Total no. of appointments	765,483		722,216	
Appointments attended	699,768	91	654,359	91
Did not attend	35,069	5	34,092	5
GP appointments given	365,650	48	356,204	49
Other healthcare professional staff	373,162	49	347,648	48
Face-to-face appointments	448,529	59	562,021	78
Home visits	6,345	0.8	8,709	1
Telephone	285,589	37	139,080	19
Video/online	5,370	0.7	1,848	0.2

Same day appointment	346,518	45	312,131	43
Next day appointment	66,730	9	38,782	5
2-7 days appointment	133,764	17	122,018	17

5. These latest figures published by NHS Digital show that in December 2021, 765,483 general practice appointments were given across HIOW – an average of 24,693 appointments a day. This is an additional 43,267 appointments given in 2021 vs 2019, which equates to around a 6% increase, and was achieved in addition to delivering the vaccination programme.

6. Almost 60% of appointments given in December 2021 were face-to-face, and while this is lower than almost 80% in December 2019, the figures reflect the amount of work also undertaken by primary care to deliver the accelerated COVID-19 booster programme and the fact that many of the appointments can be safely done virtually. Primary care colleagues continue to work hard to ensure patients who require a face-to-face appointment can have one.

7. The December appointment data reflects the same trend for the majority of the year – more appointments were given throughout the year in 2021 compared to 2019. In total, 9.8m GP practice appointments were given across Hampshire and the Isle of Wight from January 2021 to December 2021. This compares to 9.3m given in 2019 for the same 12-month period and marks an increase of more than 3,846 appointments given across GP practice in Hampshire and Isle of Wight every week on average.

COVID-19 vaccination programme in primary care

8. As we approach the two-year anniversary of our first national lockdown, it is well-known that the COVID-19 pandemic has had a significant impact on the way health services were delivered across the country, including in primary care services across Hampshire and the Isle of Wight. Many of these changes, such as wearing face coverings, maintaining social distancing, practising good hand hygiene and use of virtual appointments where appropriate, remain as we continue to deal with the different phases of the pandemic.

9. The discovery of the Omicron variant late last year required another extraordinary response from the NHS. In December, the Prime Minister announced a new vaccination challenge which was to offer a COVID-19 booster vaccination to every adult aged 18 and over by the end of the year. To help deliver this, local NHS services were asked to prioritise activities to deliver this.

10. To help support practices manage workloads while ramping up the COVID-19 booster vaccination programme, NHS England and Improvement announced that some non-urgent primary care functions could be stopped.

11. All practices had the ability to temporarily change their online consultations (e-Consult) function if they wished to do so to help them manage delivering services alongside continuing to deliver the accelerated booster vaccination programme.

12. Depending on location demand and local vaccination needs, each practice prioritised care to their population. All critical appointments relating to possible cancer, high risk patients or vulnerable people living with long term conditions or urgent and emergency care continued to be dealt with during this time. The clinical decision-making to support the prioritisation was carried our locally with full support from across our Integrated Care System.

13. To support increasing outgoing call capacity, all practice teams were given access to an increased function online on Microsoft Teams which allowed them to increase the number of calls they could make.

14. As in other parts of the country and in-line with national guidance, some routine appointments were postponed where appropriate, in order to free up resources for the vaccination programme. The CCG provided practices with appropriate updates to share with patients whose appointments were postponed. The message to each patients explained why their appointment was postponed and also gave details on where to access help and support if in the meantime their symptoms worsened.

15. The response to the Government announcement locally was tremendous, and together with colleagues in secondary and acute care sectors, more than 1m COVID-19 booster vaccinations were delivered across the Hampshrie and Isle of Wight Integrated Care System (ICS) footprint)within a three-week period, ensuring that every adult had the opportunity to receive a booster jab by 31 December 2021. Pop-up clinics were held across the area and included outreach work by primary care colleagues to some of the most vulnerable people in our communities in addition to at GP practices and other venues,

16. At the end of January NHS England and Improvement wrote again to practices to outline the steps going forward as the accelerated booster campaign drew to a close. For the period up to the end of March 2022, practices and Primary Care Networks (PCNs)are asked to focus on three key priority areas:
    - continued delivery of general practice services
    - management of symptomatic COVID-19 patients in the community
    - ongoing delivery of the COVID-19 vaccination programme

Commissioning of primary care services in Hampshire and Isle of Wight

17. General practice is the foundation upon which effective patient care rests. NHS health services are divided into primary care, secondary care, and tertiary care. Primary care is the first point of contact for the majority of people in need of

healthcare, and may be provided by professionals such as GPs, dentists and pharmacists.

18. Under current legislation, Clinical Commissioning Groups (CCGs) have delegated commissioning responsibility from NHS England and Improvement for GP services. There are three types of contract used for primary care nationwide, the most being the General Medical Services (GMS) contract. This is a nationally negotiated GP contract and the most common type of primary care contract in Hampshire and Isle of Wight. It is negotiated annually between the British Medical Association's General Practitioners' Committee and NHS Employers. The Carr-Hill Formula has been used as the basis of core funding for GMS practices for over fifteen years, which is a nationally set formula but also takes into account patient needs, demographics such as age and gender, mortality ratios, and cost of living in geographical areas.

19. A GMS contract exists in perpetuity. Unlike other areas of the health service, primary care services are predominantly delivered by small businesses (GP partnerships) and shifting market forces are placing considerable strain on this operating model. In a recent review of the partnership model, commissioned by the Secretary of State for Health and Social Care in 2018, it was concluded that if the GP partnership model were to survive in the future, then changes would be necessary. The review recognised the benefits of GP partnerships in terms of their efficiency and ability to be highly patient centred but also recommended the need for practices to work together to promote resilience and to bring in more skill-mix to support GPs in their working day.

20. CCGs are GP-led commissioning bodies and, in light of the possible conflict of interest under existing legislation, primary care is handled by the CCG's Primary Care Commissioning Committee (PCCC). CCGs are not responsible for commissioning dentists, optometrists and pharmacists, or for prison healthcare or specialised health services, all of which are currently commissioned by NHS England and Improvement. Subject to the relevant legislative approvals, from 1 July 2022 CCGs across the country will be replaced by Integrated Care Systems to help galvanise integration across health and care, encourage greater provider collaboration and deliver even better person centred care.

21. GP services in England are independently regulated by the Care Quality Commission (CQC), which monitors and inspects providers of health and care services on quality and safety standards. Practices rated as good or outstanding usually receive inspections at least every 5 years; practices rated requires improvement or inadequate will be inspected within twelve and six months respectively of the previous inspection.

Practice mergers

22. A practice merger is when two or more practices join together to form a single practice. A practice merger can occur in a variety of ways, for example when two or more practices merge or where one practice takes over another practice.

23. Ultimately, each practice wishing to merge will need to weigh up the potential advantages and disadvantages of merging to establish whether it is right for them, and more importantly to ensure the best and safest patient care can be delivered.

