Southern Health
NHS Foundation Trust

Report for Hampshire HASC
May 2022

Care Quality Commission (CQC) inspection report and Trust response

1. Introduction

1.1 In October 2021, the Care Quality Commission (CQC) carried out an unannounced comprehensive inspection of six of the Trust's mental health and learning disability services as part of its continual checks on the safety and quality of healthcare services:

- Acute wards for adults of working age and psychiatric intensive care units (PICUs) – Antelope House, Elmleigh, Parklands, Melbury Lodge
- Child and adolescent mental health wards – Bluebird House, Leigh House, Austen House
- Forensic secure wards – Ravenswood, Southfield
- Wards for older people with mental health problems – Gosport War Memorial, Parklands, Western
- Wards for people with a learning disability or autism - Ashford
- Mental health crisis services and health-based places of safety – Antelope House, Elmleigh, Parklands

1.2 Following this, the CQC carried out a Well-led inspection in November 2021, interviewing senior leaders within the organisation including the Chief Executive, Chair, Executive Directors and Non-Executive Directors.

1.3 In late December 2021, the Trust received the draft inspection report and were given ten days to carry out a factual accuracy review. The Trust submitted a response in January 2022 and CQC published the final report on 10 February 2022.

2. Report

2.1 The Trust's overall rating was changed from 'Good' to 'requires improvement':

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

2.2 The Safe domain reduced from Good to Requires improvement, Effective domain remained at requires improvement, Caring, Responsive and Well led domains remained at Good.

2.3 The CQC found evidence of progress and good practice. However, the inspectors also highlighted the challenges that teams have faced due to staffing pressures and in delivering services during the pandemic.

2.4 The CQC gave the Trust 23 actions (M1-M23) that it must take to comply with legal obligations, and a further 23 actions (S1-S23) it should take to improve services.

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.

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

3.0 Key findings

3.1 Progress & Good Practice

Overall, throughout the report, there were numerous examples of good practice and improvements seen by the CQC inspectors. Below are some key highlights:

- Staff were proud to work for the trust with lots of hope for the future. There was a strong sense of staff at all levels putting patients at the heart of everything they do and being respectful, compassionate, and kind towards patients. Staff were friendly, approachable, supportive, and highly motivated and provided care in a way that promoted patient's dignity.
- People accessing the learning disability ward were receiving safe and effective care. They were treated with dignity; risks were assessed, the environment was safe and they received kind and compassionate care.
- The engagement of younger people and employment of patients with lived experience in the development and planning of services was purposeful and innovative.
- Leadership was stable and capable and demonstrated a high level of awareness of priorities and challenges facing the trust and how these were being addressed.
- Trust was proactively working with other providers to facilitate strategic development of mental health and community health services within the Integrated Care System and actively sought feedback from patients and carers to influence and develop service delivery.
- 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 had developed good crisis pathways and had adapted these during the COVID-19 pandemic to divert people from attending Accident & Emergency (A&E).
- Staff knew about any potential ligature anchor points and there were regular ligature assessments completed on all the wards inspected. Ligature anchor points were removed, and plans put in place for any risks that could not be removed to keep people safe.
- All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.
- Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. This included monitoring the temperature medications were stored at. This was a requirement of the last inspection and trust was now complaint with this.
- Staff delivered care in line with best practice and national guidance. There was evidence in patients records that staff followed latest guidance when planning care for patients.

3.2 Areas for Improvement – Must and Should do actions

The 46 actions the CQC have told the Trust they must or should address have been grouped into 13 themes and reviewed with our teams, service users and carers. Below is a summary of these themes and the actions the Trust will make to ensure we make the required improvements.

Note: 36 of the 46 actions have already been completed (18 of these are 'must do' actions and 17 are 'should do' actions).

One action is 'partially completed' - this is action M4 (a 'must do' action). The reason for this partial completion is a supply issue with the soft play surface, the funding was agreed and it is awaiting installation - the executive director of nursing is aware of this.

Work is ongoing to complete the remaining actions, with completion dates later this summer.

