Care Quality Commission

Solent NHS Trust

Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Community hospital sites at the trust

The trust provides community services across the Southampton and Portsmouth region, including community inpatients at Royal South Hants Hospital, Western Hospital, St Marys Hospital and Jubilee House. The trust also provides a range of community based services for adults and children and young people including Sexual Health, Dentistry, Learning Disabilities and End of Life Care.

In Southampton the trust has four community inpatient wards. Two are based at the Royal South Hants Hospital (43 beds in total, 10 of which support primary care, and direct access). The other two are based at Western Hospital providing specialist neuro rehabilitation (14 beds on Snowdon Ward for neurological rehabilitation and 10 beds on Kite Unit for more specialised neuropsychiatric rehabilitation).

In Portsmouth the trust has a ward based at St Marys Hospital (Spinnaker ward). Jubilee House is based in the North of the city and cares for patients with end of life and continuing care needs. All wards provide specialised rehabilitation. They are supported by a multidisciplinary team including administration; nursing, physiotherapy, pharmacy, occupational therapy, psychologists, healthcare

assistants, care management, speech and language therapy, dietetics and medical staff. The wards provide care delivery for patients who are discharged from secondary care but require ongoing rehabilitation which cannot be delivered in their own homes (step down - RSH and Spinnaker only).

The trust provided an integrated musculoskeletal (MSK), persistent pain and rheumatology service in Southampton, and an integrated MSK and persistent pain service in Portsmouth. It provided a podiatry provision across the Solent NHS Trust geography. The trust also provides tuberculosis services and homeless healthcare services in Southampton City.

The trust provides a range of community based services to children, young people and families in the Portsmouth, Southampton and Hampshire areas. Care is provided in a variety of settings including schools, health clinics and home visits. Services provided include health visiting, school nursing, special school nursing, community children's nursing, children's continuing care nursing, community paediatricians, occupational therapy, physiotherapy, podiatry, orthotics, speech and language therapy, child protection nursing and medical services.

The trust provides a range of inpatient and community mental health services for adults of working age, older adults and children and adolescents.

The Orchards in-patient services based in St James's Hospital, Portsmouth provides mental health care for predominantly working age adults who live in Portsmouth. The Unit comprises two wards; Hawthorns, a 20 bedded Acute Ward and Maples, a 10 bedded Psychiatric Intensive Care Ward (PICU). The services form part of a planned and integrated whole system approach to care, which is delivered in conjunction with Community Mental Health Services.
Both wards accept admissions for adults with acute mental illness that require assessment and treatment, when there is no community-based alternative to in-patient admission.

Oakdene is a Residential Rehabilitation and Recovery ward located in the Limes building at St. James Hospital, Portsmouth. The ward is contracted by the clinical commissioning group (CCG) for a block contract of 14 beds, which admit both male and female adults who are experiencing severe and enduring mental illness and who have the potential to benefit from specialist rehabilitation assessment and intervention.
The aim of the ward is to provide recovery focussed, service user centred care and treatment adhering to principles of recovery, hope, self-empowerment, advocacy, education and build a support system that can enable individual function to the best of their ability.

Brooker ward is at St James Hospital, Portsmouth in a purpose built 22 bed mental health unit. This unit consists of two areas: 14 beds for dementia care and eight beds for functional care. The demographic of the average patient is over 65 years. The mix of staffing comprises registered nurses, unregistered nurses, medial staff including consultant cover and occupational therapies and physiotherapy staff. The level of care provided is upon individual needs and can involve full nursing care or one-to-one care.

The Older Persons Mental Health Community Team is a Solent NHS Trust service based in the Langstone Centre at St James Hospital in Portsmouth. The service is a multidisciplinary team of mental health specialists and comprises Psychiatrists, Mental Health Nurses, Health Care Support Workers, a Social Worker, Occupational Therapists and access to psychological services. The service offers memory monitoring for those with a diagnosis of dementia, prescribed anticholinesterase medication and has an Intermediate Care Team. The Intermediate Care Team can offer intensive support to patients at home with an increased level of need to avoid admission and support with early discharge.

The service provides a holistic assessment, with person centred care and treatment of older adults living in the community and residential care who are experiencing both functional and organic mental health conditions. The demographic of the average patient referred to the service is over 65 years,

though this is not exclusive. Care can be determined by the needs and frailty of patients below this age.

The service aims to keep people safe, independent and living at home for as long as possible. Practitioners can provide care and assess people in their homes, or where appropriate, in a clinic setting. Some of the interventions offered include carers support, specialist assessment, medication, physical health monitoring, community rehab programmes, low intensity psychological interventions and signposting to alternative agencies, including Adult Social Care.

The Integrated Learning Disability Service (ILDS) is based at St James' Hospital and includes community nurses, social workers, associate practitioners, independence support assistants, a Consultant Psychiatrist, Clinical Psychologist, Speech and Language Therapist and Occupational Therapists. The team directly supports adults with a learning disability and provides information, advice, education and support to carers and other health and social care professionals. Much of its work concerns commissioning and monitoring packages of support, promoting communication, advocacy, health promotion, mental health, psychological wellbeing and challenging behaviour, where these require specialist healthcare support.

The Learning Disability Hospital Liaison Team (LDHLT) is made up of Learning Disability Nurses from Solent NHS Trust working in partnership with Portsmouth Hospitals NHS Trust. The hospital liaison nurses work in Queen Alexandra hospital and support patients with learning disabilities throughout their planned hospital admission journey, during outpatient's appointments and with pre-admission planning as well as during emergency admissions. The liaison nurse's role is to ensure patients with learning disabilities understand their diagnosis, treatment options and support investigations and treatment.

(Source: CHS Routine Provider Information Request (RPIR) – Context CHS and MH Routine Provider Information Request (RPIR) – Context MH)

Is this organisation well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

Leaders had the experience, capacity, capability and integrity to ensure the strategy could be delivered and risks to performance addressed.

As part of the inspection we interviewed members of the board, both the executive and non-executive directors, and some senior staff across the trust. We looked at a range of performance and quality reports, audits and action plans. We reviewed previous board meeting minutes, risk registers, board assurance framework and papers to the board. We looked at investigations of deaths, serious incidents, complaints and sought feedback from staff and key stakeholders, such as the clinical commission groups (CCGs) and Healthwatch.

Since the 2016 inspection the trust had further developed a strong senior leadership team through the direction of the chair and chief executive. There had been many new appointments including the chief nurse who had been appointed in December 2017 into an interim position, and substantively appointed from April 2018. Other recent appointments included, a chief operating officer and chief people officer. The finance director was also the deputy chief executive to ensure continuity of leadership. Leaders at all levels were visible and approachable. The board executives were described by the non-executive directors (NEDs) as strong, capable, talented, values driven and very open.

There was an embedded system of leadership development and succession planning for all senior roles. For example, we were told the deputy chief pharmacist was participating in an external postgraduate pharmacy leadership programme.

We reviewed the personnel files for the non-executive directors and those of the executive team. Appropriate checks had mainly been carried out in accordance with 'Fit and Proper Person' requirements. The recently appointed chief people officer identified the areas on files that were not in order and had acted, such as where two references were required according to the trust policies and only one was in place relating to an appointment in 2014. The executive team had an appropriate range of skills, knowledge and experience. In interviews and focus groups they demonstrated professionalism, integrity and were ambitious for the trust.

NHS Improvement (NHSI) confirmed the full board was established. The director of finance and performance was appointed in August 2015 and had worked within the local health system since 2009. The board had relevant financial expertise across the executives and non-executives. The audit and risk committee was chaired by a NED who was a qualified accountant.

The trust had a board development programme; workshops had been held every two months to focus on development and strategic topics. During 2017 the board commissioned a specialist firm of business psychologists and consultants to support the delivery of the on-going board development programme.

The executive members met every Wednesday as a whole executive team. Executives also met on Monday mornings to discuss current issues and a forward view of the week. The executives also meet every Wednesday with clinical directors.

There were clear priorities for financial sustainability and strength, quality assurance, risk and workforce management. The NEDs described the committees each of them sat on. These included the people and operation development committee, finance committee, charitable funds committee, audit and risk committee, governance and nominations committee, assurance committee and

Mental Health Act Scrutiny committee. All NEDs sat on several different committees, many of which overlapped giving a wide view of the organisation.

A review of board minutes suggested appropriate time was spent covering finance and resourcing, and there was a separate finance committee chaired by a NED.

The chair of the finance committee, as part of this role, attended the assurance meetings and the mental health scrutiny committee as an associate hospital manager. Since taking up post the NED had worked on improving the data which was provided for assurance around finances. There was said to be improvement in the service lines which had become tighter and were about being open and realistic and honest if they had not been able to deliver savings they had been asked to achieve.

The NED explained they were confident finance within the trust was getting stronger in terms of assurance. We were told that the trust had a control total of a deficit of £1.0m; a month six revised forecast out-turn was a deficit of £0.6m.

Board Members

Of the executive board members at the trust, 14% were Black Minority Ethnic (BME) and 57% were female.

Of the non-executive board members 0% were BME and 16% were female.

Staff group	BME %	Female %
Executive directors	14%	57%
Non-executive directors	0%	16%

(Source: Universal Routine Provider Information Request (RPIR) – P55 Board)

Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

There was a clear statement of vision and values, driven by quality and sustainability. The vision and purpose was clearly stated to staff, that Solent NHS Trust was working with its partners for patients in the community it served and set the priorities for 2018/19 as:

- To provide great care
- To be a great place to work
- To deliver value for money

This vision was alongside the underpinning trust values of HEART

- Honesty
- Everyone counts
- Accountable

- Respectful
- Teamwork

The trust's strategic plan had been in place since 2016 and was reviewed annually for the current year priorities. This set out clear strategic objectives including financial sustainability. A framework was in place to review and monitor the strategic outcomes. The challenges for 2018 had been identified as workforce sustainability, third party providers, future organisational function and transformation, liberating business efficiency through technology and demand and capacity.

There were examples of working system wide as reflected in the trusts strategy. There was a joint medicines optimisation strategy across both community and mental health NHS trusts in the locality, with the aim to improve collaborative working to improve efficiencies, particularly in medicines supply. The joint medicines optimisation strategy had been approved by the board of Solent NHS Trust.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The trust's strategy, vision and values underpinned a culture which was patient centred. The culture was very positive, open and honest; staff were listened to and heard. We found everyone was extremely happy working at the trust. There were systems for performance management of staff through the annual appraisals, which were aligned to the values. There were processes and procedures for managers to follow if staff did not meet performance expectations. We were told of examples where the procedures had been applied where staff had not meet the trust values.

The culture had been developing across the trust in respect of Allied Health Professionals (AHP) and now all the specialisms were considered together as the whole AHP group and had a stronger voice through to the board as a result. With their own strategic framework AHPs had been able to access advanced practice roles such as for frailty. The trust had developed an intranet page for AHPs to upload information, which was said to be a very interactive platform.

An area for the trust to develop was equality and diversity for promotion in the trusts day to day work and for supporting opportunities for career progression. The trust told us there were fully developed work race equality standards action plans, which were presented to the board on an annual basis and published on the website. There was also an active Equality, Diversity and Inclusion sub-committee which met quarterly to drive the equality agenda.

Staff spoken with, including those with protected characteristics under the Equality Act, said they felt they were treated equitably in the trust, including for successful recruitment to the trust. They said they felt there were not any specific obstacles to their development and engagement with the trust, and we were given examples of promotion. It was noted the trust did not have a diverse workforce at senior leadership and board levels. We were told that two recent promotions from within the senior leadership team were of people with BME characteristics. The trust supported the wellbeing of staff but had not yet formalised a specific support group for people with BME characteristics. The trust provided prayer facilities; however, we were informed the space was limited and could be used for other purposes.

The equality and diversity lead informed us the trust had plans underway for a new strategy to meet the equality and diversity needs of the staff as well as patient groups.

We were told 93% of staff declared their race but about 25% of staff did not declare sexuality and disability. The Lesbian Gay Bisexual Transgender (LGBT) forum used the phrase ‘‘if you are not counted you don't count" for the employers' ability to plan and support a group effectively.

The induction programme had been redesigned to include an hour of diversity training and explanation of how the trust values were inclusive. The board had asked the equality and diversity lead to review the impact assessment processes of policies. This exercise encouraged the person to identify any biases rather than looking at how it supported inclusion and diversity.

There was a carers pledge on a staff intranet, which included a guide for talking to managers and for managers to discuss the needs of staff with carers responsibility. To support staff, the trust had an Optimising Well-Being and Lived Experience of Staff (OWLeS) network for optimising the lived experience of staff with mental health.

The trust now use a phrase for staff recruitment: "we want people who share our values" to encourage a diverse workforce.

Culture change had come about we were told since the change to the trust values, for example, staff and teams were encouraged to set goals around how teams worked. This was actively supported by the chief executive.

NEDs told us the trust hadset aside significant money to support organisational development work with staff to support the cultural improvements within the trust.

The trust had appointed a Guardian of Safe Working Hours (GSWH) to provide assurance to the trust board, the General Medical Council and Health Education England (and to the doctors themselves) that doctors in training were safely rostered. Furthermore, their working hours should be reported as compliant with their terms and conditions of service. The guardian was required to raise concerns to the trust board and potentially to external bodies if this was not the case.

To improve the culture the trust had a freedom to speak up guardian (FTSUG) with up to five supporting guardians across the trust. The FTSUG was seen by the trust to be embedded in the organisational development strategy and overseen by the chief nurse as executive lead. There was awareness of this through the board level. The FTSUG lead had recently left the trust, a new appointment had been made and there was an interim guardian until they arrived. The new post holder would be working 15 hours a week and was to be independent of any other trust team. We were told the national guidance for FTSUG role had been followed and several examples of how staff could contact for support was explained on the inspection. In 2017-2018 the trust had 46 cases reviewed by the FTSUG, two related to patient safety and 75% of cases had an element of bullying, harassment or conflict; all were resolved locally.

Staff Diversity

As of September 2017, Solent NHS Trust employed 3,492 people, of which:

- 87% were women.
- 41% were aged between 46 and 60, and 37% were aged between 31 and 45.
- 12% were from Black Minority and Ethnic Communities.
- 3% of staff had disclosed that they considered themselves to have a disability. 70% of staff had told the trust they don't consider themselves to have a disability, with the remainder either unknown or had chosen not to disclose.
- 70.2% of staff had disclosed as Heterosexual and 1.5% as Lesbian, Gay or Bisexual with the remainder unknown or chose not to disclose.
- 45.0% of staff considered themselves Christian, 11.2% as Atheists, and the third biggest group at 9.2% choosing to define their religion as 'Other'.
- 32.2% chose not to disclose their religion or belief.

(Source: Universal Routine Provider Information Request (RPIR) – Equality and Diversity Report)

The trust provided breakdowns of the following staff groups by ethnic group.