24. Decisions for practices to merge are not taken lightly, and require rigorous checks to ensure any changes benefit the population. The potential advantages of merging include:
    - sustainability in providing services
    - economies of scale through the ability to increase the volume and type of services offered to patients
    - the ability to offer increased/extended patient access
    - a greater chance of successfully bidding for contracts
    - the ability to bulk buy and reduce costs
    - the ability to share facilities and premises
    - the possibility of sharing administrative work
    - the potential to gain greater clinical expertise and skills
    - the ability to offer greater training functions to develop a more skilled workforce
    - the potential to reduce workload pressures

25. As part of any proposed merger, practices are encouraged to carry out patient engagement to inform them of the proposals and be able to provide the crucial public voice to help shape services going forward. All merger applications need to be approved by the CCG under its delegated commissioning responsibilities.

26. CCGs along with the Local Medical Committee (LMC) are part of the process to explore the options with practices and then, if they decide to merge gain the assurance that the care delivery will remain safe.

27. As demand on primary care has increased and the number of GPs has reduced, the resilience of practices has been a focus for the NHS. Leadership, culture, estates, patient experience, quality improvement and a focus on reducing health inequalities are key priorities. The primary care delivery model was already adapting but the COVID-19 pandemic enabled rapid digital innovation along with an emphasis on patient self-management where possible. The adaptability to deliver the vaccination programme along with maintaining access to core services including screening programmes is definitely something to celebrate.

28. As we begin to emerge from the pandemic, there is a re-calibration taking place, a desire to re-connect face-to-face and a focus on continuing to prioritise care for those who need it most. Practices are looking at their population’s needs and responding in

a targeted way to help detect cancer earlier, treat and manage long term conditions earlier and continue to support the people who have urgent physical and mental health needs.

Primary Care Networks

29. Since 2019 neighbouring practices have worked together to create Primary Care Networks (PCNs) serving populations of 30-5000 people to help meet the ambition of the NHS Long Term Plan. These networks have received investment to employ additional staff to help improve outcomes and shift the focus to one of prevention.

30. Primary Care Networks have recruited additional roles to improve care and deliver on the PCN contract. Each PCN has developed teams of healthcare professionals, including GPs, pharmacists, district nurses, community paramedics, physiotherapists and other health workers, to provide tailored care for patients in their community. A 'Social Prescriber' will be appointed in each PCN to help direct people to a whole range of non-medical services, like social clubs, community support groups and exercise activities, that will help them take greater control of their own health and stay well.

31. The benefits to patients of the development of PCNs include:
    - Easier and more efficient access to the musculoskeletal and mental health support closer to home.
    - More involvement in decision making and control over your own treatment
    - A greater focus on prevention – such as more help to improve your overall health and wellbeing through community-based activities
    - Better access to other specialists will help free up GPs' time and enable them to offer more routine appointments and greater continuity of care
    - Early intervention will reduce the pressure on hospitals and A&E
    - It is hoped 20,000 additional staff and clinicians will be working in PCNs by 2023/24
    - Services will be more cost effective

Accessing patient records through the NHS App

32. From April 2022, patients with online accounts such as through the NHS App will be able to read new entries in their health record. The change was initially due to take place on September 2021, however was pushed back to give practices more time to prepare.

33. Patients whose practices use the SystemOne and EMIS systems – which are the two patient record systems used across Hampshire and the Isle of Wight – will see any new entries added to their health record.

34. This is an NHS England and NHS Improvement programme, supported by NHS Digital. The change supports NHS Long Term Plan commitments to provide patients with digital access to their health records.

35. Patients will not see personal information – such as positive test results – until they have been checked and filed, giving clinicians the chance to contact and speak to patients first. Currently, patients will not see their historic, or past, health record information unless they have already been given access to it by their GP practice. However the aim is to enable patients to request their historic coded records in 2022 through the NHS App.

36. While the move to enable patients to view their medical record through the NHS App will be beneficial to the majority of patients, for a small minority of patients it does raise challenges, especially in relation to safeguarding vulnerable adults. A person's primary care medical record will contain information that is confidential and sensitive. This could include information about a third party which the patient must not see, or if the medical record was viewed by someone that was not the patient. In such cases of a vulnerable adult, the importance of safeguarding the patient from further harm is paramount, and it may be appropriate to redact or prevent specific information entered into the GP medical record from being shared within the patient's access and view. To help manage these situations, further materials are being produced in collaboration with the Royal College of General Practitioners and safeguarding experts. These materials will explain situations of potential safeguarding concerns, and the appropriate steps that clinicians should take to manage the challenge of vulnerable adults and medical record access. All colleagues across the NHS will do all we can to ensure patient confidentiality continues to be protected at all times.

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Urgent treatment centres update: Hampshire

1. Urgent treatment centres (UTCs) are GP and nurse-led services, open at least 12 hours a day, every day of the year.

2. The concept of UTCs were established following the publication the NHS Long Term Plan in 2018 and broaden out the range of services available in Minor Injury Units (MIUs). Whereas previously a MIU would be focused predominantly on treating injuries, a UTC can also treat a number of minor illnesses in addition to injuries. The development of UTCs in recent years mean we have moved to a genuinely integrated urgent care service, aligning NHS 111, UTC and routine and urgent GP appointments with face to face urgent care. For example, GPs have a key leadership role in UTCs which did not exist before they were established with the MIU concept.

3. In Hampshire, UTCs offer appointments that can be booked through 111, and are equipped to diagnose and deal with many of the most common ailments people attend Emergency Departments (EDs) for. Therefore UTCs play a vital role in easing pressure on EDs in our local hospitals, creating more capacity for this part of the system to treat the most serious and life threatening cases.

4. By encouraging patients to book through NHS 111, this provides an additional opportunity for the NHS to direct patients to the most appropriate and closest service to them. For example, depending on the illness, NHS 111 may connect a patient to a nurse, emergency dentist or a GP for an appointment. If a patient requires an urgent face-to-face appointment as a result of the assessment on the phone, they may be directed to the nearest urgent treatment centre and NHS 111 may be able to book an appointment directly into a UTC. Alternatively patients can walk into their nearest urgent treatment centre without an appointment and wait.

5. These services are led by experienced clinicians including highly skilled nurse practitioners, paramedics, GPs and other health professionals who can offer treatment, advice and information. Many services also have on-site x-ray facilities. Waiting times can be shorter than at Emergency Departments and the team can also refer or direct patients to the most appropriate service if required, supporting patients to access the right care in the right place, in a timely way.