Theme	Recommendation	Action	Outcome	Completion Timeframe
Workforce (M1, M10, M13, M22, M23, S1, S3, S6, S7, S9, S13, S21, S22)	To ensure there are enough suitably skilled and experienced staff on every shift to keep patients safe and meet their needs. To ensure staff are listened to when they raise concerns and that morale issues are addressed	Daily Ward leaders with the support of Matrons support decisions to move staff, redirect resources and address skill mix gaps to ensure every shift is safe and that patients' needs are met This includes the movement of super-nummary staff including practice educators, ward leaders, matrons, and staff not on the roster like occupational therapists and psychologists Future shift gaps are escalated through daily staffing huddles to support timely escalations of shifts to additional agencies. Where shifts are not safely filled patient admissions may be stopped or beds temporarily closed. Incident reporting identifies shifts where mitigations have been impossible or where staffing has affected patient care negatively. A robust recruitment and retention programme is in place supporting gaps in nursing especially mental health nursing.	Wards are staffed with enough suitability skilled and experienced staff to keep patients safe. Evidence of mitigations taken against safer staffing standards is collected through daily staffing huddles	M1, M10, M22, S1, S3, S7, S21, S22 all completed S6 due by 31/05/2022 M13 and M23 by 30/06/2002 S9 due by 30/06/2022 S13 due by 31/07/2022

		Senior leaders are visible on wards daily to enable them to listen to staff and address any concerns. Latest National NHS Staff survey results, show higher than the National average on staff feeling able to raise safety concerns.		
Physical health monitoring (M5, M7, M11, M17, M18)	To ensure that National Early Warning Score (NEWS2) observations are completed consistently, and results are escalated appropriately. To ensure that physical health monitoring is carried out for patients on anti-psychotic medication and following administration of rapid tranquilisation.	Physical health reviews undertaken and discussed at handover and in multidisciplinary team meetings. Physical health checks are reviewed as part of ward quality governance processes. Local adult mental health ward NEWS2 audits were undertaken in April and May 2022 and snapshot audits are ongoing. The results of the audits are being considered by each unit to assess compliance and identify actions for improvement. A Trust-wide NEWS2 audit has been scheduled on the audit programme for June 2022. Local adult mental health ward rapid tranquilisation audits were completed in May 2022 and snap shot audits are ongoing. The results of these are being considered by each unit to assess compliance and identify actions for improvement. A Trust-wide rapid tranquilisation audit is scheduled on the audit programme for November. A rapid tranquilisation monitoring form is in place to ensure the monitoring of patients following tranquilisation. Enhanced physical health training sessions have been held as part of the work undertaken by the ward practice educators.	All patient observations are accurately recorded via NEWS2 and escalated as prompted All patients are effectively monitored following the administration of rapid tranquilisation to keep them safe.	COMPLETED

		Rapid tranquilisation monitoring is added to the new electronic -observations module with roll out starting in July at Ravenswood. A national high dose anti-psychotic medication audit was supported by the Trust and the initial report is expected by the end of May. Additionally local mental health wards have undertaken a snap shot audit in May and the results are being reviewed to review compliance and identify areas for improvement.		
Observations (M6, M15)	To ensure that patients are observed in line with the Trust observation policy, and it is recorded correctly	Implementation of a new co-produced policy with ongoing involvement in the national improvement work. The policy was signed off at the Trust Clinical Effectiveness Group in March 2022. A roll- out plan and a supporting programme of work is developed. A project lead and practice educator will be employed to support the programme and roll-out plan. As part of the programme of work, a new electronic observations module with roll out, starting in July at Ravenswood. Observation requirements are discussed daily as part of the ward safety huddle and by shift leader for each shift. Ward leaders undertake local audits to monitor the compliance with the observation policy and feedback will be collated from carers and service users and teams on progress. There is an observation competency programme implemented for every staff member overseen by ward Practice Educators and Ward Leaders	All patients are observed in line with their individual plan of care, and this is accurately recorded.	COMPLETED
Admission & discharge pathways (M20, M21, S2)	To ensure there is a clear, effective admission and discharge pathway which demonstrate criteria for admission.	There is a pathway and criteria in place for psychiatric intensive care unit (PICU) admissions and length of stay in PICU beds is just above the lower quartile, so access is good.	Multi-disciplinary team discussions take place in a timely way on admission Staff are empowered to escalate patients for PICU	M20, M21, S2 all due by 30/06/2022