Ethnic group	Qualified nursing staff (%)	Medical and dental staff (%)	Allied Health Professional (%)
White – British	22.9%	1.7%	12.9%
White – Irish	0.3%	N/A	0.3%
Any other white background	0.5%	0.4%	0.8%
Mixed White and Black Caribbean	0.1%	N/A	N/A
Mixed White and Black African	N/A	0.0%	0.0%
Mixed White and Asian	0.2%	N/A	0.1%
Any other mixed background	0.1%	0.0%	0.1%
Asian or Asian British – Indian	0.3%	0.7%	0.2%
Asian or Asian British – Pakistani	N/A	0.1%	N/A
Asian or Asian British – Bangladeshi	0.0%	0.0%	0.0%
Any other Asian background	0.3%	0.1%	0.1%
Black or Black British – Caribbean	0.1%	N/A	0.0%
Black or Black British – African	0.8%	0.0%	N/A
Any other Black background	0.2%	0.0%	N/A
Chinese	0.0%	0.1%	0.0%
Any other ethnic group	0.2%	0.1%	N/A
Not stated	0.1%	N/A	0.1%

(Source: Universal Routine Provider Information Request (RPIR) – P6 Staff Diversity)

NHS Staff Survey 2017 – results better than average of community health trusts

The trust had 25 key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

Key Finding	Trust Score	National Average
Job satisfaction		

Key finding 1: Staff recommendation of the organisation as a place to work or receive treatment	3.81	3.68
Key finding 4: Staff motivation at work	3.96	3.93
Key finding 8: Staff satisfaction with level of responsibility and involvement	3.91	3.90
Key finding 9: Effective team working	3.90	3.85
Managers		
Key finding 5: Recognition and value of staff by managers and the organisation	3.61	3.54
Key finding 6: Percentage of staff reporting good communication between senior management and staff	39%	34%
Key finding 10: Support from immediate managers	3.97	3.89
Patient care and experience		
Key finding 3: Percentage of staff agreeing that their role makes a difference to patients / service users	90%	89%
Key finding 32: Effective use of patient / service user feedback	3.83	3.69
Violence, harassment & bullying		
Key Finding 22. Percentage experiencing physical violence from patients, relatives or the public in last 12 months	8%	14%
Key Finding 23. % experiencing physical violence from staff in last 12 months	1%	2%
Key finding 25: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	23%	26%
Key finding 26: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	16%	20%
Appraisals & support for development		
Key finding 11: Percentage of staff appraised in last 12 months	95%	92%
Key finding 12: Quality of appraisals	3.20	3.10

Key finding 13: Quality of non-mandatory training, learning or development	4.10	4.06
Equality & diversity		
Key finding 20: Percentage of staff experiencing discrimination at work in the last 12 months	7%	11%
Key finding 21: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	91%	86%
Errors & incidents		
Key finding 28: Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	21%	23%
Key finding 29: Percentage of staff reporting errors, near misses or incidents witnessed in the last month	95%	92%
Key finding 30: Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.92	3.76
Key finding 31: Staff confidence and security in reporting unsafe clinical practice	3.90	3.72
Health and wellbeing		
Key finding 17: Percentage of staff feeling unwell due to work related stress in the last 12 months	38%	40%
Key finding 18: Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	51%	53%
Key finding 19: Organisation and management interest in and action on health and Wellbeing	3.85	3.70

(Source: NHS Staff Survey 2017)

Workforce race equality standard

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of "Yes" responses to the question. Key Finding and question numbers have changed since 2014.

To preserve the anonymity of individual staff, a score has been replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

			Your Trust in 2017	Average (median) for combined MH/LD and community trusts	Your Trust in 2016
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	22%	25%	20%
		BME	22%	28%	31%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	15%	20%	16%
		BME	17%	23%	24%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	92%	88%	91%
		BME	82%	76%	83%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	4%	6%	4%
		BME	8%	11%	9%

Of the four questions above, Key Finding 21 (percentage of staff believing that the trust provides equal opportunities for career progression or promotion) showed a statistically significant difference in score between White and BME staff.

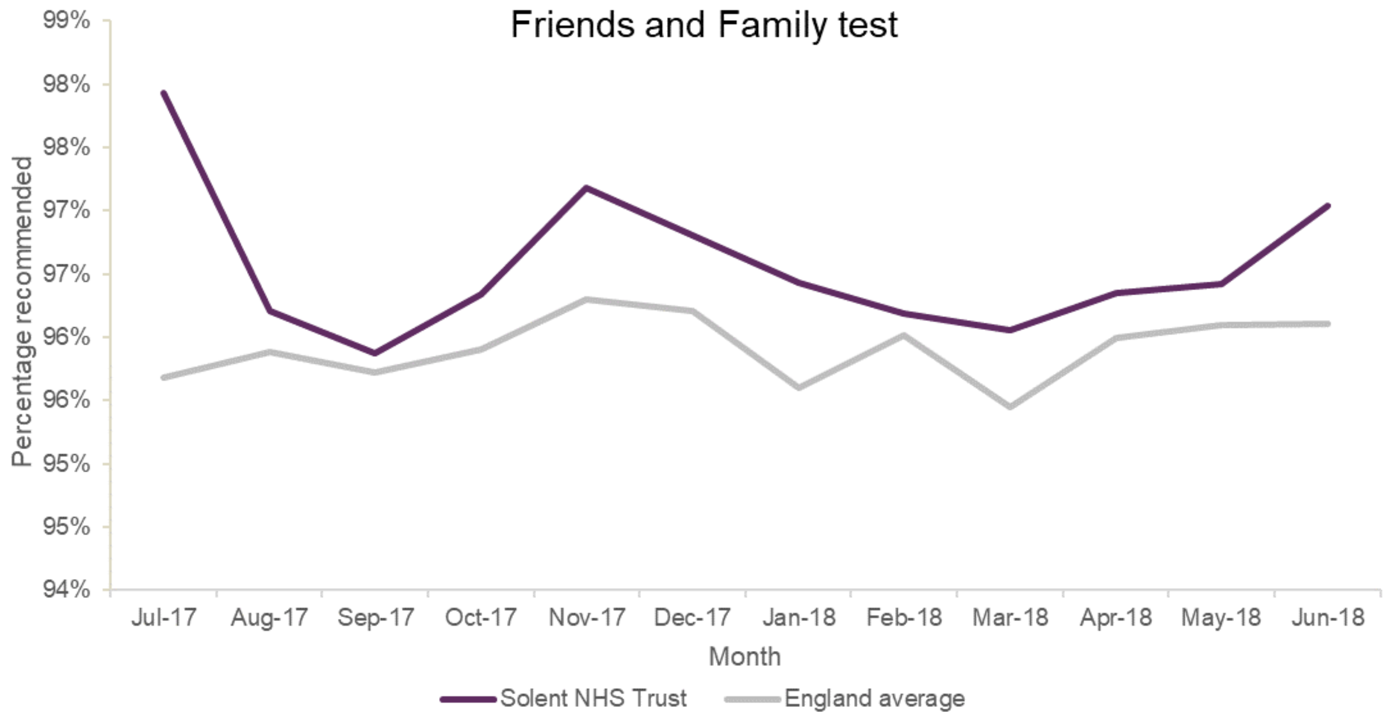
(Source: NHS Staff Survey 2017)

The trust scored above the England average for the percentage recommending the trust as a place to receive care from July 2017 to June 2018.

Friends and Family test

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored above the England average for the percentage recommending the trust as a place to receive care from July 2017 to June 2018.

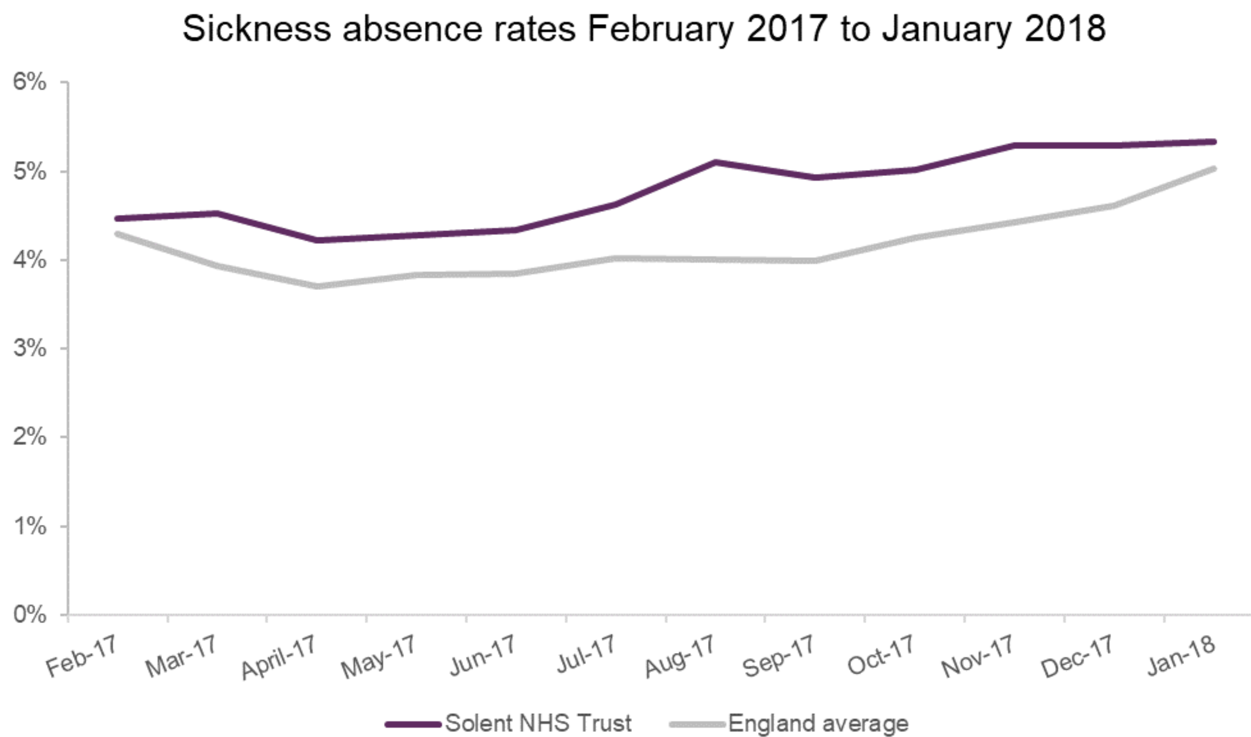


(Source: Friends and Family Test)

Sickness absence rates

The trust's sickness absence levels from February 2017 to January 2018 were higher than the England average.

The trust's trend over time is shown in the chart below.



(Source: NHS Digital)

Governance

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

There were structures, processes and systems of accountability to operate a governance system designed to monitor the service and provide assurance**.** We saw that governance had become broader across the organisation since the 2016 inspection.

There were effective arrangements to ensure the trust executive team discharged their specific powers and duties. The trust held public and private board meetings. The trust governance framework allowed for lines of assurance to be in place. The board of directors had various committees reporting to it, including: charitable funds, remuneration and terms of service, finance, quality assurance, workforce and education as well as the risk and audit committee.

Minutes and documents from board meetings reflected the board had received detailed reports. Papers for board meetings and other committees contained current and relevant information. We reviewed board minutes, agendas and associated papers over the last 12 months. There was a consistent approach to papers presented to the board. Part of the board meeting was held in private session, which was normal practice where matters were confidential at that stage. The board was informed about performance, governance and assurance. This included a look at operational performance, safety and quality of care. The trust board was provided with information regarding financial performance. This included the current performance, income and activity, with progress on the cost improvement plan, cash, and capital expenditure highlighted.

NHS Improvement (NHSI) informed us that the governance arrangements for the audit and risk as well as finance committees were effective with clear terms of reference. Roles and responsibilities were delegated as appropriate under the Scheme of Delegation and Standing Financial Instructions, which were available to all staff. NHSI described how the finance partners were embedded within operational teams to ensure they received the required financial management support and guidance.

The trust clinical services were managed as service lines and these included for the areas of specialist services such as sexual health, dental services and primary medical services; community adults; adult mental health; and community children's and families including mental health services. Mental health services for adults were provided only in the Portsmouth area of the trust's geography. Each service line was governed by a triumvirate which included a clinical director and operations director and professional lead. There were two chief operating officers one taking the lead for Portsmouth services, which included mental health, and the other leading on Southampton and wider Hampshire countywide services. The medical director was proud of the holistic approach Solent NHS Trust took to ensure that mental health was part of overall health and not separated at senior levels.

There were many examples we saw for how governance was managed across the trust such as for safeguarding. The trust recognised, acted upon and met its legal obligations to safeguard those people at risk from abuse, neglect or exploitation**;** the chief nurse was the executive lead. The safeguarding annual report for 2017 described that it had been a challenging year for the team. The recently appointed head of safeguarding was part of the overall 10 whole time equivalent safeguarding team for the trust for both adults and children. This was an increase following a review of requirements in the previous year. We learned about the way safeguarding was addressed at a meeting with the head of safeguarding, interim named nurse for children and young people, and the associate director of professional standards and regulation. We were told the operations director

for Portsmouth and East had a joint post between Portsmouth clinical commissioning group and Solent NHS Trust children's commissioner, and this had improved the clinical commissioning group and trust working. The trust attended Portsmouth and Southampton safeguarding boards. Hampshire board was not routinely attended; however, the trust was represented at sub groups. There were multiagency safeguarding hubs (MASH) in Portsmouth and Southampton.

All Solent NHS trust staff could access on the day support for both adults and children. Supervision was offered as well as case reviews for learning. We were told there had been an unprecedented amount of serious case reviews with seventeen for children and one adults over the last year and a half. There was a champions forum to support staff, as it was recognised the staff were spread out geographically, and there was a need to get messages across in a consistent way. The forum time was used to share knowledge and experience.

Safeguarding was described as a difficult place to work and the trust wanted to make the options to be involved more attractive to staff. There had been a struggle to get named doctors recruited and had at the time of inspection a doctor's session each for Portsmouth and Southampton. A steering group met every two months for looked after children and safeguarding. This was chaired by the chief nurse, and all service lines were represented, including the chair of the trust as the NED lead for safeguarding.

Training requirements had been reviewed against the intercollegiate document for children and the same was due for adults that had recently been released. Level 1 to 3 training was completed with level 3 as face to face training. For level 4 the trust had identified who needed this level of competence and had released staff for training and development such as through the Wessex safeguarding forum. We were told that some of the staff were due to attend further development soon. The Wessex forum had included talks on counter terrorism and the unaccompanied asylum seekers.

There was effective governance of the trust sites. The trust provided services at about 100 sites. They had developed clear management structures for the governance of the estates for local action to escalate issues and identify themes, and to liaise with trust staff. As needed concerns were raised through the leadership team and to landlords if required. The trust owned 11 sites at the time of inspection. Estates reported to the finance and commercial group and information was escalated to the board, such as to propose a business case that exceeded the delegated authority for the group. A backlog of maintenance required a recent financial agreement to increase the budget to resolve. For clinical areas there was a monthly review of works at a clinical group. This included a review of the garden facilities at the Kite unit, to engage with staff and patients to address what was needed. The health and safety at the trust was taken seriously and there was a fire officer who reported to the health and safety committee.

Governance of medicines management was taken seriously by the trust. The chief pharmacist had been in post for two years and held a joint role with a local trust, supported by a deputy chief pharmacist and senior pharmacy team. Recruitment to an additional deputy chief pharmacist position had recently received approval. Members of the pharmacy team were leaders in the delivery of their service. For example, the pharmacy technician lead for school nursing ensured new medicines systems and processes were embedded in the service and led by the school nurses. Joint area prescribing committee policies and guidelines were produced from Solent NHS Trust and another trust and were 'co-badged'. This meant the same medicines were prescribed across both trusts in the locality, which supported safer patient care.

There was safe governance for end of life care (EOLC). There was an EOLC steering group established in 2017. A framework had been developed to improve the governance of patients, and at the time of inspection an overarching strategy was being developed. Challenge and support from the non-executive directorates was said to be helpful and ensured the board were kept up to date with actions.

The trust could provide assurance of compliance with Deprivation of Liberty Safeguards (DoLS). There was a clear understanding among the adults' team leaders (the safeguards only apply to adults – and only those adults without the mental capacity to take their own decisions) around recent legal rulings, which had widened the threshold for the application of DoLS.

Board assurance Framework

The trust provided their strategy which detailed three strategic objectives. A summary of these is below:

- Providing great care - Many patients have complex needs that involve several different agencies. For most of our services it doesn't make sense to deliver them separately from the services provided by GPs, other NHS providers or social care. We will deliver care that is safe, joined up, simple and convenient to access, and based on the best available evidence. This is what we mean by great care.

- Delivering Great Value for Money - We see opportunities to offer better value for money:
  In our own services: by making better use of our buildings and technology, ensuring all teams work as productively as the best, and reducing waste.
  In the way the whole NHS and care system works locally: reducing duplication and hand-offs, intervening earlier to avoid patients requiring hospital care, and eradicating delays in hospital.

- Being a great place to work - Employee experience has a direct impact on patient experience, and research shows that organisations with high engagement are safer for patients. Delivering great care is only possible if employees feel engaged, supported and empowered do their very best work. We are developing the skills of our managers to lead 'people first', increasing development and learning opportunities for employees, improving how we involve and engage people in the workplace and developing behaviours to strengthen our values-based culture.

(Source: Trust Strategy)

We reviewed the board assurance framework and found this was well maintained and up to date. There were links to the trust risk register and the risks were presented with associated progress and target risk scores and timeframes. There was monthly reporting to the board via the chief executive and a private board report each quarter. The associate director of corporate affairs and company secretary told us the monitoring of progress was a dynamic process and drove the key committee agendas and discussion and was overseen by the audit committee with the risk register overseen by the quality committee.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The trust had systems to identify learning from incidents, complaints and safeguarding alerts and to make improvements. The governance team regularly reviewed the systems. The trust had a Risk Management Strategy in place, which was introduced in November 2015. The Risk Management Framework was approved by the Board in March 2018, and the strategy was due to be reviewed

November 2018. The chief executive's report to the board included the corporate risk register, which was reviewed by the audit and risk committee.