6. Urgent Treatment Centres can help with a number of conditions including:
    - Strains and sprains
    - Suspected broken limbs
    - Minor head injuries
    - Cuts and grazes
    - Bites and stings
    - Minor scalds and burns
    - Ear and throat infections

- Skin infections and rashes
- Minor eye problems
- Coughs and colds
- Feverish illness in adults
- Feverish illness in children
- Abdominal pain
- Emergency contraception

7. In Hampshire we have a mixed model of Urgent Treatment Centres and minor injuries clinics available to our population. UTCs in operation in our area are:
    - Gosport War Memorial Hospital Urgent Treatment Centre (provided by Portsmouth Hospitals University NHS Trust)
    - Lymington Urgent Treatment Centre (provided by Partnering Health Limited)
    - Petersfield Urgent Treatment Centre (provided by Southern Health NHS Foundation Trust)
    - Urgent Treatment Centre, St Mary's, Portsmouth (provided by Practice Group Plus).
    - Southampton Urgent Treatment Centre, the Royal South Hants Hospital, Southampton (provided by Practice Group Plus).

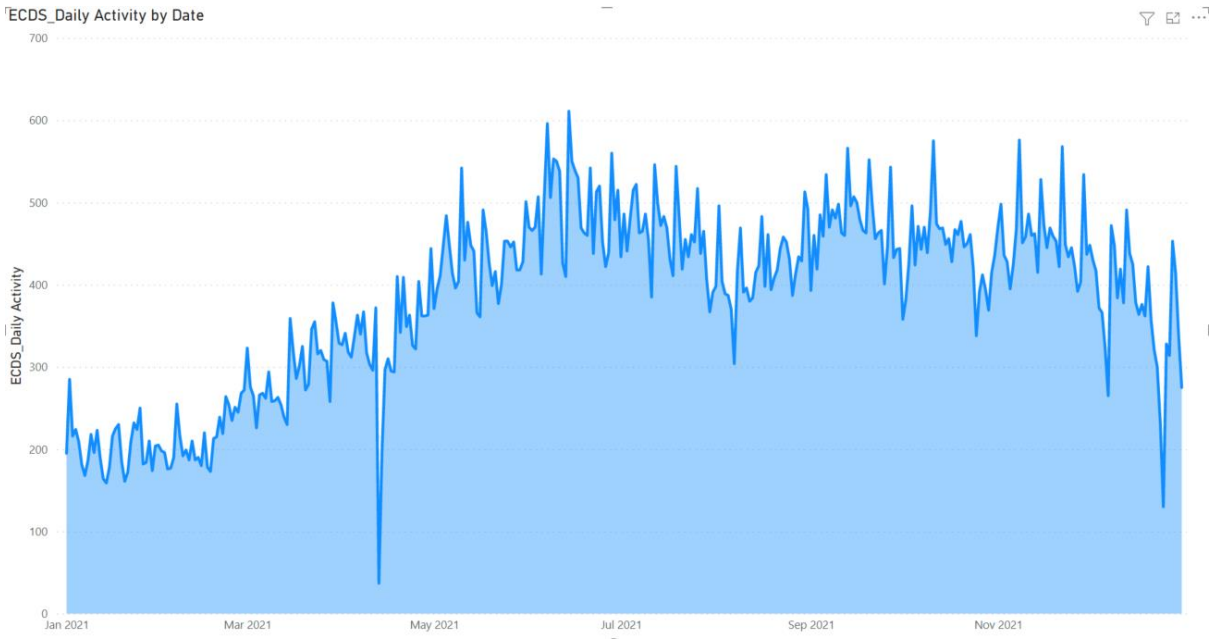
8. In Andover, a minor injuries clinic exists at Andover War Memorial Hospital. This service is provided by Hampshire Hospitals NHS Foundation Trust (HHFT). This provides similar services to UTCs which are accessible to patients by booking an appointment through NHS 111. This means the clinic in Andover is benefiting from integration with 111, in line with UTCs across the country, but a walk-in option is not currently available.

9. Throughout the COVID-19 pandemic, UTCs have played a vital role in supporting the system and, in particular, pressure on our Emergency Departments. In 2021, almost 140,000 people received treatment at a UTC in Hampshire and Isle of Wight, with our two busiest sites being in the cities of Southampton and Portsmouth.

10. Over a quarter of those who have received treatment at a UTC in Hampshire have been recorded as being discharged home following treatment and we believe this number to be much higher. If these attendances had been to ED rather than a UTC, the pressure on our system would have been considerable.

11. Across our area, we are seeing a trend of more people attending UTCs, as shown in the graph below. As a system, we continue with our work to promote this service to the public, to help patients make an informed choice of where to go. This is in addition to promoting the 111 service (both telephone and online) which will direct patients to the most appropriate service based on the information shared. We are also exploring ways to help patients make an informed choice based on issues important to them, such as waiting times.

Some UTC websites will provide detail on the live waiting times for their sites, but across Hampshire and Isle of Wight we are putting together an app/digital platform where patients will be able to access live information about waiting times at UTCs and EDs in their area.



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Update on Hampshire and Isle of Wight Dental Services for Hampshire HASC on 8 March 2022

Current situation

The dental profession continues to work under the Standard Operating Procedure (SOP) agreed with Public Dental Health and the Office of the Chief Dental Officer. Although this has been amended on several occasions, it remains in place to safeguard patients and the dental team. This has resulted in a reduction in activity and a backlog which means that many patients, including those with a regular dentist, are unable to access routine care. While practices continue to prioritise patients with an urgent need, where they have the capacity to provide more than urgent care they will prioritise according to clinical need such as patients that require dental treatment before they undergo medical or surgical procedures, those that have received temporary urgent treatment and require completion of this, looked after children (LAC) and those identified as being in a high-risk category and have been advised they should have more frequent recall intervals. It may still be necessary for patients with an urgent need to contact more than one practice as each practice's capacity will change daily dependent upon the number of patients seeking care and the practice's staffing levels.

50m additional funding for NHS dental services

Further to the government announcement of the additional £50m investment for NHS dentistry the dental team contacted all mandatory dental service contractors in the South East region with further details of this national scheme to encourage eligible dental practices to take up the offer of additional funding. It is a short-term investment to provide an immediate boost until 31 March 2022. The funding is available for dental practices to deliver activity outside of contracted hours, i.e. early morning/evenings and weekends. The additional activity will be paid at £654 per 3.5 hour session. The sessions will be for patients with urgent care and subsequent stabilisation needs who contact the practice directly, via NHS 111 or directed by Healthwatch or the out of hours emergency dental services where they need stabilisation following urgent treatment. It is expected that between four to six patients will be seen per 3.5 hour session.