		Within older people's mental health services, an assessment is carried out within 48hrs of admission, which includes the patient and their carer, and starts the discharge planning process. A Quality Improvement programme is planned to address concerns raised from ward teams	admission following assessment Patients are at the forefront of admission discussions	
Mixed sex breaches (M2)	To ensure there are no mixed sex breaches on the wards and there is access to a female-only lounge	All wards are compliant with same-sex regulations, with exception of Beechwood therapy room. To maintain privacy and dignity therapists ensure male patients are fully dressed and escorted to the room and this is documented in therapy notes. Requests to breach this standard are approved by the Director of Nursing & AHP and reported to Quality & Safety Committee	All patients are cared for in an environment which promotes privacy and dignity. All female patients have access to a female-only lounge.	COMPLETED
Incident reporting (M3, M14)	To ensure that all incidents, including safeguarding incidents are reported in line with Trust policy.	Patient Safety Lead and Safeguarding Lead are supporting staff on reporting incidents and raising Safeguarding concerns. The Safeguarding Lead is based on wards on a regular basis to provide training and support. The Patient Safety Lead provides Ulysses incident reporting training. Further improvements are to be made to support the reporting of all incidents and local actions have been identified to support this. Incident reporting is discussed at local and divisional Quality and Safety meetings. Prompts have been included in the safety huddles to ask if incidents have been reported on to the Trust system. All incidents have oversight from the Quality Governance Team as well as other senior leaders in the Trust. A quality dashboard is in place which benchmarks teams and enables the Quality Governance Team to identify any teams where we would expect to see more incident reporting, so this can be investigated, and support provided to teams as required.	All incidents are reported and managed in line with Trust policy	ONGOING

		The Trust is committed to embedding a just and learning culture where all staff feel safe to raise concerns and report incidents.		
Risk assessment & care planning (M8, M12, M16, S4, S10, S11, S15)	To ensure patient care plans are consistent, personalised and reflect patient involvement, and that all patients are offered copies of their care plans. To ensure risk assessments are completed correctly, and care plans are updated following all risk events.	Specific incidents are discussed at daily safety huddle to ensure that risk assessments have been appropriately recorded Reviews of risk assessments and care planning are undertaken as part of ward processes and ongoing snapshot audits will be included to this programme of work from May onwards. A Trust-wide audit is scheduled on the audit programme for 2022. Patients are asked whether they feel involved in their care planning as part of the Service User-Led Audits. Local audits are completed weekly with oversight from Ward Leader	All patients have holistic and personalised care plans which reflect their involvement. All patients are offered a copy of their care plan All patients have their risk reassessed following their needs changing and the care plan updated accordingly	M8, M12, M16, S10, S11, S15 all completed S4 due by 30/06/2022
Environment, facilities, and equipment (M4, S12, S14, S18, S23)	To ensure the outside space on Beechwood ward is safe for patients To ensure acoustics issues at Austen House are rectified To ensure food provision on forensics wards is reviewed To ensure clean equipment is clearly labelled To ensure ligature risk assessments have completion dates for actions and control measures to mitigate risks	Immediate remedial works have been carried out at Beechwood to clear the courtyard and make it safe for patients to use. The grounds and garden are maintained monthly from November to April and forth nightly for the rest of the year. Sound absorption panels were fitted in open communal foyer area which has been successful in improving acoustics. Food is discussed regularly with patients as part of community meetings, menus are reviewed with catering team and updated accordingly. Improved portion size and choice of menu for service users. Checks of clean equipment has been added to daily environmental checklist and included as part of weekly audit schedule Ligature risk assessments have been reviewed with estates to add the specific completion dates.	Beechwood garden made safe and patients are using it Acoustics issues at Austen have been minimised Food provision is improved based on feedback All clean equipment is appropriately labelled All ligature risk assessment actions have completion dates	S12, S14, S18, S23 all completed M4 partially completed (due to a supply issue with soft play surface, funding agreed and awaiting installation) – due by 30/04/2022