Financial risks were clearly highlighted in reports to the board and sub committees. The trust's financial position was reviewed at the finance committee and the board. We were told the financial information was submitted to NHS Improvement monthly, and this was discussed with the director of finance through the oversight arrangements at the trust.

We reported in 2016 the issue of wheelchair provision for Solent NHS Trust patients for both adults and children, where at that time there were delays for up to two years. On this inspection we found the delays had continued and we spoke to patients who had a two year wait still in 2018. Since 2016 the trust had worked with the commissioners to assess the risks to their patients and a serious incident review of July 2017 set out the findings that there was harm to some patients both physically and psychologically. In April 2018, NHS Southampton clinical commissioning group (CCG) commissioned an independent review on behalf of other commissioners to look at the clinical impact of delays. The review identified physical harm to patients. However, the expert did not consider psychological harm at this stage. In September 2018, the CCG commissioned an external expert to provide an independent opinion on psychological harm. This work was ongoing, estimated to complete in December 2018. We were told by the chief nurse there were 19 patients identified at risk of harm. An external review concluded that five patients had suffered physical harm. The trust reviewed its own processes to make improvements and reduce risk; however, this had not been sufficient, and was said by the trust to be due to the demand being more than the capacity of the commissioning arrangements for the wheelchair provider. Discussions to address the needs of patients were ongoing with NHS England, NHS Improvement and the Clinical Commissioning Groups.

The trust recognised and understood its risks in terms of business continuity and planned for major incidents. The trust had a major incident response plan, which set out its responsibilities and roles in the event of an incident. NHS England required trusts to have suitable and up to date plans when faced with disruptions, but recognised these needed to be proportionate. Disruptions could be, for example, from severe weather, failure of systems or power, or an outbreak of an infectious disease.

Management of pharmacy risks, issues and performance:

The trust had a medicines safety officer (MSO) who managed the response to drug alerts, recalls and incidents. Incidents involving medicines were reported and then reviewed by the medicines safety sub group. Any identified themes were given a lead to work through identifying learning and sharing best practice. Learning was cascaded through the clinical service lines. For example, recent work had been carried out on insulin due to increased incidents noticed. The factors contributing to these incidents included rota problems leading to administration mistakes, and communication problems leading to duplicate treatment given. These issues had been addressed and there had been no further duplicate insulin administrations.

The pharmacy risk register was reviewed regularly at pharmacy governance group and high-risk items were escalated to the corporate risk register. An e-learning package for mandatory medicines management training had been developed. This had led to a significant increase in the number of staff undertaking medicines management training (from 30% to 83.3% - target 85%). Areas of low compliance were identified and supported.

Workforce sustainability was on the trust risk register. The chief nurse identified the safe staffing areas of focus as tissue viability, children and adolescent mental health, adult mental health and community nursing vacancies being the riskiest. This was also reflected in risk registers. For example, in the service line for Adults Portsmouth, the top risks as per the trust risk pyramid September 2018 was for high numbers of band 5 vacancies. The trust felt staff vacancies were reflective of the national picture; however, they had secured new staff after reviewing the type of skills needed and by not following a pattern of like for like replacement. The trust confirmed eight

nurse degree apprentices had started in September 2018. To improve retention the trust induction period had been revised to a four-week programme for newly qualified nurses in addition to the preceptorship programme.

Demand and capacity was on the risk pyramid for trust wide operational risks. This related to an increase in demand that had been difficult to meet impacting on treatment and waiting times. This was noted in the Adults Southampton top risks, with the increased demand for insulin administration in the community, and as a direct result of change of approach in general practice in the city where the threshold for insulin prescribing had been lowered.

Finances Overview

	Historical data		**Projections**	
Financial metrics	**Previous Financial Year (2016/17)**	**Last Financial Year (2017/18)**	**This Financial Year (2018/19)**	**Next Financial Year (2019/20)**
Income	£181m	£187m	£185m	£182m
Surplus (deficit)	(£2m)	£0.7m	(£1m)	£0
Full Costs	£183m	£186m	£186m	£182m
Budget (or budget deficit)	(£3.5m)	(£1.6m)	(£1m)	£0

(Source: Universal Routine Provider Information Request (RPIR) – P59 Finances)

Trust corporate risk register

The trust provided a document detailing their ten highest profile risks. Four of these had a current risk score of 12 or higher, and are detailed below:

ID	Description	Risk score (current)	Risk level (target)	Last review date
55	**Workforce Sustainability** There is a risk that we are unable to recruit and / or retain sufficient numbers of clinical staff with the qualifications, skills and experience required Consequences: increase vacancy rate, turnover & sickness, impact on quality of service is adversely affected resulting in potential patient harm, breach of contracts, performance notices, breach of regulatory compliance Link to Corporate Risk Register, 726,793,1013,1057, 1059,1110,1123, 1124, 1126, 1128, 1131, 1134, 1142, 1144, 1145,1146,1147,1148, 1154,1160,1162,1167, 1174, 1179, 1186,1187, 1189	**16**	**9**	**July 2018**

ID	Description	Risk score (current)	Risk level (target)	Last review date
58	**Future organisational function** There is a risk that due to significant environment changes both nationally and within the local system that the Trust is not able to respond effectively to market forces and emerging opportunities. Consequences: A lack of preparedness for service change. Future viability of the services provided by the organisation, public sector unable to deliver cost effective quality care Link to Corporate Risk Register: None	**16**	**6**	**July 2018**
13	**ICT** There is a risk that our staff have not been provided with sufficient training /business change programmes to enable us to leverage the best IT capability and vulnerabilities in IT systems could impact negatively on patient care, staff morale, staff productivity and organisational reputation. These vulnerabilities include: • Risk of security issue (virus/hacking/misuse/ human error) • Gaps in SystmOne functionality and • Risk of staff disengagement and failure to realise and utilise opportunities for productivity gains Recent incidents and events have demonstrated lack of basic control processes which need to be urgently addressed (including asset ownership, and storage capacity) Consequences: Service delivery will be impacted upon and staff productivity reduced. Link to Corporate Risk Register: 498,538,752,755,849, 1017,1041,1100, 1112,1118, 149, 1150, 1157, 1161,1169	**12**	**6**	**July 2018**
57	**Quality Governance, Safety and Professional Standards** • Lack of embedded risk management framework which ensures a consistent approach across the organisation • Lack of embedded assurance processes to ensure regulatory standards are consistently adhered to at all levels within the organisation which may result in an inadequate safety culture • Clinical supervision arrangements are not consistent within and across services impacting on implementation of safe standardised practice • There is a risk that we are unable to provide clinical care due to the unavailability of staff Consequences: There is a risk that this would result in poor patient outcomes. There is also a risk that there would be a direct impact on the workforce's ability to live the Trust's values and be a great place to work. There is a risk of regulatory failure and a negative impact on reputation.	**12**	**6**	**July 2018**

ID	Description	Risk score (current)	Risk level (target)	Last review date
	Operational risks links to capacity to deal with increasing demand for services (as opposed to staff availability) - 685, 710, 1050, 1140, 1151, 1156,1172, 1176, 1185 Operational risks relating to medial equipment – high replacement cost (756, 1005), wheelchair provision (1009, 1177, 1178)			

(Source: Universal Routine Provider Information Request – Board Assurance Framework)

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The trust had appointed a new Information Technology (IT) director about six months prior to our inspection to address areas for improvement in both systems and staff usage of systems. Dental and sexual health services had their own IT system and all other areas were on the same electronic patient record. Where GPs were also on same system the community nurses could order dressings more easily than when they were not on the same system. New laptops had been issued. This was recognised as a change of culture and group sessions had been set up to support staff.

We were told there had been issues with the IT system. The trust had included the IT infrastructure on their risk register in terms of recording e- learning and mandatory training, and that the data was therefore not up to date. Improvement had been made to the Wi-Fi availability in the hydrotherapy pool area for therapists to complete the electronic patient record.

Increased use of technology was important across the trust and for example was part of the pharmacy strategy, including a plan to roll out electronic prescribing and medicines administration across Solent and another trust.

Other changes planned were for the complaints electronic system, as the management tool for the Patient Advice Liaison Service team. This would enable the generation of emails to remind staff of time frames and deadlines, and to add compliments to this system as well.

There was good preparation for the information governance changes across the trust, including how to manage any breaches. The trust had prepared in advance of the implementation of the General Data Protection Regulations (GDPR) and felt this was imbedded into usual working. Where there had been information governance breaches these had been dealt with according to policy keeping the patient as the focus. Solent NHS Trust had reported in a public board meeting the improvement in its Information Governance compliance and awareness within the last financial year and had achieved the ranking second out of 55 Mental Health Trust's on the IG Toolkit.

The IG Toolkit is an online system which allows organisations to assess themselves or be assessed against Information Governance policies and standards. It also allows members of the public to view participating organisations.

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The trust made sure it included and communicated effectively with patients, staff, the public, and local organisations.

Staff felt engaged with through team meetings and the senior leadership team had regular interactions with line managers. For instance, there were regular manager meetings, a staff survey, team briefs and chief executive bulletins. Staff informed us the professional leads fed learning back to the front-line teams through local governance groups and team meetings. We were told about leadership visits by executive and non-executive members to talk informally with staff in their work environments. Staff communication included through electronic media by the chief executive with blogs, webcasts and along with monthly chief executive open surgery. A member of domestic staff was nominated by the trust under NHS 70 years celebrations for their workplace contribution and received a National Lifetime Achievement Award.

There were six public trust board meetings held per year, where experience of patients was shared both positive and following complaints. There was a communications team to engage the public, for example the daily use of social media for health promotion.

The trust had plans for further engagement and the equality and diversity lead told us the trust wanted a stronger dialogue and to link to the community. They were part of NHS employer diversity programme and met locally with other groups in the community. Such as a Hampshire and Isle of Wight inclusion network. We were told the trust were in process of setting up a local Lesbian Gay Bisexual and Transgender (LGBT) and Black and Minority Ethnic (BME) staff networks. The trust had started links with Stonewall and had support from Non-executive directors (NED) around this.

A NED informed us the trust had been involved in some community groups. We were given an example of outreach work at a local temple in Southampton around the topic of diabetes. The trust was looking to further develop patient groups and improve the use of accessible information. At the recent annual general meeting (AGM) we were told a more inclusive approach was taken to support community groups to actively participate through the adoption of the Communication Access UK Standards. These groups included Young Shapers, Learning Disability Service user groups, volunteers and people with a range of communication and information needs. A member of the trust's veterans network briefed the board on how to be more accessible prior to the AGM. British Sign Language signers were arranged to support presenters.

We were told how the trust invited family members to reflect on their experience of the trust services through the end of life care stages of a loved one, and how this had influenced staff to reflect on their practice alongside a local hospice. We were given examples of the palliative care team working in collaboration with the acute trust in Southampton to promote continuity of care for patients.

The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans. We were told of the trusts proactive approach to system changes and integration being essential for the future and to manage resources. The chief executive had taken a lead in local system reviews aiming to reduce duplication across organisations even if this meant Solent NHS Trust as a brand changed its identity. There were plans described of a Wessex system wide collaborative bank to address workforce issues. To meet the increase in the pharmacy team resource, the pharmacy team had developed a collaborative programme with Portsmouth University where fourth year pharmacy students could experience working in the trust. The pharmacy department workforce plan identified the need to train pre-registration pharmacists.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

We were given many examples of learning from outcomes such as incidents and deaths. All learning was recorded on a database where the source was a serious incident or from learning from death panels. There were panels held which each service line attended to both support and challenge colleagues with a focus on change.

We reviewed ten serious incident reports all were well written and covered the key principles expected. Eight of the ten were completed in given timeframes, where they were not the reasons were clearly explained such as police investigations. All provided recommendations, lessons learnt and decisions taken to prevent similar incidents.

Examples of learning were many. We were told that on a mental health ward a patient had sustained a fall and there was an issue with how to communicate well enough with the emergency services. Following on from this a box was created with a checklist for staff including what information to give during a 999 call plus protective equipment such as gloves.

We were told the trust had recorded an increase in pressure ulcers in the summer months of 2018 with a 0.3% prevalence this was a local spike. The trust took action and increased tissue viability awareness and nursing hours for better case load management.

Another example followed an emergency incident where a patient had a cardiac arrest, that was said not to be a frequent occurrence for the trust. The experiences of the staff led to a review of the resuscitation training programme to now include scenarios.

There were also examples of learning from positive outcomes for patients such as reflection on joint working of the trust’s Community Children’s Nurses together with a local children’s hospice.

The trust promoted innovation. For example, following an audit and a pilot in the sexual health clinic, staff had reviewed ways to contact patients such as through on-line services and texting whilst maintaining data protection rights.

The trust was proud of the length stay for patients being lower than the England national averages in both emergency and acute mental health services, enabled by the crisis team supporting people at home. There were plans for further development of the crisis team to work in local emergency departments to encourage earlier intervention.

There were a variety of different specialities in the trust at the time of inspection: psychiatrists, older people’s psychiatrists, Children and Adolescent Mental Health psychiatrists, Learning Disability psychiatrists, paediatrics, Genito urinary medicine, rehabilitation and pain management. The trust had up to 70 post graduate trainee posts at any one time. There were 199 undergraduate students within the trust, some specialities worked collaboratively with another local trust. There was a joint induction for this.

The director of medical education, oversaw the safety and quality of training of students with four sessions a week in the role. The University of Southampton were involved in the medical education programme. The director of medical education had close links with the Deanery for post graduate doctors in training and oversight of the Health Education England (HEE) funding and told us he worked to ensure it matched up to the demands of the programme.

The biggest trainee group in the trust was psychiatry. The Royal College of Psychiatrists mandated that every trainee had an hour of one-to-one protected face to face time with their supervisor every week. GP trainees were not expected to do this nationally but the trust ensured they received the

same support. The GMC visited the trust in March 2018 and highlighted this as exceptional and innovative practice.

There was a strong quality improvement culture in the trust. with the provision of the academy for research and improvement. The academy offered training in quality improvement from foundation to advanced practitioner level and supported several externally funded improvement fellowships. There were nurses, allied health professionals and doctors who were part time clinicians and part time researchers remaining in their substantive teams. The trust acted as hosts for national and international studies. The trust was included in the National Institute for Health Research's annual league tables in 2018, named as the top performing trust having involved over 2,500 participants in 50 clinical trials, that focused on building an evidence base for community care and worked in partnership with a number of local universities to design research that was relevant to community services. A number of joint clinical academic roles are in place across the organisation, linking research, clinical practice and education. A member of staff had won the Nursing Times Clinical Research Nursing award for increasing access to seldom-heard groups in care homes.

The Solent Quality Improvement programme had been established to equip staff with confidence and skills to deliver improvements, there had been 500 staff trained in quality improvement. The Solent's Dragons Den was an innovation for improvement for staff team or patients to put forward ideas to improve or enhance care and the patient experience. Grants were awarded up to the value of £10,000.

Side by Side was another initiative for a group of patients and members of the public that worked in partnership with the academy to complete joint approaches to activities such as the annual conference, setting annual priorities and judging annual awards. In 2017 this resulted in Solent NHS Trust becoming the first NHS trust to be awarded the international Patient's Included accreditation. Each year a research and improvement conference was held to showcase and celebrate excellence across the trust.

Complaints process overview

There was clear learning from complaints and patient feedback with early resolution being actively sought by the trust.

We were told when people began the complaints procedure they were given leaflets to explain the process. The Patients Advice and Liaison Service (PALs) team advised where to get independent support such as from Healthwatch or advocacy services and carer support services. PALs always spoke to people during the process if they wanted the contact that way to keep them up dated as defined in the process.

The trust was in the process of writing a revised complaint procedure to include the action needed for direct resolution and to include how to act when a complaint was not resolved. Direct resolution was where the trust met with complainants within two weeks and the trust had found that having contact with people early in the complaints process had improved the management of complaints. As part of the meeting with the complainant a first draft of the trust response was written together, to better identify what the complaint was about, what needed to be investigated and what the person wanted from the trust. We were told this generally provided a speeder and more satisfactory response from the trust. Examples were given regarding repeat or persistent complaints and staff demonstrated trust values when discussing the processes followed. The chief nurse told us they reviewed all complaints and complaint responses along with the director of finance.

Across the trust professional leads fed learning back to the front-line teams through local governance groups and team meetings and were told learning was shared via the intranet.