Listed below are the details of the practices in Hampshire:

Name of practice	Contract Town	Contract Postcode	Number of Sessions	Value of Payment
Quaintways Cottage	Hartley Wintney Hook	RG27 8NS	16	£10,464.00
Stratfield Road Dental Practice	Basingstoke	RG21 5SA	18	£11,772.00
Smile Dental Care	Eastleigh	SO50 5JH	80	£52,320.00
Smile Dental Care	Portsmouth	PO1 4ND	16	£10,464.00
Palmerston Dental Practice	Fareham	PO16 7DP	18	£11,772.00
Alton Dental	Alton	GU34 2RE	18	£11,772.00

Days of operation and times are listed separately below:

		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
ICS:	Practice Name:	28/02/2022	01/03/2022	02/03/2022	03/03/2022	04/03/2022	05/03/2022	06/03/2022
HIoW	Quaintways Cottage			17:00-20:30	17:00-20:30			
HIoW	Stratfield Road Dental Practice	08:00-09:00 17:00-18:00			08:30-09:00 17:00-18:00		09:00-12:30	
HIoW	Smile Dental Care - Eastleigh						09:00-17:00	
HIoW	Smile Dental Care - Portsmouth						13:00-16:30	13:00-16:30
HIoW	Palmerston Dental Practice					09:00-16:30	10:00-13:30	
HIoW	Alton Dental		18:00-19:30				10.15-13.45	

Some practices have offered different hours depending on the week; however, across Hampshire the above hours are duplicated from 28 February until 31 March 2022. Unfortunately, there are no additional sessions on the Isle of Wight; practices have advised they do not have capacity to undertake any additional sessions.

Looked After Children (LAC) Pilot Scheme – Access sessions

A pilot scheme was developed following reports from across the region that foster carers and Lead Care Workers from Local Authorities were having difficulties in accessing the required assessment within the defined timescales. As a result, NHSE/I commenced a pilot to create a pathway for LAC to supplement the ongoing requirement for all practices to continue to prioritise patient groups with the greatest need (which includes LAC). The pilot is in place until 31 March 2022 and is funded on a sessional basis. Sessions operate outside a practice's current NHS commitment/contracted hours. Funding is offered at £115 per hour and can be a stand-alone hour on one or more day, or blocks of hours (eg 2 hours one evening, half or a full Saturday or Sunday).

Currently one practice across Hampshire is providing LAC access sessions as below:

The Triangle Surgery, 3 The Triangle, Cobden Avenue Bitterne Park Southamptom SO18 1FZ LAC session hours:							**Total LAC hours offered per week:**
Mon	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**	
		08:00-09:00	08:00-09:00	13:00-15:00			4

LAC and Dentaid **-** In addition to the LAC pilot, the dental team are working with the local CCGs and Looked After Children Leads to support additional access sessions being undertaken by Dentaid. This is currently under development with sessions currently being agreed across Hampshire and the Isle of Wight where access for the mobile unit can be established.

Non-Recurrent Funding/Additional Activity

In 2019, Colosseum Group gave notice on three contracts they held to provide NHS Mandatory Dental Services in Portsmouth in the areas of Portsea, Southsea and Paulsgrove. Although these contracts were for over 37k Units of Dental Activity (UDAs) in total, the Colosseum group was not able to achieve this level of activity. Following a procurement exercise across Portsmouth, Alton and Tadley (PATp, two contracts together delivering 31,500 UDAs (equivalent to approx. 4.5 dentists) were awarded with one in the north of the city in Cosham (10,000 UDAs) and one in the south of the city in Portsea (21,500 UDAs). These contracts were due to commence from 1 April 2021 however due to COVID-19 the start date of the one in the south was delayed until 1 June 2021. The practice in Cosham has had several issues with recruitment and will commence services early March 2022. In addition to these contracts two further contracts were awarded in Alton (18,000 UDAs) and Tadley (15,000 UDAs). Services in Alton were awarded to an existing provider with capacity to commence services on award. These commenced in December 2020. Tadley was a new practice, however due to COVID-19 lockdown the bidder lost their preferred location and was required to find alternative premises. The provider experienced further delays with building works at the new site but is ready to commence services on 1 April 2022.

Whilst the dental team undertook the procurement of the practices from the PAT procurement exercise, all practices across Hampshire and the Isle of Wight were asked to undertake additional non recurrent

activity where they had capacity. Initially this activity was due to end on 31 March 2020 however this was extended due to the delays experienced with the start date of the new practices.

Since 1 April 2021, nine practices have served notice on their NHS Mandatory Dental Service contracts in the Hampshire and Isle of Wight locality: two in Fareham, two in Winchester, four in Portsmouth and one on the Isle of Wight in Bembridge. The total UDAs which handed back are 46,792. All practices in the locality have been approached once more to establish if they can undertake additional activity whilst a procurement exercise is undertaken. The end date of the non-recurrent activity has been agreed as 31 March 2023 for all practices to allow time for the procurement to take place. All non-recurrent activity remains in place until such times that the whole procurement process is finalised; so even though the PAT procurement nearing completion, the additional funding will remain in the system until at least 1 April 2023. This will assist with the recovery of dental activity across Hampshire and the Isle of Wight.

Below is a list of locations where practices have agreed to additional activity and non-recurrent activity until 31 March 2023.

Practice Town	***Temporary (22/23) UDAs***
East Cowes	3,510
Fareham	4,000
Fareham	1,821
Lee On The Solent	600
Grayshott	1,623
Farnborough	2,511
Fleet	5,069
Camberley	295
Fleet	1,106
Basingstoke	1,596
South Ham	5,118
Winchester	4,550
Eastleigh	1,200
Bursledon	2,753
Southampton	647
Havant	1,238
Havant	4,888
Basingstoke	892
Winchester	5,791
Southampton	6,000
Southampton	4,000
Southampton	1,713
Southampton	1,996
Southampton	2,424
Southampton	3,272
Havant	1,694
Alton	4,525
Ryde	TBC
Portsmouth	5,000
Southsea	5,000
Portsmouth	5,000
	89,832

Patients should continue to ring 111 or use the NHS website https://www.nhs.uk to find a dentist who has capacity to offer treatment at the time of contact. All practices have been advised to update their entry on the NHS website to show they are accepting patients; this is for urgent care and where they have capacity, for routine care for patients in line with their clinical need as previously mentioned. However as advised, patients may need to ring several practices as capacity will change daily.

Procurement South East – MDS 3

As part of a planned procurement process across the South East region, the dental team are currently prioritising procurement in Hampshire and the Isle of Wight (as mentioned above). A review of commissioned General Dental Services and associated documents is currently with key stakeholders for comment. It is anticipated to commence the procurement process once the documentation is agreed. The lead time for procurement is variable but it is anticipated that where possible contracts will commence on 1 April 2023.

Dual Post to assist with dental transformation

NHSE/I, the CCGs and Local Authority are working collaboratively to develop a job role which will work alongside key stakeholders such as Health Education England, Portsmouth Dental Academy, the Community Dental Service and local dental practices to find alternative ways of recruiting and retaining dentists into the area. This post will support recommissioning and explore options for joint posts across multiple organisations so this may make working in these areas more attractive; this will initially focus on Portsmouth, Isle of Wight and Gosport, due to the proximity of Portsmouth Dental Academy.