Mental Health Act / Mental Capacity Act (M9, S17)	To ensure those detained under S136 are assessed in a more timely manner by a doctor and approved mental health professional (AMHP) To ensure all capacity assessments are reviewed to ensure they all explain why the patient lacks capacity.	The Trust follows good practice as detailed within the MHA Code of Practice. This is monitored across the county via the pan-Hampshire s136 group. Any s136 breaches are reviewed via the Trust s136 panel and discussed by the Mental Health Legislation Committee. Learning is shared via the Trust and pan-Hampshire s136 groups. Capacity assessment for individual raised during the inspection was reviewed and updated to include why the patient lacked capacity.	All people detained under s136 are assessed in accordance with MHA Code of Practice. There are no delays in assessments being carried out. All mental capacity assessments state why the patient lacks capacity	COMPLETED
Medicines management (M19, S19)	To ensure that staff follow the controlled drug policies. To ensure there is a system in place for monitoring the company contracted to check the emergency medications in grab bags	Weekly controlled drugs stock checks are in place and are monitored by pharmacy team. Any issues are reported as incidents and discussed with ward. Trust resuscitation team will carry out random spot-check audits of emergency grab bags as part of ongoing assurance checks and our findings will be fed in to the quarterly contract meetings	Controlled drugs are effectively managed as per Trust policy There is system in place for monitoring service provided by contractor in managing emergency grab bags	COMPLETED
Shared learning (S5)	To ensure lessons learned are shared with all staff to support improvements in provision of care.	This specific action relates to our crisis service and health-based places of safety. The crisis team runs out of two bases – Basepoint in Gosport and Leigh Park (Havant). The team hold multidisciplinary team meetings weekly, to discuss patients, and a monthly business meeting. New meetings have now been introduced: • Community pathways meeting – these occur twice a week across crisis resolution home treatment teams and community teams to discuss patient flow across these teams. • Whole pathway meetings three times a week – to look at patient flow across the whole mental health system	All crisis teams share good practice and lessons learned with each other. Good practice is shared	ONGOING

		All meetings include opportunities to sharing learning and improvements. Trust-wide learning from incidents is shared via the Trust Learning from Events meetings and in learning newsletters.		
Activities (S8, S20)	To ensure there are high quality activities and education sessions throughout the week, including at weekends and these are displayed clearly for patients	Ward teams, under the supervision of ward leader and matron take responsibility of oversight of the activities programme. All wards have a programme of scheduled activities, developed with service users and published on notice boards. This is monitored by community meetings involving service users, which take place weekly, fortnightly or monthly depending on the setting. The activities are also reviewed by the Trust's user involvement manager on a quarterly basis.	All patients have access to programme of co-produced, interesting activities and education sessions	ONGOING
Restrictive interventions (S16)	To ensure no local restrictions are in place regarding bedroom or cup access.	Daily safety huddle is used to ensure all restrictive interventions are appropriate and proportionate on a shift-by-shift and individual by induvial basis Service users are informed on admission about keys for bedrooms. Leaflet has been produced to provide a reminder for patients. A programme of ongoing snapshot reviews will be included to ward governance processes May 2022 onwards.	Any restrictions put in place for individuals due to a safety risk assessment are reviewed on a shift-by-shift basis	COMPLETED

4.0 Assurance

4.1 At the point the Trust submitted its improvement plan to the CQC, it had already completed:

- 10 of the 23 Must do actions
- 12 of the 23 Should do actions

This figure has now risen from 22 completed actions to 36 completed actions.

4.2 All actions when completed are being monitored through local audit with assurance overseen at monthly Divisional Governance meetings. The Trust is also using a new self-assessment and accreditation process, 'Aspire' which has been co-produced with patients and is currently being piloted. Divisional and Trust Governance processes will report ongoing compliance and improvements.

4.3 The improvement plan is being monitored, and assurance of completion gained by the Quality Governance Programme Management Office (PMO) lead by the Head of Quality Assurance.

4.4 Individual actions are being monitored via divisional quality and safety meetings and evidence of completion submitted to the PMO for review.

4.5 All completed actions are signed off by the Executive Directors responsible and reported to Quality and Safety Committee.

5.0 Conclusion

5.1 CQC found evidence of progress and good practice which is encouraging. However, the inspectors also highlighted the challenges that 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.'

5.2 CQC praised our staff and 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.

5.3 The Trust is responding to the staffing pressures by continuing to prioritise the engagement, health, and wellbeing of our teams, and carrying out extensive recruitment and retention programmes.

5.4 Trust staff have already addressed a number of the issues raised by CQC within the report and have plans in place to deliver the outstanding actions over the next 6 months.

5.5 The evidence of actions, learning and improvements from this action plan will be shared at a Trust wide panel with Executive sign off. This will be aligned with ongoing quality and governance work programmes to ensure it is not seen in isolation.