The PALs team provided reports on complaints, with feedback from professionals and from MPs for the chief nurse to be included in monthly reports on themes and trends to the board. Challenges at the time of inspection included appointments for sexual health clinics and computer services as staff were not able to record calls on the current system. The team had escalated this to the board and was waiting for a solution.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

Question	In days	Current performance
What is your internal target for responding to complaints?	3	100%
What is your target for completing a complaint	30	100%
If you have a slightly longer target for complex complaints please indicate what that is here	45 and 60	100%
Number of complaints resolved without formal process in the last 12 months? (April 2017 to March 2018)	402	

The trust did not provide the total number of complaints referred to the ombudsman (PHSO) from April 2017 to March 2018, only that zero complaints were upheld.

The trust outlined the following changes because of these complaints:

Following on from a Ewing's Sarcoma case (Ewing's Sarcoma is a rare form of cancer found in the bone or soft tissues). The ombudsmen asked the service to develop an action plan to raise awareness amongst clinicians for the potential for Ewing's Sarcoma being indicated by presenting symptoms.

Action taken:

- The Musculoskeletal (MSK) Specialist Service held "learning from incidents" session within their specialist quarterly workshop in September 2017. This included clinical overview of Ewing's Sarcoma.
- January 2018 there was a Target session to ensure all MSK Staff have increased awareness of Ewing's Sarcoma and the identification of "red flags" symptoms that may be external to their specific speciality that may impact on the patient's diagnosis and treatment.

The trust had a PALS service. The trust had outlined the following themes from complaints made to PALs over the last 12 months.

The top four themes were the same across service concerns and complaints, with different weighting as outlined below:

Theme	Service Concerns	Complaints
Appointments	31%	12%
Communications	28%	25%
Clinical Care	24%	42%
Attitude of staff	11%	16%

The top theme for service concerns was appointments at 31%, whereas only 12% of complaints related to this theme. During 2017/18 there was an ICT upgrade which negatively impacted on the SPA telephony i.e. calls were disconnected before they were answered and some calls were not connected when they were answered. Improvements to the system have now been made. In addition, the Sexual Health Service changed their appointment system and were now principally pre-booked rather than walk-in clinics; this had created challenges for some who preferred the flexibility of walk-in clinics.

The top theme for complaints was clinical care at 42%, and there were several reasons for this e.g. patients whose onward referral to another provider had not been made; expectations about home visits and disagreement with diagnosis. In 2018/19 the PALS and complaints service would support the clinical leads in reviewing opportunities to further reduce the percentage of complaints that related to clinical care.

(Source: Universal Routine Provider Information Request (RPIR) – P51 Complaints Overview)

Number of complaints made to the trust

From April 2017 and March 2018, the trust received 195 complaints. The core service that received the most complaints was community health services for adults with 70.

A breakdown of complaints by core service is below.

Core Service	Number of complaints	Percentage of total
CHS - Adults Community	70	36.4%
MH - Community-based mental health services for adults of working age.	24	12.3%
CHS - Sexual Health	23	11.8%
MH - Acute wards for adults of working age and psychiatric intensive care units	14	7.2%
CHS - Children, Young People and Families	13	6.7%
Other - PMS service	11	5.6%
Other	10	5.1%
CHS - Community Inpatients	9	4.6%
MH - Mental health crisis services and health-based places of safety	7	3.6%
MH - Wards for older people with mental health problems	5	2.6%
CHS - Community Dental	4	2.1%
MH - Specialist community mental health services for children and young people.	2	1.0%
MH - Community mental health services for people with a learning disability or autism	2	0.5%
MH - Long stay/rehabilitation mental health wards for working age adults	1	0.5%

Total	195	100.0%

A breakdown of the themes of complaints is below.

Complaint theme	Number of complaints	Percentage of total
Patient Care	67	34.4%
Communications	37	19.0%
Values & behaviours (staff)	26	13.3%
Integrated care (including delayed discharge due to absence of care package)	23	11.8%
Appointments	12	6.2%
Other (specify in comments)	7	3.6%
Privacy, dignity & well being	7	3.6%
Access to treatment or drugs	5	2.6%
Waiting times	4	2.1%
Admin/policies/procedures (Inc. patient record)	2	1.0%
End of life care	1	0.5%
Facilities	1	0.5%
Restraint	1	0.5%
Staff numbers	1	0.5%
Transport (ambulances)	1	0.5%
Total	**195**	**100.0%**

(Source: Universal Routine Provider Information Request (RPIR) – P52 Complaint)

Compliments

From April 2017 to March 2018 the trust received 830 compliments. The core service that received the most compliments was community health services for adults with 458.

A breakdown of compliments by core service is below.

Core service	Number of compliments	Percentage of total
CHS - Adults Community	458	55.2%
CHS - Children, Young People and Families	141	17.0%
CHS - Community Inpatients	95	11.4%
CHS - Community Dental	35	4.2%
CHS- Sexual Health	24	2.9%
MH - Community-based mental health services for adults of working age.	24	2.9%

MH - Community-based mental health services for older people	22	2.7%
MH - Acute wards for adults of working age and psychiatric intensive care units	19	2.3%
Other	10	1.2%
CHS - End of Life Care	2	0.2%
Grand Total	**830**	**100.0%**

The trust also noted the following themes from their compliments data:

Positive information received in the main related to the clinical care provided to the patient or to a family member and to the positive attitude of staff toward patients and their carer/family member. Some examples of the comments received: ‘staff were kind and caring', ‘she is an absolute credit to you and the nursing profession…we are sure she saved X’s life that day by her prompt assessment and treatment and we cannot thank her enough’. The feedback was shared with teams to support learning and encouraging services to replicate the approaches across the teams. Where individuals were named this was shared directly with them so that they received the recognition deserved for the care they had provided and the positive experience because of their attitude toward patients.

(Source: Universal Routine Provider Information Request (RPIR) – P53 Compliments)

Accreditations

NHS Trusts can participate in many accreditation schemes whereby the services they provide are reviewed and a decision is made if to award the service with an accreditation. A service will be accredited if they are able to demonstrate they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed to continue to be accredited.

The table below shows which of the trust's services have been awarded an accreditation or where accreditation is pending.

Accreditation scheme	Team/Service accredited
Anaesthesia Clinical Services Accreditation (ACSA)	The Special Care Dental Service has been accredited as a trainer for Inhalation sedation by the Intercollegiate Advisory Committee for Sedation in Dentistry. This means that more staff can provide inhalation sedation for patients who are unable to accept dental treatment under local anaesthetic alone reducing the need to treat patients under general anaesthetic. Not only have we trained staff of the service but have extended this externally.
Clinical Pathology Accreditation and it's successor Medical Laboratories ISO 15189	Accreditation pending for all Trust labs: Portsmouth Hospital Trust, University Hospital Southampton, Hampshire Hospital Foundation Trust, Frimley Hospital Foundation Trust, Acculab, The Doctors Lab. Accreditation pending due to national delay from UKAS.
Quality Network for Community CAMHS (QNCC)	CAMHS Portsmouth

(Source: Universal Routine Provider Information Request (RPIR) – P66 Accreditations)

In addition, the trust informed us of achievements of other nationally recognised awards such as:

- Diabetes Specialist Nurse; winner of the Quality in Care Award for Diabetes Healthcare Professional of the Year 2018
- Two new Queen's Nurses in 20*18.* The title of 'Queen's Nurse' is available to individual nurses who have demonstrated a high level of commitment to patient care and nursing practice.

Community health services

Community health services for adults

Facts and data about this service

The trust provided the following information about their community services for adults:

In Southampton the trust provides services across the city including community nursing, case management, palliative care and domiciliary phlebotomy. Specialist nursing covers a range of long term conditions including diabetes, tissue viability, cardiac, chronic obstructive pulmonary disease (COPD), bladder & bowel and stoma, home oxygen and pulmonary rehabilitation. These teams work closely with secondary care colleagues and COPD is an integrated team across both organisations. Community Wellbeing is a service jointly provided by Solent and Solent Medical Services (SMS) a primary care organisation.

Rehabilitation & Reablement is a service across the trust which included in-patient rehabilitation wards and associated therapy support. It also included a community in-reach service and two teams integrated with social care, an Urgent Response service and a Community Independence Service. The Neuro Rehab teams included two inpatient wards, Community Neuro Rehab, Snowdon at Home, vocational rehab, specialist nurses for conditions including Parkinson's, epilepsy and MS. The trust also provided general spasticity clinics, intrathecal baclofen services and botulinum clinic.

Portsmouth community provision was delivered within three city locations in partnership with primary and social care. The teams were integrated into locality hubs with health and social care teams working with GP practice based populations. The multi-disciplinary team (MDT) practitioners were working towards the development of an integrated health and social care record due to 'go live' in March 2019. The service supported and cared for patients with complex health conditions and co-morbidity including life limiting and long-term conditions. The Portsmouth rehabilitation and reablement team were delivering the Urgent Response Service through integrated care pathways with social care.

The trust provided an integrated musculoskeletal (MSK), persistent pain and rheumatology service in Southampton, and an integrated MSK and persistent pain service in Portsmouth. It also provided podiatry across the Solent NHS Trust geography. The trust provided tuberculosis services and homeless healthcare services in Southampton City

(Source: CHS Routine Provider Information Request (RPIR) – Context CHS)

Mandatory training

Mandatory Training completion

The service provided mandatory training in key skills to all staff but could not evidence they made sure everyone completed it.

2018/19

The trust set a target of 90% for completion of mandatory training in 2018/19.

A breakdown of compliance for mandatory training courses from April 2018 to June 2018 for qualified nursing staff in community services for adults is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Non-Clinical Resuscitation	263	271	97%	90%	Yes
Duty of Candour	260	271	96%	90%	Yes
Equality and Diversity	251	271	93%	90%	Yes
Dementia Awareness (including Privacy & Dignity standards)	243	271	90%	90%	Yes
Moving and Handling	244	271	90%	90%	Yes
Infection Prevention (Level 1)	242	271	89%	90%	No
Health and Safety (Slips, Trips and Falls)	229	271	85%	90%	No
Information Governance	226	271	83%	90%	No
Deteriorating and Resuscitation Training – Adults	200	251	80%	90%	No
Fire Safety 2 years	217	271	80%	90%	No
Prevent Awareness	208	271	77%	90%	No
Medicine management training	172	262	66%	90%	No
Infection Prevention (Level 2)	152	270	56%	90%	No
Hand Hygiene	140	270	52%	90%	No
Preventing Falls at Solent NHS Trust – Classroom	45	105	43%	90%	No
Preventing Falls in Hospitals – Online	23	83	28%	90%	No

We requested further information and this demonstrated an improvement in training compliance levels for the period April 2018 to September 2018. For example, by September 2018 in community services for adults, the 90% target was met for seven of the 16 mandatory training modules for which nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to June 2018 for medical staff in community services for adults is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Equality and Diversity	7	9	78%	90%	No
Infection Prevention (Level 1)	7	9	78%	90%	No
Moving and Handling	7	9	78%	90%	No
Duty of Candour	5	9	56%	90%	No
Fire Safety 2 years	4	9	44%	90%	No
Non-Clinical Resuscitation	4	9	44%	90%	No
Dementia Awareness (including Privacy & Dignity standards)	3	9	33%	90%	No
Health and Safety (Slips, Trips and Falls)	3	9	33%	90%	No
Infection Prevention (Level 2)	3	9	33%	90%	No
Prevent Awareness	3	9	33%	90%	No
Information Governance	2	9	22%	90%	No
Medicine management training	2	9	22%	90%	No
Preventing Falls at Solent NHS Trust - Classroom	1	6	17%	90%	No
Deteriorating and Resuscitation Training - Adults	1	8	13%	90%	No
Hand Hygiene	0	9	0%	90%	No

In community services for adults, the 90% target was not met for any of the 15 mandatory training modules for which medical staff were eligible.

2017/18

The trust set a target of 85% for completion of mandatory training in 2017/18.

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for qualified nursing staff in community services for adults is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Information Governance	259	265	98%	85%	Yes
Non-Clinical Resuscitation	259	265	98%	85%	Yes
Duty of Candour	248	265	94%	85%	Yes
Moving and Handling	240	265	91%	85%	Yes
Dementia Awareness (including Privacy & Dignity standards)	237	265	89%	85%	Yes
Equality and Diversity	237	265	89%	85%	Yes
Infection Prevention (Level 1)	219	265	83%	85%	No
Health and Safety (Slips, Trips and Falls)	212	265	80%	85%	No
Fire Safety 2 years	200	265	75%	85%	No
Prevent Awareness	199	265	75%	85%	No
Deteriorating and Resuscitation Training – Adults	168	246	68%	85%	No
Infection Prevention (Level 2)	139	264	53%	85%	No
Medicine management training	126	261	48%	85%	No
Preventing Falls at Solent NHS Trust – Classroom	44	106	42%	85%	No
Hand Hygiene	107	264	41%	85%	No
Preventing Falls in Hospitals – Online	23	80	29%	85%	No

In community services for adults, the 85% target was met for six of the 16 mandatory training modules for which nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for medical staff in community services for adults is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)

Information Governance	9	10	90%	85%	Yes
Equality and Diversity	7	10	70%	85%	No
Infection Prevention (Level 1)	7	10	70%	85%	No
Moving and Handling	7	10	70%	85%	No
Fire Safety 2 years	5	10	50%	85%	No
Non-Clinical Resuscitation	5	10	50%	85%	No
Duty of Candour	4	10	40%	85%	No
Health and Safety (Slips, Trips and Falls)	3	10	30%	85%	No
Prevent Awareness	3	10	30%	85%	No
Dementia Awareness (including Privacy & Dignity standards)	2	10	20%	85%	No
Infection Prevention (Level 2)	2	10	20%	85%	No
Deteriorating and Resuscitation Training – Adults	1	9	11%	85%	No
Medicine management training	1	10	10%	85%	No
Hand Hygiene	0	10	0%	85%	No
Preventing Falls at Solent NHS Trust – Classroom	0	6	0%	85%	No

In community services for adults, the 85% target was met for one of the 15 mandatory training modules for which medical staff were eligible.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)

Community adult services had a comprehensive mandatory training programme for their staff. The training included a range of modules to ensure that staff provided safe and appropriate care and treatment to patients. This was mainly provided as on-line training or there was the opportunity for classroom based training.

We were told on the inspection that staff were compliant with statutory and mandatory training targets and were shown figures to that effect. Staff we spoke with also told us they had completed the mandatory training for their role.

However, the data provided by the trust and detailed in the above tables indicated that staff were not compliant with the trust's statutory and mandatory training targets. We requested further information that demonstrated an improvement in training compliance levels for the period April to September 2018. The trust informed us that Information Governance (IG) is reset to zero at the start of April and carries a separate target of 95%, which is not due to be met until the end of the year.

Safeguarding

Safeguarding Training completion

Trust wide

2018/19

The trust set a target of 90% for completion of safeguarding training in 2018/19.

A breakdown of compliance for safeguarding training courses from April 2018 to June 2018 for qualified nursing staff in community services for adults is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults (Level 1)	235	271	87%	90%	No
Safeguarding Children (Level 1)	217	271	80%	90%	No
Safeguarding Children (Level 2)	265	352	75%	90%	No

In community services for adults the 90% target was not met for any of the three safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding courses from April 2018 to June 2018 for medical staff in community services for adults is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children (Level 1)	4	9	44%	90%	No
Safeguarding Adults (Level 1)	3	9	33%	90%	No
Safeguarding Children (Level 2)	3	10	30%	90%	No

In community services for adults the 90% target was not met for any of the three safeguarding training modules for which medical staff were eligible.

2017/18

The trust set a target of 85% for completion of safeguarding training in 2017/18.

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for qualified nursing staff in community services for adults is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults (Level 1)	224	265	85%	85%	Yes
Safeguarding Children (Level 1)	197	265	74%	85%	No
Safeguarding Children (Level 2)	234	340	69%	85%	No

In community services for adults the 85% target was met for one (33%) of the three safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding courses from April 2017 to March 2018 for medical staff in community services for adults is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children (Level 1)	5	10	50%	85%	No
Safeguarding Adults (Level 1)	2	10	20%	85%	No
Safeguarding Children (Level 2)	2	10	20%	85%	No

In community services for adults the 85% target was not met for any of the three safeguarding training modules for which medical staff were eligible.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)

Community adult services had a comprehensive safeguarding training programme for their staff. This was mainly provided as on-line training or there was the opportunity for classroom based training.