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date:	8 March 2022
Title:	Proposals to Develop or Vary Services
Report From:	Chief Executive

Contact name: Members Services

Tel: 0370 779 0507 **Email:** members.services@hants.gov.uk

Purpose of this Report

1. The purpose of this report is to alert Members to proposals from the NHS or providers of health services to vary or develop health services provided to people living in the area of the Committee. At this meeting the Committee is receiving an update on the following topics:
    a) Integrated Primary Care Access Service – update (Commissioners)
    b) Alton Community Hospital – new ward (Southern Health NHS Foundation Trust)

Recommendations

a) Integrated Primary Care Access Service - update

2. That the Committee receive an update on extended access to primary care in Hampshire once the expectations on Primary Care Networks in this regard are clear.

b) Alton Community Hospital – new ward (Southern Health NHS Foundation Trust)

3. That the Committee welcome and support the proposal to increase capacity at Alton Community Hospital.

Executive Summary

4. Proposals that are considered to be substantial in nature will be subject to formal public consultation. The nature and scope of this consultation should be discussed with the Committee at the earliest opportunity.

5. The response of the Committee will take account of the Framework for Assessing Substantial Change and Variation in Health Services (version agreed at January 2018 meeting Framework for Assessing Substantial Change and Variation in Health Services). This places particular emphasis on the duties imposed on the NHS by Sections 242 and 244 of the NHS Act 2006, includes new responsibilities set out under the Health and Social Care Act 2012, and takes account of key criteria for service reconfiguration identified by the Department of Health.

6. This Report is presented to the Committee in three parts:

a. *Items for information:* these alert the Committee to forthcoming proposals from the NHS to vary or change services. This provides the Committee with an opportunity to determine if the proposal would be considered substantial and assess the need to establish formal joint arrangements

b. *Items for action:* these set out the actions required by the Committee to respond to proposals from the NHS or providers of health services to substantially change or vary health services.

c. *Items for monitoring:* these allow for the monitoring of outcomes from substantial changes proposed to the local health service agreed by the Committee.

7. This report and recommendations provide members with an opportunity to influence and improve the delivery of health services in Hampshire, and to support health and social care integration, and therefore assist in the delivery of the Joint Health and Wellbeing Strategy and Corporate Strategy aim that people in Hampshire live safe, healthy and independent lives.

Items for Monitoring

a) Integrated Primary Care Access Service - update

8. In July 2019 the HASC was notified of plans to integrate primary care services in Southern Hampshire by the Primary Care Alliance across Fareham, Gosport and south east Hampshire. The IPCAS service was developed to bring together two services: the GP Extended Access Service, which was a pilot, and the GP Out of Hours Service. These were delivered by two separate providers with differing access points for local people.

9. The HASC last received an update in March 2021, when Primary Care Networks (PCNs) were expected to become responsible for providing extended access to their patients. However, at that time, it was reported that this was being delayed for a year. A further update was requested for this meeting and has been provided (see Appendix 1). This indicates the change in responsibility has been further delayed until September 2022 so existing services will be extended until then.

Items for Information

b) Alton Community Hospital – new ward

10. The HASC has been notified in February 2022 that Southern Health NHS Foundation Trust plans to provide a new ward with an additional 22 beds at Alton Community Hospital. The new ward is expected to be operational by July 2022. (see briefing at Appendix 2)

Finance

11. Financial implications of any proposals will be covered within the briefings provided by the NHS appended to this report.

Performance

12. Performance information will be covered within the briefings provided by the NHS appended to this report where relevant.

Consultation and Equalities

13. Details of any consultation and equalities considerations of any proposals will be covered within the briefings provided by the NHS appended to this report.

Climate Change Impact Assessment

14. Consideration should be given to any climate change impacts of proposals where relevant.

Conclusions

15. The HASC may wish to be updated on the plans for extended primary care access once further details of the expectations on Primary Care Networks in relation to this is known.

16. The HASC will welcome plans to extend provision at the Alton Community Hospital.

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	no
People in Hampshire live safe, healthy and independent lives:	yes
People in Hampshire enjoy a rich and diverse environment:	no
People in Hampshire enjoy being part of strong, inclusive communities:	no

Other Significant Links

Links to previous Member decisions:	
Title 2021-03-01 HASC IPCAS update.pdf (hants.gov.uk)	Date 1 March 2021
Direct links to specific legislation or Government Directives	
Title	Date

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. **Equality Duty**

The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

Due regard in this context involves having due regard in particular to:

- The need to remove or minimise disadvantages suffered by persons sharing a relevant protected characteristic that are connected to that characteristic;
- Take steps to meet the needs of persons sharing a relevant protected characteristic that are different from the needs of persons who do not share it;
- Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low.

2. **Equalities Impact Assessment:**

This is a covering report which appends reports under consideration by the Committee, therefore this section is not applicable to this covering report. The Committee will request appropriate impact assessments to be undertaken should this be relevant for any topic that the Committee is reviewing.

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Integrated Primary Care Access Service - update

1. Purpose

This paper provides an update on the development of the Integrated Primary Care Access Service (IPCAS) provided by the Southern Hampshire Primary Care Alliance across Fareham, Gosport and south east Hampshire.

The IPCAS service was developed to bring together two services: the GP Extended Access Service, which was a pilot, and the GP Out of Hours Service. These were delivered by two separate providers with differing access points for local people.

The contract originally ran until 2021 when Primary Care Networks (PCNs) were expected to become responsible for providing extended access to their patients.

This position has now changed nationally and the purpose of this paper is to provide an update to the Committee on the CCG's response to the latest national guidance.

Within this paper sections 2-4 provide a recap of the situation. Section 5 provides information about how we now expect this to evolve from here.

2. Background

During the summer in 2019 the CCGs and Primary Care Alliance worked together to seek the views of local people about the services, hubs, travel, and their preference for accessing the service.

Following feedback the service model was determined as summarised in the table:

	Site	Opening times
Patients ring their practice to book an appointment (both routine and urgent) or NHS111 when their practice is closed for an urgent appointment	Fareham Community Hospital	• Mon to Fri 6.30pm to 10.30pm
	Forton Medical Centre, Gosport	• Tues and Thurs 6.30pm to 10.30pm (for urgent appointments) • Sat and Sun 8am to 10.30pm
	Portchester Health Centre	• Sat and Sun 8am to 10.30pm
	Chase Community Hospital	• Fri 6.30pm to 10.30pm
	Swan Surgery, Petersfield	• Tues and Thurs 6.30pm to 10.30pm • Sat and Sun 8am to 10.30pm
	Waterlooville Health Centre	• Mon, Wed and Fri 6.30pm to 10.30pm • Sat and Sun 8am to 10.30pm

3. Impact of COVID-19

The impact of the COVID-19 pandemic, although challenging, has accelerated the pace of change and transformed the way in which primary care services are delivered. This includes the way the IPCAS service operates. There has been a further breakdown of traditional roles and boundaries, with continued strong collaborative working with NHS 111, community and mental health services, secondary care and the voluntary sector to deliver the best outcomes for the communities we serve.

Primary care services have remained open throughout the pandemic but the way in which services are delivered fundamentally changed to ensure patient safety, the effective implementation of infection, prevention and control measures and ensure patients were cared for in the most appropriate setting for

their needs. At all times we have followed national guidance on how primary care services should be delivered during the pandemic and continue to do so.