We were told on the inspection that staff were compliant with safeguarding training targets and were shown figures to that effect. Staff we spoke with also told us they had completed the safeguarding training applicable to their role.

However, the data later provided by the trust indicated that staff were not all compliant with its safeguarding training levels. There was a risk that some staff delivering services did not have up to date knowledge of safeguarding procedures.

Staff we spoke with knew where to find information on safeguarding and knew how to recognise abuse and to raise concerns. The trust had a designated safeguarding lead. We observed a good example of a safeguarding issue where a patient was causing concern for a district nursing team. The team discussed developing a care plan focused on observing specific issues to gather more information, prior to a senior member of the team visiting the patient later that week to make an assessment.

The trust had a policy and procedure for safeguarding which it reported on annually. The policy referred to national guidance including the Government Statement of Policy on Adult Safeguarding, 2013 and Safeguarding; roles and responsibilities in health and care services (Department of Health, Local Government Association, ADASS, NHS Confederation, Association of Chief Police Officers, 2013)

Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will

work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Community services for adults made 86 safeguarding referrals between July 2017 and June 2018, all of which concerned adults.

(Source: Universal Routine Provider Information Request (RPIR) – P11 Safeguarding)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

Infection prevention and control formed part of the trust mandatory training and staff we spoke with at the time of inspection were compliant with infection control training. The trust provided us with figures for the period April to end of September 2018 that showed adult services in Southampton were 95.7% complaint with infection control training and adult services in Portsmouth were 95.3% complaint.

All clinical areas we visited were visibly clean and tidy and gel dispensers and hand washing facilities were available. Treatment rooms had waste disposal bins for non-clinical and clinical waste and sharps containers were not overfilled. Staff who cared for patients who lived in the community had sharps bins in their car for disposal of syringes. Clinical waste was not brought back to the clinical base. Arrangements were made for hazardous and non-hazardous material to be segregated and disposed of in accordance with the Trust's policy for the safe handling and disposal of health care waste. Hazardous clinical waste was collected from the patient's property by the local authority. Non-hazardous waste was double bagged and disposed of by the patient in their own domestic waste.

Nursing teams had an infection prevention control team (IPCT) nurse as a link nurse who would provide appropriate support and guidance. Various aspects of infection prevention control techniques, such as hand washing, were audited monthly. For example, in the summer period in 2018, hand hygiene audit results for adult services in Southampton and Portsmouth were 100% compliant overall.

Across all the services we visited staff washed their hands with soap and water or sanitised their hands before and after contact with patients. All staff had access to personal protective equipment such as aprons and gloves and used them appropriately. Staff complied with the trusts policy and national guidance about being bare below the elbow when providing care.

Environment and equipment

The trust did not have processes and systems in place that ensured people could always receive mobility and home adaptation equipment in a timely fashion.

Mobility equipment, home adaptation equipment and pressure-relieving equipment was supplied through third party suppliers, who were responsible for servicing and delivering equipment to patients at home. However, staff told us of delays of more than six weeks in the delivery of adaptation equipment, such as ramps and grab rails, and continuing problems with timely delivery of wheelchairs, with delays regularly of three to six months. In addition, one service provider for the Southampton area was commissioned for weekend provision and the other for the Portsmouth area was not.

At the last comprehensive inspection, we were told by almost every service we spoke with about the extremely long delays in accessing wheelchairs, with examples of delays of up to two years, which had affected the well-being and outcomes for patients. We noted: "there were delays in the wheelchair provision and repair service commissioned by the Clinical Commissioning Group and provided by an external provider. This affected the safety and well-being of some patients who received adult community services."

After our inspection the trust was issued with a requirement notice to appropriately monitor and manage the wheelchair service with the private provider to ensure a more responsive service and to ensure the risk to patients and their quality of life was not affected. During this inspection we had several reports from staff that this problem was continuing. Staff reported long delays in wheelchairs being issued or being repaired, with lost referrals, and lack of information from the suppliers. The trust gave us information about a serious incident review investigation they had conducted into a two year delay before a patient received a wheelchair. Staff were aware of the continuing problems and that this was on the risk register.

Although the Trust was neither a provider nor commissioner of this service, it had undertaken a considerable number of actions to understand and mitigate the impact on patients. This matter affected the whole trust and was considered in more detail in the Well Led report which accompanies this section of the overall report.

We inspected a range of services. The podiatry and tissue viability team at the Adelaide Health Centre had a treatment area with clean and maintained equipment which had up-to-date service records and current electrical safety checks. They also had a treatment chair suitable for bariatric patients, and there was a workshop for making orthotics. They had recently received funding on the back of a successful bid for a specialist `off-loading` device for the treatment of foot ulcers.

The Community Clinical Advisory teams in Portsmouth and in Southampton had equipment stores for specialist equipment (but not wheelchairs) to support patient's mobility, comfort, pressure relief and daily living needs, such as slings and posture chairs.

The Portsmouth Rehabilitation and Re-enablement team had an equipment store with a range of essential transfer equipment including basic wheelchairs, commodes, and toilet aides and provided cover seven days week from 7am to 10pm daily. At the last inspection we found that not all staff were aware of the process of ordering and obtaining essential patient safety equipment, particularly out of hours and weekends. However, the cover provided by the Rehabilitation and Re-enablement team in Portsmouth, and the service provider in Southampton who was commissioned to provide a weekend service meant that staff had access to equipment out of hours and at weekends. During our inspection we found that staff we spoke with knew how to obtain equipment out of hours and at weekends.

During the inspection we visited several premises and clinics and checked a range of consumable items. All items that were checked were correctly stored and within date. We also checked resuscitation bags at various locations within the trust. These were all sealed and tagged. At some locations the resuscitation bags and oxygen bags have all their contents recorded electronically and a weekly online check was carried out.

Assessing and responding to patient risk

Comprehensive risk assessments were carried out for people who used the services and risk management plans were developed in line with national guidance. These were assessed, monitored and managed appropriately.

Teams discussed and reviewed patients through a virtual ward or quality and safety meetings. We observed a virtual ward which met every morning and every Wednesday afternoon. All patients had their specific risks assessed.

We observed a district nursing team's quality and safety meeting, to which all staff were required to attend. The issues discussed included: unusual patient behaviour; blood sugar results; falls risks; patients that required manual handling with a minimum of two staff per visit; equipment issues; stock availability; medication and prescription issues with a local GP's service; a care plan review which considered the impact on the family; tissue viability referrals; and a full review of all patients requiring insulin.

Staff on the community team used appropriate guidance and tools to assess patients. We saw the use of the SBAR approach (Situation, Background, Assessment, Recommendation) which was used for all patient assessments together with a confidential team whiteboard which detailed patients national early warning score (the NEWS tool was developed by the Royal College of Physicians to improve the detection and response to clinical deterioration in adult patients and was a key element of patient safety and improving patient outcome. The trust was rolling out NEWS2 training and NEWS2 audits at the time of the inspection).

In addition, the SBAR considered patient acuity; a Malnutrition Universal Screening Tool (MUST) assessment; risk stratification; any referrals; psychiatric and mental health assessment; Waterlow chart score for assessing the risk of acquiring a pressure ulcer; bowels; mobility; and resuscitation status. The trust had a sepsis policy which was in date and based on NICE guidance. Staff we spoke with understood sepsis and how to assess the risk.

The trust had experienced a significant rise in the number of diabetic patients, and had developed a new care planning approach for patients on insulin. There was improved multidisciplinary working to detect deterioration earlier in diabetic patients and initiate early interventions.

We accompanied a community nurse on a visit to a patient for a routine chronic obstructive pulmonary disease (COPD) review. The nurse conducted a holistic review using the NEWS tool to assess and exclude sepsis. MUST and pressure areas were discussed with the patient.

Staff were attentive to the risk of pressure ulcers. Patients were given an alert sheet about the prevention of pressure ulcers. Staff explained this advice to patients and their relatives and told them that they must contact their healthcare team immediately if they noticed any of the described symptoms on the sheet.

Other tools we noted being used included:

- The Barthel scale or Barthel ADL index, an ordinal scale used to measure performance in activities of daily living.
- The modified Rankin Scale, a commonly used scale for measuring the degree of disability or dependence in the daily activities of people who have suffered a stroke or other causes of neurological disability.
- The Caregiver Strain Index which can be used to quickly identify families with potential caregiving concerns.
- The Patient Health Questionnaire-9 to facilitate the recognition and diagnosis of depression in patients.

Staffing

Planned v Actual Establishment

Year 1 section:

Details of staffing levels within community services for adults by staff group as at March 2018 are below.

Community adults total

Staff group	Planned staff (WTE)	Actual Staff (WTE)	Staffing rate (%)
NHS infrastructure support	54.6	32.7	59.9%
Qualified nursing & health visiting staff (Qualified nurses)	266.7	224.3	84.1%
Qualified Allied Health Professionals (Qualified AHPs)	259.5	239.9	92.4%
Support to doctors and nursing staff	93.4	242.3	259.5%
Support to ST&T staff	117.2	44.0	37.6%
Medical & Dental staff - Hospital	8.1	6.6	80.5%
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	38.9	33.6	86.4%
Public Health & Community Health Services	0.00	1.0	Over-established
Total	**838.3**	**824.4**	**98.3%**

The staff group 'Support to doctors and nursing staff' was considerably over-established, whilst there was a low fill rate (38%) for 'Support to Scientific, Therapeutic & Technical staff'.

(Source: Universal Routine Provider Information Request (RPIR) – P16 Total Staffing)

Vacancies

The trust set a target of 5.40% for vacancy rate. From June 2017 to May 2018, the trust reported an overall vacancy rate of 2.4% in community health services for adults. The trust have let us know the vacancy rate has changed since the first data submission which was as follows:

A breakdown of vacancy rates by staff group in community services for adults at trust level is below:

Community adults total

Staff group	Total vacancies (12 months)	Total WTE establishment (12 months)	Annual vacancy rate
Medical & Dental staff - Hospital	4.1	97.7	4.2%
NHS infrastructure support	-532.4	914.9	-58.2%
Qualified Allied Health Professionals (Qualified AHPs)	284.1	3,574.6	7.9%
Qualified nursing & health visiting staff (Qualified nurses)	404.1	3,162.6	12.8%
Support to doctors and nursing staff	86.0	2,529.9	3.4%

All Staff groups	245.9	10,279.7	2.4%

(Source: Universal Routine Provider Information Request (RPIR) – P17 Vacancy)

The community nursing service in Portsmouth was aiming to recruit associate tissue viability nurses and associate diabetic nurses to support the community nursing teams.

Turnover

The trust set a target of 12% for turnover rates. From April 2017 to March 2018, the trust reported an overall turnover rate of 16.2%%% in community health services for adults. This did not meet the trust's target. Across the trust the overall turnover rates in community services for adults for nursing staff were 27.6%, for medical staff they were 14.5% and for allied health professionals they were 10.4%.

A breakdown of turnover rates by staff group in community services for adults at trust level for the year ending March 2018March 2018March 2018 is below:

Community adults total

Staff group	Turnover rate
Medical & Dental staff - Hospital	12.9
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	16.0%
Support to ST&T staff	8.2%
NHS infrastructure support	9.2%
Support to doctors and nursing staff	11.1%
Qualified nursing & health visiting staff (Qualified nurses)	24.4%
Qualified Allied Health Professionals (Qualified AHPs)	8.4%
Public Health & Community Health Services	0.0%
Total	**13.6%**

(Source: Universal Routine Provider Information Request (RPIR) – P18 Turnover)

The trust has informed us further changes to the turnover rates to September 2018.

Sickness

The trust set a target of 4% for sickness rates. From April 2017 to March 2018 the trust reported an overall sickness rate of 4.5% in community health services for adults. This did not meet the trust's target. Across the trust the overall sickness rates in community services for adults for nursing staff were 5.5%, for medical staff they were 0.0% and for allied health professionals they were

2.3%.

A breakdown of sickness rates by staff group in community services for adults at trust level is below:

Community adults total

Staff group	Total available permanent staff (days)	Total permanent staff sickness (days)	Sickness rate
Medical & Dental staff - Hospital	2,531.6	0.0	0.0%
NHS infrastructure support	22,297.6	1,193.9	5.4%
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	12,625.2	423.8	3.4%
Public Health & Community Health Services	373.4	14.1	3.8%
Qualified Allied Health Professionals (Qualified AHPs)	90,986.8	2,115.1	2.3%
Qualified nursing & health visiting staff (Qualified nurses)	86,232.2	4,742.9	5.5%
Support to doctors and nursing staff	81,079.4	4,913.7	6.1%
Support to ST&T staff	16,430.1	612.3	3.7%
All staff groups	**312,556.3**	**14,015.9**	**4.5%**

Source: Universal Routine Provider Information Request (RPIR) – P19 Sickness)

Nursing – Bank and Agency Qualified nurses

From April 2017 to March 2018, of the 148,358 total working hours available, 7% were filled by bank staff and 15% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, 4% of available hours were unable to be filled by either bank or agency staff.

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Community Nursing West	62,400	2,427	4%	2,809	5%	527	1%
Community Nursing East	75,660	797	1%	7,070	9%	308	0%
Community Nursing Central	37,245	1,913	5%	2,230	6%	188	1%

Phlebotomy Service	5,850	450	8%	0	0%	0	0%
Eneurisis	5,070	227	4%	0	0%	0	0%
Portsmouth Management	7,800	688	9%	0	0%	0	0%
Ports Comm Nurse North	29,250	271	1%	1,938	7%	1,259	4%
Ports Comm Nurse Central	35,295	796	2%	3,246	9%	1,360	4%
Ports Comm Nurse South	34,905	1,495	4%	2,714	8%	1,570	4%
Frailty Interface Team	5,850	320	5%	0	0%	0	0%
DN Out of Hours Service	17,940	1,093	6%	2,020	11%	1,237	7%
Community adults total	**317,265**	**10,474**	**3%**	**22,024**	**7%**	**6,448**	**2%**

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)

Nursing - Bank and Agency Non-Qualified nurses

From April 2017 to March 2018, of the 68,669 total working hours available, 5% were filled by bank staff and 0% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, 0% of available hours were unable to be filled by either bank or agency staff.

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Community Nursing West	13,697	1,512	11%	44	0%	0	0%
Community Nursing East	19,084	521	3%	30	0%	0	0%
Community Nursing Central	15,277	259	2%	0	0%	0	0%
DN Out of Hours Service	9,048	593	7%	7	<1%	103	1%
GP Surgeries	6,299	205	3%	0	0%	0	0%
Cardiac Nurse Service	5,265	550	10%	0	0%	0	0%
Community adults total	**68,669**	**3,640**	**5%**	**81**	**0%**	**103**	**0%**

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)

Medical locums

From April 2017 to March 2018, zero working hours were covered by locums to cover sickness, absence or vacancy.

(Source: Universal Routine Provider Information Request (RPIR) – P21 Medical Locum Agency)

Suspensions and supervisions

During the reporting period from April 2017 to March 2018, community services for adults reported that there were three cases where staff have been either suspended or placed under supervision. Two staff were placed under supervision and one has been suspended.

(Source: Universal Routine Provider Information Request (RPIR) – P23 Suspensions or Supervised)

The challenges of staff recruitment and turnover in community nursing had been recognised by the trust and local management teams. In Portsmouth band 5 nurse recruitment was at the top of their local risk register. In Southampton a demand and capacity tool had been developed to calculate daily clinical and non-clinical staffing demands, based on patient need. The tool provided teams with information about demand, with supporting algorithms, to aid decision making on where staff were most needed. This enabled the teams to use staff across the wider teams and to escalate where demand exceeded capacity. The system was being tested with an audit planned before the system went fully operational in September 2018.

Quality of records

The trust had systems in place to ensure that people's individual care records, including clinical data, was written and managed in order to deliver safe care and treatment to people.

The trust had introduced an electronic patient record system which could be used remotely away from the trust's premises. The system provided for a single shared record, which allowed direct sharing with other staff in the Trust as well as other primary care service providers though it was not yet fully integrated with all GP services. This meant staff could share relevant information about patients' care, with the patient's consent. It had a wide range of functionality including appointments, document management, care plans, and goals. There were also paper versions of specific forms that were also used during downtime periods.These were then scanned or transcribed retrospectively onto the clinical system. The system was secure with access by card and password.

All bank staff in Southampton had access to electronic records. For any temporary staff who did not have access to the electronic patient record system the care plans for patients were printed off by the shift co-ordinator. These were placed in a lockable clipboard box which was given to the temporary staff member. These records were later scanned into the patient record by administration staff.

Staff told us they liked using the electronic patient record system and felt it was an improvement in patient care. We reviewed a selection of patient records on the electronic patient record system and these were written and managed in a way that kept people safe.

We also reviewed three sets of patients notes which were kept at the patient's home address. These notes contained district nursing contact numbers, permissions, NEWS sheet, MUST sheet, ambulance care plan, drug administration record, visit records, pressure area care information and a patient satisfaction survey. Two sets were complete, correct and signed and dated by visiting nurses; one set was completely empty of any written record. This was raised with the district nurse at the time.

Medicines

Medicines were appropriately prescribed and administered to people in line with the relevant legislation and current national guidance. For example, the trust had a standard operating procedure (SOP) for the administration of intravenous antibiotics; and an SOP for insulin administration in the community by non-registered nursing staff.

Most medicines were prescribed by GPs, though a number of community staff were independent prescribers. For example, community matrons and specialist teams, such as podiatry, could prescribe local anaesthetics and antibiotics.

Staff had to be assessed as competent in the safe administration of medicine and there were a range of training courses available for staff to develop those competences. Staff recorded the administration of medicines on the trust's electronic patient records system. We saw evidence that community nursing staff administered medicines safely to patients. We checked records and noted that nursing staff checked blood sugar levels before giving insulin to patients in their home in line with practice recommendations.

There were detailed care plan proformas for injections. We examined an injections care plan for anticoagulant medication and a Vitamin B12 Injection care plan and both were correct and met the standards required.

The primary purpose of the medicines management group was to ensure best practice was followed in all aspects of medicines management by promoting an evidence based approach to the safe use of medicines. Supporting it was a medication safety group which met six times a year. There was also a non-medical prescribing steering group (NMPSG) which was the governing body of the Non-Medical Prescribing Forum (NMPF) for Nurses and Allied Professional Health personnel who had been accredited to prescribe to patients.

The trust had appropriate Patient Group Directions (PGDs) which were available to staff on the trust's internal website and which allowed staff to give certain medicines.

Medicines and their administration were discussed at local governance meetings. We observed various medicines were discussed well as issues around prescriptions. There was also a reminder to staff to monitor medicine cupboards to ensure the temperature did not exceed 30° and, if so, to adjust expiry dates. This had been risk assessed by the pharmacy team. There were daily checks of medicines cupboards. We examined a sample record which showed daily checks and a log of any actions taken.

Safety performance

Safety Thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free

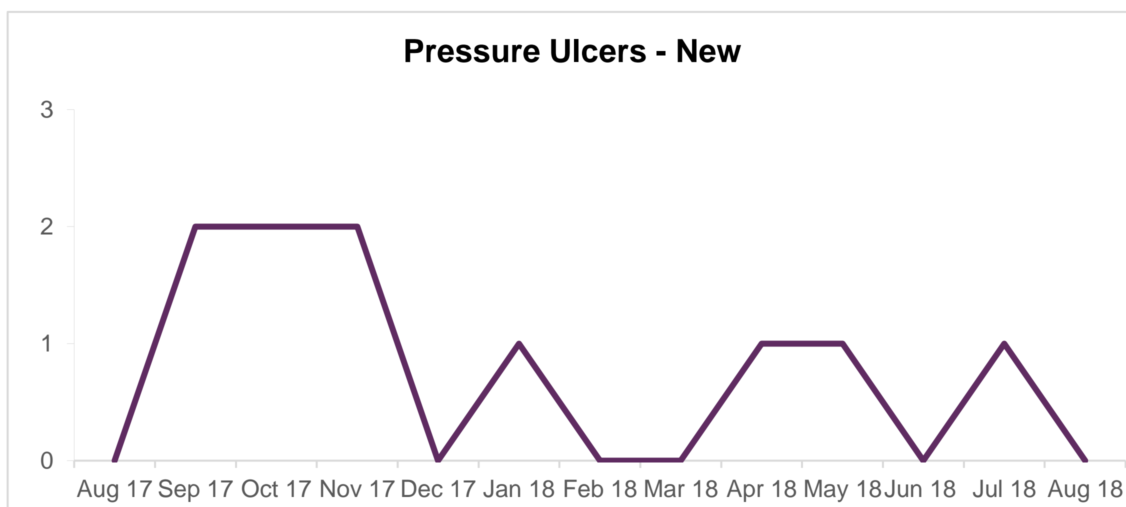
care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

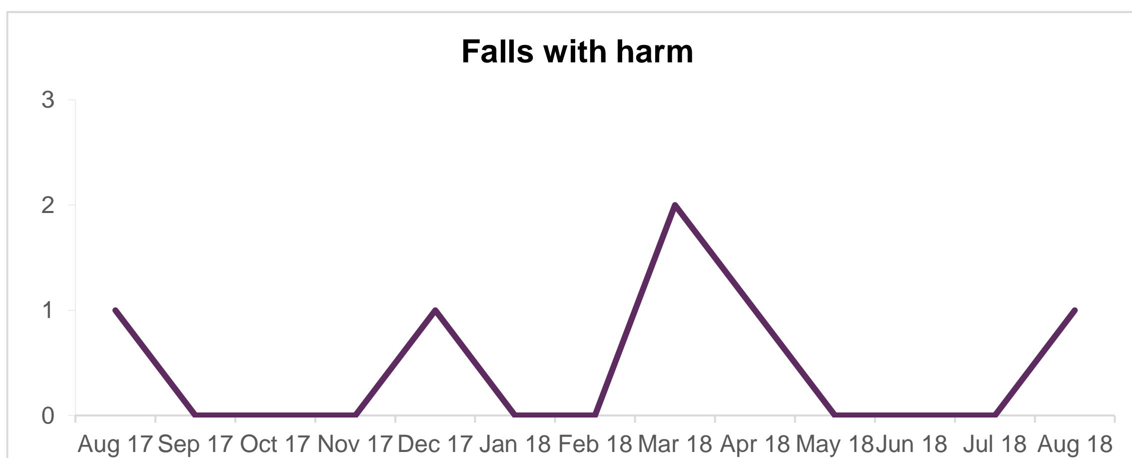
Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

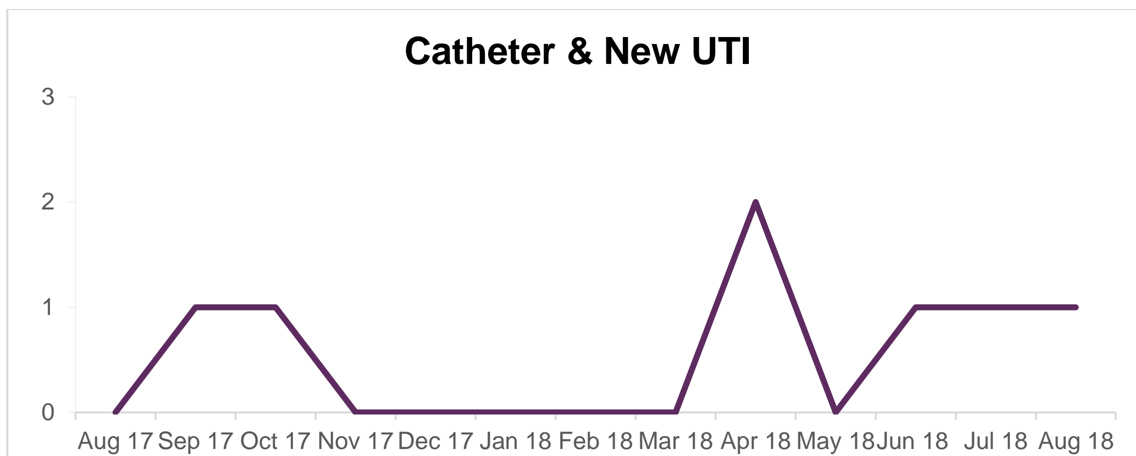
Community Settings

Data from the Patient Safety Thermometer showed that the trust reported 10 new pressure ulcers, six falls with harm and seven new catheter urinary tract infections from August 2017 to August 2018 within community settings.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Solent NHS Trust – Community settings.







Source: NHS Safety Thermometer: https://www.safetythermometer.nhs.uk/index.php/classic-thermometer

The trust placed a strong emphasis on the prevention of pressure ulcers and all of the staff we spoke with understood the need to prevent pressure ulcers. At Portsmouth and Southampton, a quarterly senior team meeting reviewed issues including pressure ulcer awareness and ensured identifications were made and reported at stage 2 and 3 before they developed any further. The trust had also introduced the Solent Moisture Pathway which was a moisture lesion pathway, where staff were being trained on the differences between pressure damage and moisture damage.

We were told that all complex insulin diabetics were reviewed weekly by a registered nurse who checked care plans, injection site, feet and pressure areas during visits. Tissue viability nurses told us about the pressure ulcer panel, and the essential timeliness of referral to tissue viability nurses. They also told us how photographic evidence was required especially if the pressure ulcer worsened from a stage 2 to a stage 3 wound assessment.

Incident reporting, learning and improvement

Never events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From April 2017to March 2018, the trust did not report any never events in community services for adults.

(Source: Strategic Executive Information System (STEIS))

Serious Incidents

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include 'never events' (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported 46 serious incidents (SIs) in community services for adults, which met the reporting criteria, set by NHS England from

April 2017 to March 2018. Of these, the most common type of incident reported was pressure ulcers with 38 incidents (82.6% of total incidents)

Incident Type	Number of Incidents
Pressure ulcer	38
Pending review	4
Medication incident	1
Slips/trips/falls	1
Confidential information leak/information governance breach	1
Treatment delay	1
Total	**46**

(Source: Strategic Executive Information System (STEIS))

Serious Incidents (SIRI) – Trust data

From April 217 to March 2018 trust staff within community services for adults reported 44 serious incidents.

One of these involved the unexpected death of a patient at home.

The most common types of serious incidents were pressure ulcers with 39 incidents.

The number of the most severe incidents recorded by the trust incident reporting system is comparable with that reported to Strategic Executive Information System (STEIS). This gives us more confidence in the validity of the data.

Incident Type	Number of Incidents
Pressure ulcer	39
Other	2
Slips/trips/falls	1
Medication incident	1
Treatment delay	1
Total	**44**

(Source: Universal Routine Provider Information Request (RPIR) – P29 Serious Incidents)

The service managed patient safety incidents well. Staff understood how to report incidents using the electronic reporting system and were encouraged to do so.

Managers investigated incidents and shared lessons. We were shown incidents that had been reported together with lessons learnt on boards in team offices. Staff knew about the duty of candour and when to apologise and could give examples to us. For example, we were given two examples of pressure ulcer wounds being reported and shown three completed incident reports, which included one for a pressure ulcer incident that included an action plan and outcome and where duty of candour had been observed.

Staff discussed incidents at governance meetings across community adults, and managers shared lessons learnt with their staff. At one governance meeting we attended a list of recent incidents was passed around and each staff member read out an incident, the conclusion, and shared the learning.

Prevention of Future Death Reports (Remove before publication)

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

Within the last 12 months, there had not been any prevention of future death reports sent to Solent NHS Trust.

(Source: Universal Routine Provider Information Request (RPIR) – P76 Prevention of future death reports)

Is the service effective?

Evidence-based care and treatment

People's physical, mental health and social needs were comprehensively assessed, and their care, treatment and support was delivered in line with legislation, standards and evidence-based guidance. This included the National Institute for Clinical Excellence (NICE) guidelines, and other quality standards, national service frameworks and good practice guidance. This was being followed by staff, who had access to evidence-based guidance and policy through the trust intranet. Staff we spoke with told us they could access information on a relevant topic; for example, one community nurse told us told us how she could access guidance on pressure ulcers.

The Community Stroke Team used the British Society of Rehabilitation Medicine (BSRM) guidelines for acquired brain injury; the Royal College of Physicians national clinical guideline for stroke; and the NICE guidelines for multi-sclerosis.

We attended a staff meeting where patient results were discussed. Decisions on patients ongoing care and treatment were made in line with national guidance, such as tissue viability referrals or insulin treatments.

We were told by a tissue viability team member of their use of the leg ulcer management pathway, and the NICE guidance on lymphoedema care and treatment.

The Solent Urgent Response Team held a virtual ward every morning and Wednesday afternoon, which included a doctor (a geriatrician or a registrar). The virtual ward meeting reviewed existing patients, patients with long term health conditions and complex care plans, and any new patients and specific risks. Guidelines used in the care of patients and practice were discussed and advice given.

Therapists delivered an intervention physiotherapy course for people diagnosed with Parkinson’s Disease (PD). This was based on evidence that this type of intervention, to actively train the brain, can slow the progression of PD. The team worked with newly diagnosed patients, who would not normally receive intensive physiotherapy, and reviewed their goals over an 8-week programme of 20-30 mins a day challenges. Results showed all patients fully achieved their goals and mood.

The trust had participated in 31 local and national clinical audits in relation to this core service.

There were active developments for effective care and treatment such as the trusts introduced a new treatment in musculoskeletal medicine for treating hip impingement which reduced onwards surgical referral and led to new skills being adopted by the staff and an overall improvement in outcome for patients.

A team member had won a national award at the Nursing Times Award Ceremony in 2018 for the management of latent TB.

Participation in a clinical trial led by one of the Solent pain consultants highlighted the effectiveness of transforaminal injections in averting surgery. Also through the establishment of new clinical pathways with pain clinics the number of patients requiring surgery has reduced. This involved cross system working with both acute providers and commissioners over a prolonged period.

Nutrition and hydration (only include if specific evidence)

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences

Care plans had an appropriate nutrition and hydration assessment and management plan. We were shown a detailed care plan for a patient titled `capacity to decide food & fluid’. This demonstrated a

thorough assessment of the patient's capability to cope with food, with swallowing and with different textures. A plan for the patient was then agreed in discussion with the patient and with a close relative.

We also accompanied district nurses on visits to patients. Nurses told us they used the Malnutrition Universal Screening Tool (MUST) to assess patient's nutrition and hydration intake. On those visits we saw that nurses checked on patient's diet and provided general advice and guidance and used the MUST tool.

The diabetes team had specialist nurses who worked with dieticians to support patients with diabetes by developing weight loss programmes.

Pain relief (only include if specific evidence)

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

We were shown evidence that pain was assessed and managed, particularly for those people where there were difficulties in communicating. A form for pain assessment was available for staff to use, it included a universal pain assessment tool together with the Wong-Baker facial grimace scale.

During our visits to patients homes we saw examples of patients had their pain assessed and were given appropriate pain relief. We saw one patient who reported feeling pain, the patient was reassured, medications were given for pain relief and the dressings were changed. The nurse was kind and reassuring throughout.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

Audits – changes to working practices

The trust has participated in 31 clinical audits in relation to this core service as part of their Clinical Audit Programme.

Audit name	Area covered	Key Successes	Key actions
Shoulder injection practice in specialist MSK teams	Musculoskeletal	Solent NHS Trust is consistent with Trust guidance that no more than 3 injections are performed on a patient in a 12 month period and that a radiograph is completed prior to injecting. Compared with the service evaluation completed in 2016, there appears to be less variation between clinicians' practice. This audit identified that 20% of patient contacts	Adjust the audit tool to ask for dates of previous injections over the last 12 months to clarify adherence of standard 1; consider evaluation of use of suprascapula nerve blocks; feedback results of the audit to specialist MSK shoulder clinicians by December 2017.

		involved the use of corticosteroid injections or the referral on for a guided injection. There was some variation in practice between clinicians noted during the study in the number of injections performed; this appears to reflect the service that the clinician was part of as each of the different services appears to engage with the patient at a slightly different part of the patient's journey some having closer links with physio with others having closer links with orthopaedics.	
Patient experience & clinical effectiveness of a 6 week Spinal Fitness Class	Musculoskeletal	47 patients completed the spinal fitness program between October 2016 & February 2017, 28 of these patients attended the first and last session meaning pre and post intervention scores could be gathered. Of these, 64% reported some form of improvement; 25% made a clinically significant improvement, 21% reported a non-clinically significant deterioration; 0% experienced a clinically significant deterioration. Qualitative data suggested that all of those that completed the classes found them useful and felt confident with exercise and the management of their low back pain. Analysis of completion rate suggests 60% of patients that attend complete the class.	A number of strategies to improve the service are being implemented: follow up of patients that do not complete the spinal fitness classes to ascertain why; work with the MSK department at QAH to develop consistency between spinal fitness classes across sites and to put together a pack for each patient to include exercise resources; include a brief talk on resources to aid continued exercise in the community including NHS fitness studio; carry out a literature search to establish optimum class content based on current best evidence.
Re-audit: Appropriateness and completeness of referrals from GPs to Podiatry Services	Podiatry	23% of 62 referrals were classed as fully complete, having all the required information to enable effective triaging of patients; 76% of referrals were classed as minimally completed with 1% incomplete; 77% of referrals were appropriate referrals.	Liaise with other healthcare professionals to highlight referral standards and to identify possible barriers with referral format; develop plan of agreed changes to improve referral standards.