This accelerated pace of change has led to new models of delivery supported through strong clinical leadership, greater partnership working and digital technology:

- ❑ 100% of general practices open are operating **a total triage model** to support the management of patients remotely where possible. This means operating a model where all patients requiring GP care are assessed either on the phone or via an electronic system (eConsult) to determine the best option for their care. All practices operate telephone and online consultations.

- ❑ Strengthened working with **NHS 111**, with NHS 111 able to directly 'book' patients into a practice.

- ❑ Continued provision of **essential face-to-face** services (including home visits) through designation of 'hot' and 'cold' sites and teams to minimise the spread of infection. Hot and cold is essentially the separation of care for those with suspected COVID-19 and those not.

- ❑ Greater use of **Electronic Repeat Dispensing (ERD)** to reduce footfall within practices.

This has meant a significant change for patients in how services are accessed and used, but has meant that primary care and general practice could continue to operate and provide essential services during this very challenging time.

4. **Changes to local delivery**

Several 'hot' sites were set up across our two CCG areas to ensure there was safe separation in the way services were delivered for patients, with these hub sites providing care for those patients with suspected COVID-19. Additional 'cold' sites were then identified within the remaining general practice facilities to provide services to those who also needed care but did not have suspected COVID-19.

It was extremely important to ensure all primary care services operated in this way to minimise the spread of infection wherever possible and ensure the continued safety of patients and staff. Therefore the IPCAS service was also aligned to this model.

As a result the sites of delivery were identified to align to the 'hot' service hubs set up across the patch so that the IPCAS service could focus on service provision that was absolutely critical and needed at this time (in line with national guidance). The sites identified were therefore:

	Site	**Opening times**
Patients ring their practice to book an appointment (both routine and urgent) or NHS111 when their practice is closed for an urgent appointment	Forton Medical Centre, Gosport	• Mon to Fri 6.30pm to 10.30pm • Sat and Sun 8am to 10.30pm
	Waterlooville Health Centre	• Mon to Fri 6.30pm to 10.30pm • Sat and Sun 8am to 10.30pm

NHS England and Improvement determined nationally which services were vital to continue throughout the pandemic phase and therefore 'cold' sites were also aligned in the IPCAS service to day time delivery to ensure safety for patients, these were as follows:

	Site	**Opening times**
Patients ring their practice to book an appointment (both	Portchester Health Centre	• Mon to Fri 6.30pm to 10.30pm Sat and Sun 8am to 10.30pm

routine and urgent) or NHS111 when their practice is closed for an urgent appointment	Swan Surgery, Petersfield	• Mon to Fri 6.30pm to 9pm (from mid-September to increase to 10.30pm) • Sat and Sun 8am to 2pm

During the first wave of the pandemic the service model was adjusted to also allow patients to be booked into a video consultation, reducing the need for patients to travel and reduce the risk of infection.

Given the ongoing critical nature of the pandemic, it is not expected that this will change in the near future and the committee will be kept appraised of any plans to change this.

5. Longer term service provision and next steps

A Plan for Improving access for Patients and Supporting General Practice published by NHS England and Improvement in October 2021. This document stated that "***to support core general practice capacity and avoid disruption to existing service provision over the winter period, the planned transfer of current CCG-commissioned extended access services to PCNs will now be postponed until October 2022***." This was in response to the additional pressure GP practices were experiencing in continuing to support delivery of the COVID-19 vaccination programme.

NHS England and Improvement then published a letter last month which outlined that the responsibility for the delivery of extended access service would not go to PCNs in April 2021, and that this would be delayed for a further year.
The CCG is therefore required to ensure a service runs until end of September 2022. The option of going out to procurement on this contract is ruled out on account of the timeframes. A procurement process would take six months, and mobilisation a further three to six months which would be near to the end of the contractual term. The CCG will therefore be extending the existing service until end of September 2022.

Throughout the next period further work will be undertaken with PCNs to establish what the plan will be, however this is subject to NHS England publishing the requirements from October onwards. Engagement with patients and reviewing the service that has been in place will form a large part of ensuring that future provision is fit for purpose.

At this point it remains unknown what the PCN contract detail will look like. For example financial details and specific requirements in terms of operating hours and locations has not be published.

NHS England and Improvement has, however, confirmed that Primary Care Networks will become responsible for providing extended access to their patients and therefore this currently integrated service may be split again as follows:

- the GP Extended Access Service provided by Primary Care Networks
- the GP Out of Hours Service provided by a Primary Care Provider Organisation

The Primary Care Alliance and CCGs are working together to develop the longer term model further taking into account the views of local people, the lessons from running the service to date and aligning the service to the wider vision for urgent care services in Portsmouth and South East Hampshire.

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Alton Community Hospital – new ward

Introduction

Alton Community Hospital provides a range of services for the Mid & North Hampshire system and local population. We have an opportunity to modernise the offer to improve services for people and meet changing needs across community and inpatient pathways.

The focus of the improvements to provision will be for Discharge-to-Assess Pathways 2 (rehab and recovery), including our end of life care (EOL) for patients.

There will be two main focuses for rehabilitating patients, Alton Community Hospital will continue to focus on step down from Hampshire Hospitals Foundation Trust (HHFT) and step up from Primary Care Networks (PCNs) and the community.

In conjunction, we will also be able to support with preventing acute hospital admissions, working closely with our Urgent Community Response (UCR) team. Alton Community Hospital will further develop closer working relationships with UCR colleagues to admit directly to the ward in the community hospital to prevent acute hospital admissions, this will ultimately support HHFT patient flow.

Background

Alton has provided community step up beds for GP practices and rehabilitation pathways for patients from HHFT for many years. As demand has changed and discharge to assess pathways have become more widely understood, Alton continues to provide support for patients requiring rehabilitation alongside ongoing medical needs.

Using data to inform change, an options appraisal has been developed identifying the safest and most sustainable way to provide additional high-quality care provision in a bed-based setting for patients and to support the wider Hampshire and Isle of Wight system.

After reviewing the options, the recommended option 3 was approved for consideration as it is the most cost effective and will provide an additional 22 beds in a purpose-built ward on the first floor of Alton Community hospital. Increasing total occupancy to 40 beds - where infection prevention and control standards are closely adhered to ensure appropriate care for patients with reablement and recovery needs.

Funding

- £1.7 million for the renovation (Southern Health NHS Foundation Trust)
- £3.5 million for staffing (HIOW CCG)

Impact

This new ward will provide an additional 22 beds increasing the bed capacity at Alton from 18 (currently on Anstey ward) to 40.

This will enable timely transfers from HHFT once they no longer meet the criteria to reside on a discharge-to-access pathway 2, providing rehabilitation and recovery in a community environment, thereby reducing inpatient length of stay, a national NHS priority to improve outcomes and experience for patient, releasing capacity for urgent and planned care pathways.