Accessible Information (2017-18 Qtr 1)	Adults Southampton	95% of patients admitted and reported during the audit do not have an LD but some of these will have an AI need; patient needs were met using an individualised approach with the method meeting their needs.	Ensure staff have access to information regarding accessible information needs, especially for patients with LD, by disseminating information by a variety of methods: face to face, e-mail, newsletters and sharing of audit results at governance meetings; inform staff via newsletters, Governance meetings, team meetings and training that they need to record AI needs on the AI template on SystmOne.
Pressure Ulcers (2017-18 Qtr 1) (NICE CG 179 / QS 89)	Adults Southampton	Records of 42 patients with 46 pressure ulcers were audited, including 3 inpatients. These figures are not comparable to previous audits, which gathered quarterly data. Compliance was very good in all cases apart from an at risk care plan not in place in 2 cases; recommended TIMEs wound assessment not always being completed at assessment, but does not affect compliance with this audit.	1. Pilot of Purpose-T, consideration of extension to Community teams; 2. Roll out of Intentional Rounding to all localities once new community nursing structure is embedded; 3. Introduce use of TIME wound assessment tool (Tissue, Infection, Moisture & wound Edge); 4. Ensure staff know that they need to assess patients' risk of developing pressure ulcers and apply a care plan appropriately.
Documentation of discussion concerning Total Contact Casting EZ in patients with A1 Texas Classified Foot ulcers (NICE NG 19)	Podiatry	Documented justification for NO discussion: East team 100%.	The following are to be considered: further training for staff regarding how the TCC-EZ system works so they have increased confidence discussing it with patients; further training around the use of the Texas classification system.
CQUIN: Improving the assessment of chronic wounds (those that have failed to heal after 4 weeks should receive a full wound assessment) (2017-18 Qtr 2)	Community Nursing & Tissue Viability Specialist Nursing Team	349 wounds were audited of which 227 had a TIMES wound assessment (65%).	Share results with staff in order to highlight the current level of compliance and February 2018 improvement target: by email, by discussing at Business and Governance meetings in November 2017, by adding as an agenda item to Band forums in October and December; Tissue Viability team to provide update training to staff which will include informing staff of changes to the TIMES wound assessment; set up induction programme to ensure that all new starters either have an

			induction session on wound assessment & TIMES and / or attend the Foundation TV training day.
Re-audit: Nutritional Assessment (Improve Nutrition and Hydration for all patients) (Community 2017-18 Qtr 1)	Community	Compliance with the Nutrition & Hydration policy and quality requirements was excellent at 98%, exceeding the target of 95%; previous audit found some staff were only completing step 1 of the MUST assessment on SystmOne but no evidence was found of this during Quarter 1 - indicating that learning has taken place; there was evidence that patients had the care required, despite not having a care plan.	Add to next audit (Qtr 3): for patients who have a MUST score of 1 or more, collect data on what percentage have care planned and how.
Do the majority of patients referred by the SMSK lower limb service to an orthopaedic Surgeon convert to surgery?	Musculoskeletal	86.5% was the overall conversion rate for onward referrals of lower limb patients, exceeding the 85% stipulated in the service specification. 16 patients out of 121 were not converted for various reasons; 6 of the 16 were considered appropriate referrals despite not converting; 2 of the 16 were referred directly to Orthopaedics and therefore not seen face to face by an SMSK clinician; unable to source letters on 13 patients - 9 of which were patients referred to The Spire Hospital Portsmouth under the NHS contract. The rate of conversions was lower than the 94% measured in the previous year.	Liaise with The Spire over receiving letters about referred patients.
Prescriptions of tramadol or pregabalin with antidepressant drugs in a pain service outpatient clinic (NICE-CSK Analgesia)	Pain		Consider a method to ensure information of concomitant use of SSRI, SNRI and TCA and tramadol are always included in GP correspondence; create a Patient Information Leaflet & process by which leaflets will be printed & disseminated; recommend to GPs that repeat the GAD score to consider appropriate treatment; create a service standard to document that if patient reports euphoria /

			internet buying, then a need for care has been exercised on endorsing repeat scripts of pregabalin; add to system one alerts to warn of concomitant use of SSRI, SNRI and TCA and tramadol & Pregabalin as risk factors for addiction.
Pressure Ulcers (2017-18 Qtr 3) (NICE CG 179 / QS 89)	Adults Southampton	Records of 24 patients with 26 pressure ulcers were audited. Of these, 6 were inpatients and 2 were Urgent Response Service. Compliance was very good in all cases – average was 99.4% compared to 97.1% in June 17; non-compliance was lack of ulcer measurement and MUST in one case each; completion of audit form remains patchy and not as agreed; there was not one main causal factor.	Continue to try and introduce measures to reduce pressure ulcers by: (i) Roll out of Intentional Rounding to all localities once new community nursing structure is embedded, (ii) Consideration of extension of Purpose-T pilot to community teams (Purpose-T = Pressure Ulcer Risk Primary Or Secondary Evaluation Tool); Launch updated “TIMES” wound assessment tool on SystmOne (TIMES = Tissue, Infection, Moisture & wound Edge); advise staff about using the updated “TIMES” wound assessment tool on SystmOne for the measurement of wounds.
Re-audit: Triage and prioritisation of referrals (Speech and Language services in Portsmouth community teams)	SLT: Portsmouth	A comparison was made with the initial audit which highlighted that receipt of referrals was slow, the use of triage and prioritization was limited as was use of the single point of access (SPA). The re-audit shows significant improvement in the majority of areas measured. In particular the average time taken from sending to triage of referrals had reduced from 8 to 3 days. It would appear that the main influencing factors are changes to the SystemOne process and use of SPA.	A centralised triage team and process will be developed to ensure that referrals are triaged equitably across the three general caseload areas. A tool will be developed alongside training for resource and demand planning.
Completion of diabetic foot assessment tools by GP’s and nurses	Podiatry	The correct patients are being referred - overall over 80% of referrals were successful but only 51% of forms were actually filled out correctly / fully; most referrals were from practise nurses. The sample size was small - only one referred in from a GP and one	Attend meeting between podiatry and the nursing team to discuss findings and get feedback about DFA forms from nurses; a new DFA is now available online which may increase accuracy and completeness of forms.

		referred in from community nurses.	
Re-audit - Regional: Podiatry use of PGD (Patient Group Directions) for the provision of antibiotic therapy (2017-18)	Podiatry	In 2016/17 there have been significant improvements in issuing appropriate antibiotic therapy to patients with penicillin sensitivity or MRSA; in all cases where antibiotics have been provided, signs of clinical infection have been well documented in the patients' notes, although there is some slight room for improvement in the use of existing templates; taking of swabs and documentation of microbiology results remain at low levels - reasons include some logistical issues at some sites and possibly audit data collection issues.	Audit findings have been fed back / discussed with Podiatry staff at Target days, to refresh skills and practices; changes to some audit objectives to be investigated, to better reflect meaningful outcomes; recently improved integration of the patient record with the pathology platform will have beneficial outcomes for this area in terms of requesting pathology tests directly from the patient record and then automatically collecting results on the patient record.
Pressure Ulcer Prevention and Management (NICE CG 179 / QS 89)	Adults Portsmouth	The three community nursing teams have a focus on improving Tissue Viability awareness and PU management; for in-patient units this shows progress.	Remind staff to upload care plan to relevant area for all colleagues to see; remind staff after assessing wounds to ensure this information is in the correct area on S1; ask staff to ensure any equipment prescribed to improve the wound is recorded and that the team are aware of need for review of efficacy.
Southampton Clinical Commissioning Group (SCCG) patient electronic triage scores compared to patient contact assessment scores	Podiatry	Of the 222 referrals received, 131 were community patients who were offered a face to face appointment, of these only 56% (73) underwent the completion of both the electronic triage and face to face questionnaire; there was a 45 % increase in scoring face to face as opposed to electronic triage and 29% remained the same, resulting in a total of 74% of electronic triage scoring being effective in determining patient risk and eligibility and therefore meeting criteria for a face to face appointment.	Liaise with other Podiatrists within the Trust to identify barriers to utilising the questionnaire data electronic triage and face to face assessments; develop plan of agreed changes to improve utilisation of questionnaire at electronic AND face to face.
Appropriateness of direct referral to the pain clinic for nerve root block	Musculoskeletal	100% of patients (11) were referred directly to the pain clinic as fulfilled the following conditions: a) had clinical signs & symptoms consistent with sciatica; b) had	None required as the current policy of referring appropriate patients directly to the pain clinic for nerve root injection should continue as this represents a potential

		confirmation by an MRI scan. Of these patients, 10 received a spinal injection - 9 had a nerve root block and one an epidural injection. The remaining patient had improved sufficiently by the time they were seen so they didn't require an injection.	reduction in time to treat, for patients with sciatica.
Physical Health Monitoring and Medication review in people with Learning Disability	Learning Disability Team	This audit collected data which was compared to previous POMH data collected in 2015. Results of data collected in 2018 have shown an overall significant improvement.	Patient to be supported by named worker for annual health check at GP surgery and Measurement of waist circumference in consultant clinics.
System One Records Management for the Falls Prevention Exercise Team	Community Physiotherapy Team	Informed consent for each assessment and intervention is excellent at 100%. General Documentation and storage of Physiotherapy Records is also of a high standard.	Recommendations to the team at the next weekly meeting: document that patients consent has been asked for permission to share in and out on System One Recommendations; all pre-exercise assessment forms must be uploaded to Comms and Letters section on S1; that the provision of a Get up and Go Leaflet to patients is recorded on System One; the question 'Have you had any falls in the last year?' has been asked and documented on System One. Team to devise and implement a S1 template for patient problems, interventions and goals.
Re-audit: End of Life Medication Records (2017-18 Qtr 4)	Community	Of the 12 patients who died during January 18, 2 had no records on SystmOne (they may not have needed medication), one was excluded (relative of the auditor so inappropriate to look at record), and 2 had no medication record scanned on but had other records of medication use; therefore, 7 records had all the required charts and information available. There was improvement in: (i) use of current paperwork (all records used it - previous audit showed staff not using latest paperwork); (ii) dating & signing errors - done for the	Remind staff of the following standards, using newsletters and staff & governance meetings: deletions in medication records should be clearly dated and signed; record what happens to medication when no longer needed (e.g. after patient has died); use newest paperwork; admin staff should promptly upload records to SystmOne following discharge of patient. Plus: re-send newest form to staff to help with raising awareness; carry out administration review to ensure admin support provided for all teams; with Medicines Management team, discuss

		one error seen (previous audit showed deletions/errors not dated and signed); (iii) recording of medication disposal at end of care episode – from 38% to 56% compliance.	method of liaising with GPs re not completing medication documentation fully, including when to make incremental changes.
Re-audit: Nutritional Assessment (Improve Nutrition and Hydration for all patients) (Community 2017-18 Qtr 4)	Community	96% of 72 patients had a Malnutrition Universal Screening Tool (MUST) assessment; of 11 patients requiring care, 10 had care planned and the other had advice; all patients recorded as requiring supplements and referral to a dietician had the appropriate intervention; 4 patients had step one completed only (there was no evidence these patients would have scored higher if remaining steps had been completed); several patients scoring 1 or higher were referred to GP for medical assessment; many patients scoring 0 still had evidence of advice re nutritional intake and / or appropriate weight management given.	Share report with staff at governance meetings, and then team meetings, to remind staff to complete all steps of the MUST.
Care Pathway for Sciatica Patients in Portsmouth against the National Low Back and Radicular Pain Pathway 2017 guidelines	Musculoskeletal	There were 33 patients who received an injection in 2016-17 and met the project criteria. Results of compliance with the Standards for accessing services were: physiotherapy - 20/31 (65%), specialist appointments - 13/31 (42%) and specialist review appointments - 3/28 (11%) and for timely MRI report was 9/27 (33%). There are significant delays throughout the sciatica care pathway that need addressing, both within Solent MSK service and PHT Pain service (the current provider of TESI - transformational epidural steroid injections). Related findings are covered in CA-1092 (comparing Solent's practice for spinal injection referrals against national standards) and these findings will be taken into	Deliver in-service training to Portsmouth MSK staff regarding severe sciatica presentations; adopt SCOPiC (Research) protocol; discuss strategies to improve access to timely review of management options with patients; discuss access to timely TESI with pain services; develop a local care pathway for patients with severe sciatica & disseminate to staff; disseminate information about actions to the spinal teams in Southampton and Fareham & Gosport (and include them in both planned re-audit); where relevant, take into account the findings of the service audit of the injection pathway for patients with spinal pain (CA-1092).

		account when planning the required actions to improve the pathway for patients with severe sciatica.	
Does Solent specialist MSK service spinal injection referral practice align with national standards? (NICE NG 59)	Musculoskeletal		Inform Portsmouth Hospitals NHS Trust (PHT) Pain clinic of the findings of the audit, to enable a resolution to the problem of low compliance of epidural / nerve root blocks being undertaken within national target of 18 weeks; highlight the need for urgent access to their service for patients presenting with severe, progressive pain of less than 6 months duration; agree upon use of better outcome measures to facilitate more accurate measurement of effectiveness. Offer to refer all eligible patients with severe progressive pain of less than 6 months duration to the ISTC in Southampton for intervention & disseminate information regarding this process to all spinal clinicians working within specialist MSK services. Highlight to spinal clinicians in specialist MSK services, that epidural injections are no longer recommended by NICE to treat neurogenic claudication in those with central spinal canal stenosis.
Osteoarthritis Guidelines (NICE CG 177)	Musculoskeletal	Highly compliant across all sites with providing a holistic assessment; most sites demonstrated that shared decision making has taken place; most sites fail to document that both verbal & written information have been given to the patient (apart from SMCH Physio Outpatients which scored 80%); there was a range in compliance with prescribing both strengthening & aerobic exercise - a re-design of the SystemOne record for could help prompt therapists to document more effectively. area of good practice - audit standard of not giving acupuncture to patients with	Give clinicians information on NICE Guidelines for OA; discuss with SystemOne team: (i) the options to remind clinicians to record handing out written information to patients, (ii) changes to assist with recording weight & height and calculating BMI; discuss audit feedback in team meeting, particularly re lack of recording of advice; reinstate paper tick box sheet scanned onto records as interim measure; revise audit tool to exclude criterion on use of Acupuncture.