The Anstey and Inwood wards would be run as two separate units, but the medical cover and staff could support one another. Having two wards would provide 8 side rooms which would allow a greater level of isolation for patients as well as increased cohorting.

Engagement

Service users and carers engagement

All patient facing services currently operating from Alton Community Hospital will continue. No inpatients are affected by this ward redevelopment.

The Trust's Patient Involvement Manager is on the project board and is engaging with service user and carer groups on plans for the ward use and clinical model, as well as ward layout and design. In addition, service users will be included in recruitment processes to the new staffing model.

Staff

There are around 40 staff currently located at Alton Community Hospital who are non-patient facing. These staff will be permanently relocated to alternative accommodation.

A staff consultation started in November to inform and engagement with staff on this relocation and teams successfully relocated to new premises in early January.

External

Southern Health briefed the Alton Town Council on this project in September 2021.

The clinical model for the ward has been consulted on with all system partners – including our Clinical Commissioning Group, Hampshire County Council (HCC), South Coast Ambulance Service (SCAS), Hampshire Hospitals Trust (HHFT) and primary care networks and has been signed off.

Timescales

It is expected that the new ward will open 8 beds in May 2022 and be fully opened by July 2022

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select (Overview and Scrutiny) Committee (HASC)
Date of meeting:	8 March 2022
Report Title:	Work Programme
Report From:	Chief Executive

Contact name: Members Services

Tel: 0370 779 0507 **Email:** members.services@hants.gov.uk

Purpose of Report

1. To consider the Committee's forthcoming work programme.

Recommendation

2. That Members consider and approve the work programme.

WORK PROGRAMME – HEALTH AND ADULT SOCIAL CARE SELECT OVERVIEW & SCRUTINY COMMITTEE

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	8 March 2022	24 May 2022	5 July 2022	27 Sept 2022	29 Nov 2022
Proposals to Vary Health Services in Hampshire - *to consider proposals from the NHS or providers of health services to vary health services provided to people living in the area of the Committee, and to subsequently monitor such variations. This includes those items determined to be a 'substantial' change in service.* **(SC) =** Agreed to be a substantial change by the HASC.									
Urology Services Reconfiguration	Proposal to centralise emergency urology care to Royal Hampshire County Hospital in Winchester	Starting Well Living Well	Hampshire Hospitals NHS FT	Proposals considered June 2021 and supported. Update requested Autumn 2021.					
Andover Hospital Minor Injuries Unit	Temporary variation of opening hours due to staff absence and vacancies.	Living Well Healthier Communities	Hampshire Hospitals NHS FT and West CCG	Last update Sept 2020 (invite West CCG to joint present with HHFT). Update spring 2021 deferred as no change to report.					
Spinal Surgery Service	Move of spinal surgery from PHT to UHS (from single clinician to team).	Living Well Ageing Well	PHT, UHS and Hampshire CCGs	Proposals considered July 2018. Determined not SC. Last Update March 2020 (UHS). Next update deferred due to					

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	8 March 2022	24 May 2022	5 July 2022	27 Sept 2022	29 Nov 2022
				pandemic.					
Chase Community Hospital (Whitehill & Bordon Health and Wellbeing Hub Update)	Hampshire Hospitals NHS FT - Outpatient and X-ray services: Reprovision of services from alternative locations or by an alternative provider.	Living Well Ageing Well Healthier Communities	HHFT and Hampshire CCGs	Item considered at May 2018 meeting. Sept 2018 decision is substantial change. Latest update circulated Oct 2021. Request further update when developments.					
Integrated Primary Care Access Service	Providing extended access to GP services via GP offices and hubs.	Living Well Ageing Well Healthier Communities	Southern Hampshire Primary Care Alliance	Presented July 2019, last update March 2021. Requested further update late 2021. Nov 2021 suggested defer to Feb 2022 when further detail likely to be known.	x				
Orthopaedic Trauma Modernization Pilot	Minor trauma still treated in Andover, Winchester and Basingstoke. An elective centre of excellence for large operations in Winchester.	Living Well Ageing Well Healthier Communities	HHFT	Presented September 2019, last update March 2021. Requested further update early 2022.					

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	8 March 2022	24 May 2022	5 July 2022	27 Sept 2022	29 Nov 2022
Out of Area Beds and Divisional Bed Management System	Plan to tackle the Out Of Area (OOA) bed issue within the adult mental health services.	Living Well Ageing Well Healthier Communities	Southern Health NHS FT	Presented September 2019, update Sept 2021. Update Jan 2021 on Abbey ward, to be notified when it opens (expected summer 2022)					
Hampshire Together: Modernising our Hospitals and Health Infrastructure Programme	To receive information about a new hospital being built as part of a long term, national rolling five-year programme of investment in health infrastructure.	Starting Well Living Well Ageing Well Healthier Communities Dying Well	HH FT and Hampshire CCGs	Presented July 2020. Last update Nov 2020. Agreed SC. 3 Dec Council established joint committee with SCC. Met Dec 2020 and March 2021. Next meeting tbc as consultation on hold.					
Building Better Emergency Care Programme	To receive information on the PHT Emergency Department (ED) capital build.	Starting Well Living Well Ageing Well Healthier Communities	PHT and Hampshire CCGs	Presented in July 2020 following informational briefings. last update June 2021. Next update requested spring 2022.		**x**			

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	8 March 2022	24 May 2022	5 July 2022	27 Sept 2022	29 Nov 2022
Issues relating to the planning, provision and/or operation of health services – *to receive information on issues that may impact upon how health services are planned, provided or operated in the area of the Committee.*									
Care Quality Commission Inspections of NHS Trusts Serving the Population of Hampshire	To hear the final reports of the CQC, and any recommended actions for monitoring.	Starting Well Living Well Ageing Well Healthier Communities	Care Quality Commission	To await notification on inspection and contribute as necessary. Updates on hold during pandemic (unless priority due to new report or poor outcome) PHT last report received Jan 2020, update March 2020. SHFT – latest full report published Feb 22. HHFT latest report April 2020 received Sept 2020. Solent – latest full report received April 2019, written update on minor improvement areas	**x**				

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	8 March 2022	24 May 2022	5 July 2022	27 Sept 2022	29 Nov 2022
				in November 2019. Frimley Health NHS FT report published March 2019 and update provided July 2019. Further update March 2020. UHS FT inspected Spring 2019. Update provided July 2019. Further update March 2020.					
Independent Review of Southern Health NHS Foundation Trust			Southern Health NHS FT	Stage 2 Report published in September 2021. Initial item Oct 2021, action plan at Jan 2022 meeting. Requested update March on actions with early completion dates. CCG/ICS update for Sept 2022.	x			x	

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	8 March 2022	24 May 2022	5 July 2022	27 Sept 2022	29 Nov 2022
Dental Services	Concern over access to NHS dental appointments post pandemic	Starting Well Living Well	NHS England	Initial Item heard Nov 2021, requested update for March 2022.	x				
Primary Care Services	Concern over access to GP appointments post pandemic	Starting Well Living Well Ageing Well Healthier Communities	HS&IOW CCG/ICS	Initial Item heard Nov 2021. Request update March 2022.	x				
Sustainability and Transformation Plans: One for Hampshire & IOW, Other for Frimley	Subject to ongoing scrutiny the strategic plans covering the Hampshire area.	Starting Well Living Well Ageing Well Healthier Communities	STPs	H&IOW initially considered Jan 17 and monitored July 17 and 18, Frimley March 17. System reform proposals Nov 2018. STP working group to undertake detailed scrutiny – updates to be considered through this. Last meeting in Dec 2019 and report to HASC April 2019. Last report alongside WG report in Oct 19. Final					

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	8 March 2022	24 May 2022	5 July 2022	27 Sept 2022	29 Nov 2022
				papers circulated Nov 2019 (minus Appendices D and I) Timing of next update tbc					
Urgent Treatment Centre Model	Services offered by a UTC compared to a MIU or A&E	Living Well	CCG	Chairman and Vice Chairman visited Petersfield UTC Nov 2021, requested briefing for cttee on role and scope of UTC and moving from an MIU	x				
Pre-Decision Scrutiny – *to consider items due for decision by the relevant Executive Member, and scrutiny topics for further consideration on the work programme*									
Budget	To consider the revenue and capital programme budgets for the Adults' Health and Care department.	Starting Well Living Well Ageing Well Healthier Communities	HCC Adults' Health and Care (Adult Services and Public Health)	Considered annually in advance of Council in February (January) Transformation savings pre-scrutiny alternate years at Sept meeting.					
Integrated Intermediate Care	To consider the proposals relating to IIC	Living Well	HCC AHC	Initial briefing on IIC Oct 2019. Update tbc					

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	8 March 2022	24 May 2022	5 July 2022	27 Sept 2022	29 Nov 2022
	prior to decision by the Executive Member.	Ageing Well							
Working Groups									
Sustainability and Transformation Partnership Working Group	To form a working group reviewing the STPs for Hampshire.	Starting Well Living Well Ageing Well Healthier Communities	STP leads All NHS organisations	Set up in 2017, met in 2018 and 2019. Report back to HASC Oct 19.	Will meet as needed going forwards.				
SP23 Savings Proposals re Demand Management Grants and Social Inclusion Services	Regarding services covering: substance misuse, stop smoking, sexual health, 0-19 public health nursing	Living Well Ageing Well	AHC Dept	Working Group proposal agreed Oct 2021. To feed in to pre-decision scrutiny May/June 2022.	Holding meetings starting in Nov 2021 to feed back to May 2022 HASC				
Update/Overview Items and Performance Monitoring									
Adult Safeguarding	Regular performance monitoring adult safeguarding in Hampshire.	Living Well Healthier Communities	Hampshire County Council Adult Services	For an annual update to come before the Committee. Last update Nov 2021. (from 2020 to					

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	8 March 2022	24 May 2022	5 July 2022	27 Sept 2022	29 Nov 2022
				combine with Hampshire Safeguarding Adults Board annual report)					
Public Health Updates	To undertake pre-decision scrutiny and policy review of areas relating to the Public Health portfolio.	Starting Well Living Well Ageing Well Healthier Communities	HCC Public Health	Last item was pre-scrutiny of decision regarding SP21 savings Oct 2021 following summer 2021 consultation and working group.					
Health and Wellbeing Board	To scrutinise the work of the Board.	Starting Well Living Well Ageing Well Healthier Communities	HCC AHC	HWB annual report received June 2021.		X?			
Public Health Covid-19 Overview and Impact on Health and Wellbeing and Outbreak Control Plans	To receive an overview on the three different aspects in relation to COVID-19.	Starting Well Living Well Ageing Well Healthier Communities Dying Well	HCC Public Health	First received July 2020. Updates to be received at each meeting until further notice.	**x**	**x**	**x**	**x**	**x**

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	8 March 2022	24 May 2022	5 July 2022	27 Sept 2022	29 Nov 2022
Adults' Health and Care Covid Response and Recovery	To receive an overview of the systems that have been put in place by Hampshire organizations, partners and voluntary sector.	Starting Well Living Well Ageing Well Healthier Communities	HCC AHC, Borough and District Councils, Hampshire Council for Voluntary Service Network, and voluntary sector	First received July 2020. Updates to be received at each meeting until further notice	**x**	**x**	**x**	**x**	**x**
Hampshire and Isle of Wight Covid-19 NHS System Approach Overview	To receive a report setting out the Hampshire and Isle of Wight Local Resilience Forum response	Starting Well Living Well Ageing Well Healthier Communities Dying Well	Hampshire and Isle of Wight Integrated Care System Southampton City, West Hampshire and Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups	First received July 2020. Updates to be received at each meeting until further notice. To cover recovery once crisis period over	**x**	**X**	**x**	**x**	**x**

Topic	Issue	Link to Health and Wellbeing Strategy	Lead Organisation	Status	8 March 2022	24 May 2022	5 July 2022	27 Sept 2022	29 Nov 2022
NHS 111	To request an item on performance of NHS 111 following concerns raised by a committee member	Living Well Ageing Well Healthier Communities Dying Well	Hampshire CCGs	Item on NHS 111 First Nov 2020 on link with Emergency Departments. Performance item March 2021. Further update Nov 2021. Requested update in 6 months.		x			
Development of Integrated Care Systems (ICS)	Commissioning moving to ICS. Hampshire residents served by H&IOW ICS and Frimley ICS.	Living Well Ageing Well Healthier Communities Dying Well	Hampshire CCGs	Item heard at Sept 2020 meeting regarding merger of CCGs due to take place April 2021. Last update Jan 2022. Request further update July 2022.			x		

*** Work program to be prioritized and updated accordingly to note items that can be written updates only.**

Other Topic Requests for scheduling:

June 2021 – request for update on water fluoridation powers in the Health and Care White Paper

July 2021 – request for a briefing on the 'Carers and Working Parents Network' (a HCC Staff Network. Requested by a member as a result of a member briefing on our workforce)

September 2021 – request for item on encouraging responsibility for health

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	No
People in Hampshire live safe, healthy and independent lives:	Yes
People in Hampshire enjoy a rich and diverse environment:	No
People in Hampshire enjoy being part of strong, inclusive communities:	No

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. Equality Duty

The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

Due regard in this context involves having due regard in particular to:

- The need to remove or minimise disadvantages suffered by persons sharing a relevant protected characteristic that are connected to that characteristic;
- Take steps to meet the needs of persons sharing a relevant protected characteristic that are different from the needs of persons who do not share it;
- Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low.

2. Equalities Impact Assessment:

This is a forward plan of topics under consideration by the Committee, therefore this section is not applicable to this report. The Committee will request appropriate impact assessments to be undertaken should this be relevant for any topic that the Committee is reviewing.