		OA was achieved 100% across the board; compliance with documenting medications and advice to obtain medication was good, apart from one site with low compliance. Sites that have to make changes regarding documentation and practice could learn from the good practice of SMCH Physio Outpatients - this peer learning may be best discussed in a team meeting.	
Re-audit: Appropriateness and completeness of referrals from GP's in to Podiatry Services	Podiatry		Liaise with other healthcare professionals to highlight referral standards and to identify possible barriers with referral format, at CCG meetings & GP target days; email podiatrists to highlight that if referrals are not minimally complete, they need to be sent back for more information (so triaging is not done using insufficient information).
Re-audit: Falls Assessments and Interventions (NICE CG 161) (2017-18 Qtr 4)	Community	18/28 (64%) of Falls Assessments contained a correct assessment of postural blood pressure; 10/27 (37%) had been assessed with standardised measures; 15/28 (54%) had a home environment assessment; in only 1 to 3 cases was it documented that verbal or written falls / bone health information was given; 17/28 (60%) had goals set; 6/17 had their goals monitored / reviewed (100% of those for whom this was applicable at their stage in their rehab); for 71% (18) patients it was documented that a medical CGA (Comprehensive Geriatric Assessment) was not indicated; 2 patients received a CGA home visit, leaving 8 patients for whom no consideration of a CGA was documented (28%); 8 patients had a medication review; 1 patient had an AACP - this was considered	Share report with staff at governance & team meetings and at Band 4 forum; use e-records from discharged patients for future audit; do a system-wide audit of patients who are seen by CIS for falls, tracing back what happened at other hospitals applicable.

		appropriate, as the majority were too early in their rehab process. Postural blood pressure taking and recording has improved since the 206-2017 audit.	
CQUIN Re-audit: Improving the assessment of chronic wounds (those that have failed to heal after 4 weeks should receive a full wound assessment) (2017-18 Qtr 4)	Community Nursing & Tissue Viability Specialist Nursing Team	546 wounds were audited of which 437 had a TIMES wound assessment (80%) which is an improvement on the 65% baseline result in Quarter 2 and meets the required improvement target of a further 15%, which was set after the previous audit.	Share results with staff to ensure benefits are realised and onward use of TIMES assessment is assured; inform staff of changes to TIMES wound assessment; provide update training; add TIMES assessment training to the primary induction programme for all new nursing staff joining the Community Nursing Team; work with the data team to develop a method for automating data collection; establish a process for automated delivery of data set from SystmOne; complete a weekly automated data analysis to ensure improvement in data entry; ensure that all wound care plans on community nursing case load and Tissue Viability caseload meet the requirements for automated data collection by carrying out data validation; ensure an on-going monitoring process for each team by embedding into the monthly quality review.
Re-audit: Adherence to local triage guidelines for referrals to Community Geriatrics across Southampton City	Community	There was evidence that all referrals were being triaged; as a result of action from the previous audit, there was improvement in recording of clinical activities by each Consultant so running a report of activities on System One was easier; there was an improvement in the time taken to see patients from triage but this improvement was offset with some deterioration in the East locality, though in the majority of delays, it was only a matter of 1-2 weeks or less. There has been some improvement in the turn round time for GP letters in East and Central	Disseminate report to ensure everyone is aware of the triage system and that GP letters need to be written within 5 days of visits; standardise documentation of activities on System One; consider employing medical secretaries to facilitate timely GP letter write up; educate SpR's to work within the 5 day turn round target of GP letters.

		localities but deterioration in the West locality.	
National Chronic COPD Obstructive Pulmonary Disease (COPD) Pulmonary Rehabilitation **ORGANISATIONAL** Audit		Audit recommendation was that PR programmes should ensure that all patients referred for PR should be enrolled to the programme within 90 days of receipt of the referral - Solent's results showed that patients commenced PR from date of receipt of referral within 37 days (average)with 37 days. Audit recommendation was that PR services that solely run cohort programmes could consider switching to rolling programmes (or using a combination of both) to reduce waiting times - in Solent only 1 out of the 4 programmes are Cohort; due to staff changes this may well become a rolling programme in the future. Audit recommendation was that particular attention should be paid to ensure that exercise testing at assessment is performed to accepted standards - the Solent PR programme performs exercise testing as per ATS standards. Audit recommendation was that exercise training is accurately prescribed from an exercise test performed at assessment - in Solent, exercise is prescribed according to Assessment findings including 6MWT. Audit recommendation was that patients are provided with a written, individualised exercise plan at discharge from PR - audit shows that Solent PR discharges show 100% written exercise plans for patients.	Solent PR staff to make every effort in encouraging their COPD patients to complete PR and encourage them to attend their last review session
National Chronic COPD Obstructive Pulmonary Disease (COPD) Pulmonary Rehabilitation **CLINICAL** Audit			Solent PR staff to make every effort in encouraging their COPD patients to complete PR and encourage them to attend their last review session

National Audit of Cardiac Rehabilitation	Cardiac Rehabilitation	Audit recommendation was that programmes should aim to recruit a greater proportion of eligible female patients - in Solent, there is good attendance from female clients. Audit recommendation was that a greater range of modes of delivery, beyond just centre-based, should be offered and strongly promoted to patients - the Solent service provides a home programme which, following assessment, clients undertake with a DVD and are monitored weekly by an exercise professional via telephone or email contact for a 8 week period. Audit recommendation was that assessment of patients as they complete their programme should be a major priority and should be at 100% - the Solent service end assessment includes local criteria .e.g. achievement of lifestyle changes such as maintenance of smoking cessation, improved HAD scoring, improvement in 6MWT distance, increase in CV exercise at home, improved BP, return to work if relevant and achievement of the client's goal determined at initial assessment. CNT also determine if regular exercise will be continued e.g. a phase 4 referral has been made (percentage not noted). Audit recommendation was that the duration of CR should meet the minimum requirement of eight weeks - the Solent service provides 9 sessions as minimum which include 1 (or more) face to face assessments, a 6MWT if criteria indicates and a 8 week community programme of clinical review, exercise, health education and relaxation supported by an additional written home exercise plan following the	This has been brought forward to cardiac services manager for consideration.

first 2 weeks of observing response to exercise.

(Source: Universal Routine Provider Information Request (RPIR) – P35 Audits)

The trust had a clear approach to monitoring, auditing and benchmarking quality. The outcomes from these audits were used to improve the quality of care for patients. For example, the pressure ulcer audit in Portsmouth for the period April 1st to June 30th 2018 measured care given against NICE Clinical Guideline 179 (2014) and NICE Quality Standard 89 (2015) for wounds categorised against European Pressure Ulcer Panel (EUPAP) guidelines (2014). The outcomes included the need to remind staff to upload care plans; to ensure information on wounds was documented correctly; and to record the equipment prescribed to improve the wound.

Across the board, these audits were used to demonstrate that the service provision for patients (which included avoidance of hospital admissions and the management of long term conditions) was effective or to identify improvements to care and process.

Competent staff

Clinical Supervision

Staff had the right skills and knowledge and were provided with appropriate training to meet their learning needs.

The trust provided the following information about their clinical supervision process:

All services followed the Solent NHS Trust Policy for Clinical Supervision. Clinical supervision compliance was recorded and monitored at service line clinical governance meetings and through the individual care group performance meetings. It was also considered as a discussion point as part of management supervision to ensure that direct reports were receiving regular clinical supervision in accordance with trust policy. Clinical supervision was actively encouraged and open to all grades of staff working clinically. The trust-wide clinical supervision policy required clinical supervision at least every 6 - 8 weeks.

Staff in some specialist roles at a more senior level received clinical supervision from other relevant clinicians either inside or outside the organisation. For example, the Admiral Nurses had clinical supervision from Dementia UK and the older people's mental health (OPMH) support worker received supervision from a Southern Health NHS Foundation Trust psychologist.

Individual services agreed the model of supervision with the clinical director and supervision could be provided in several different ways which could include: individual, group, peer and observational supervision of practice. The trust recently agreed the implementation of an IT solution which would enable it to centrally monitor compliance more easily. Service leads ensured compliance was followed and staff were realising the value of such practice.

The Board would receive assurance through the Chief Operating Officers Trust Performance Management Report.

(Source: CHS Routine Provider Information Request (RPIR) – CHS4 Clin Supervision)

Staff told us they had their competencies reviewed and received clinical supervision in line with the timescales set out in the trust policy. We were given extensive evidence from a range of staff in community adults of opportunities to develop their competencies and skills.

Tissue viability staff told us they had clinical supervision every six weeks as part of a group, but also with an option for clinical supervision on a 1:1 basis with a line manager. A community nurse told us she received clinical supervision monthly and had a 1:1 weekly with her matron. The podiatry team had a bi-monthly `target day` with feedback from the preceptorship programme, clinical case studies and training.

Staff had opportunities to develop their skills and knowledge. a member of staff told us they had been given an opportunity to engage in research; on an apraxia study and on care restraint. Another member of staff had been involved in the World Health Organisation (WHO) study and report into the Deprivation of Liberty Safeguards (DoLS).

Appraisal rates

Community adults total

From April 2018 to June 2018, 40% of permanent non-medical staff within the community services for adult's core service had received an appraisal compared to the trust target of 95%.

Staffing group	Number of staff appraised	Sum of Individuals required	Appraisal rate (%)	Trust target (%)	Target met (Yes/No)
NHS infrastructure support	24	36	67%	95%	No
Other Qualified Scientific, Therapeutic & Technical staff	30	43	70%	95%	No
Qualified Allied Health Professionals	137	286	48%	95%	No
Qualified nursing & health visiting staff	88	271	32%	95%	No
Support to doctors and nursing staff	88	284	31%	95%	No
Support to ST&T staff	26	52	50%	95%	No
All staff	**393**	**972**	**40%**	**95%**	No

Medical staff

Staffing group	Number of staff appraised	Sum of Individuals required	Appraisal rate (%)	Trust target (%)	Target met (Yes/No)
Medical & Dental staff – Hospital	1	3	33%	95%	No

None of the staff groups within the community services for adult's core service met the appraisal target.

(Source: Universal Routine Provider Information Request (RPIR) – P39 Appraisals)

During the inspection staff and managers told us they were up-to-date with staff appraisals and we were shown figures to that effect. However, the data provided by the trust and detailed in the above tables indicated that the trust was not compliant with its appraisal rate targets. We requested further information from the trust to reconcile the data provided with what we had been told on inspection. The trust said there could be a delay in entering the appraisal date into staff records. We noted the trust had made improvements in appraisal rates to September 2018. However, appraisals across the trust were reset to 0% on April 1 each financial year. This meant the target of 95% completion of appraisals was not due to be achieved until 31 March 2019.

Multidisciplinary working and coordinated care pathways

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare and social care professionals supported each other to provide good care

As reported in the last inspection many teams were multi-disciplinary and included a range of specialisms; medical, nursing, therapies, psychology and social services. There were regular multidisciplinary (MDT) meetings and virtual ward meetings which identified the best care options for patients.

The Southampton Response Service (SRS) is an integrated service model which provided intermediate care to support discharges from secondary care as well as acute admission prevention. The teams within SRS operated under a multidisciplinary team model.

The Urgent Response Team was an integrated service between Solent NHS trust and Southampton City Council. The team provided crisis response admission prevention to the community, secondary care discharge facilitation and reablement care. The structure of this team included administration staff, specialist nursing, physiotherapy, occupational therapy, care management, associate practitioners, healthcare assistants and medical support. In Portsmouth the Rehabilitation and Reablement team (PRRT) delivered the Urgent Response Service through integrated care pathways with social care. It was a combined team of over 100 staff drawn from nursing, clinical specialisms and social services. They accepted referrals from any part of the health and social care sector (including private) for any adult who could benefit from intervention to remain at home.

Other examples of the comprehensive MDT work underway within the trust included:

- The community stroke team were commissioned to provide six weeks focused care at home for stroke patients. They had a weekly MDT meeting where plans across services were agreed for patients. Specialisms immediately available to them included psychology, physiotherapy, occupational therapy, and speech and language therapy (SALT).
- The Snowdon at Home team also had a fully structured MDT meeting, which addressed all aspects of physical, emotional and social needs of the patient and the carer. They also worked closely with the early supportive discharge team. These teams also took part in the multi-agency safeguarding hub, which reviewed all safeguarding incidents at a monthly MDT meeting.
- A Clinical Advisory Team was commissioned for both Southampton and Portsmouth areas. These teams combined tissue viability, with specialist advisors for movement and handling, pressure relief and posture management. On referral they reviewed patients and provided or requested specialist equipment.

Health promotion

Staff we spoke with were committed to helping people with long term conditions manage their own health and wellbeing.

Community nurses told us how they worked with patients with chronic obstructive pulmonary disease (COPD), empowering them to manage their condition. They gave patients support and advice and showed us the pulmonary rehabilitation information folder for patients with COPD. This contained a COPD management plan (provided by the British Lung Foundation), information on how to stop smoking, and diet and exercise sheets contained easy to understand advice and guidance.

While visiting patients with community nurses we saw a nurse explain to patients how they could improve their health, gave them support and encouragement and suggested achievable targets for them to attempt.

The diabetes team in Southampton held type 1 and type 2 education seminars in public venues across the city; and provided general educational support to healthcare professionals. They had also provided outreach services into secure mental health facilities providing inpatient advice on wards. New projects were being developed which included the `WISDOM` project where a GP diabetes champion held multi-disciplinary clinics for clusters of GP surgeries to improve care and support for type 2 diabetes patients. The diabetes team were also beginning work with the Black and Minority Ethnic (BAME) community by recruiting volunteers to act as `community champions' to promote healthy eating initiatives. In addition, the specialist diabetes team worked with the local acute hospital trust and the Diabetes Research and Wellness Foundation to screen people at football matches, and provide advice about diabetes. The service was also compiling a database of people living in Southampton with Type 1 diabetes to help improve support.

The trust supported national priorities to improve the population's health and staff had access to health improvement training included weight management intervention, drug and alcohol dependency intervention and smoking cessation.

At the trust premises we visited we saw a range of health promotion boards with health care related information displayed for patients to read and to take away.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we interviewed understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and other relevant national standards and guidance. However, the recorded training rates did not achieve the targets the trust had set itself.

Mental Capacity Act and Deprivation of Liberty training completion

2018/19

The trust set a target of 90% for completion of Mental Capacity Act training in 2018/19.

From April 2018 to June 2018 the trust reported that Mental Capacity Act Level 1 training had been completed by 76% of staff within community health services for adults.

A breakdown of compliance for Mental Capacity Act Level 1 training from April 2018 to June 2018

for all staff in community services for adults is shown below:

Staff Group	Staff trained	Eligible staff	Completion (%)	Target (%)	Target met (Yes/No)
Qualified Allied Health Professionals	240	284	85%	90%	No
Support to ST&T staff	42	52	81%	90%	No
Support to doctors and nursing staff	140	190	74%	90%	No
Qualified nursing & health visiting staff	197	271	73%	90%	No
Other Qualified Scientific, Therapeutic & Technical staff	28	43	65%	90%	No
Medical & Dental staff – Hospital	1	9	11%	90%	No
Public Health & Community Health Services	0	3	0%	90%	No
All staff groups	**648**	**852**	**76%**	**90%**	**No**

Since the data submitted the trust informed us they had met the target for Mental Capacity Act level 1 training in one of the seven staff groups in community services for adults; the qualified allied health professionals.

2017/18

The trust set a target of 85% for completion of Mental Capacity Act training in 2017/18.

From April 2017 to March 2018 the trust reported that Mental Capacity Act Level 1 training had been completed by 68% of staff within community health services for adults.

A breakdown of compliance for Mental Capacity Act Level 1 training from April 2017 to March 2018 for all staff in community services for adults is shown below:

Staff Group	Staff trained	Eligible staff	Completion (%)	Target (%)	Target met (Yes/No)
Qualified Allied Health Professionals	235	293	80%	85%	No
Support to ST&T staff	38	55	69%	85%	No
Support to doctors and nursing staff	123	190	65%	85%	No
Qualified nursing & health visiting staff	170	265	64%	85%	No
Other Qualified Scientific, Therapeutic & Technical staff	22	44	50%	85%	No
Medical & Dental staff – Hospital	1	10	10%	85%	No
Public Health & Community Health Services	0	3	0%	85%	No
All staff groups	**589**	**860**	**68%**	**85%**	**No**

The trust did not meet the target for Mental Capacity Act (MCA) level 1 training for any of the staff groups in community services for adults.

(Source: Universal Routine Provider Information Request - P38 Training)

Deprivation of Liberty Safeguards

From April 2017 to March 2018 the trust reported that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for community adult services.

(Source: Universal Routine Provider Information Request (RPIR) – P13 DoLS)

Staff used the electronic patient record system to record consent. The proforma care plan staff used to assess patients included a section to note that the patient had given consent to the care plan. Paper records kept at home had a record of consent given for the care plan. These care plans were adapted for patients with communication difficulties.

We accompanied community nurses on their visits and observed that staff requested patients to consent before they carried out treatment.

All the staff we spoke with demonstrated a good understanding of the Mental Capacity Act 2005, and of the standards underpinning the Deprivation of Liberty Safeguards (DoLS).

The trust's Mental Capacity Act and safeguarding training included training in DoLS. The trust reported they provided separate DoLS training in specialist areas where needed.

Is the service caring?

Compassionate care

Staff understood and respected the personal, cultural and social needs of people and took these into account in the way they delivered services. We observed that people were treated with kindness, dignity, respect and compassion, and were given emotional support.

We observed three patients in one clinic and saw that staff were sensitive and supportive towards them. Staff explained the treatment and answered questions fully and checked the understanding of the patient and their family. The privacy and dignity of the patients was respected.

At the pulmonary rehabilitation clinic at Bitterne health centre, nurses reassured and supported a patient who had severe anxiety about being part of the class. We also observed a new patient appointment. The nurse assessed the patient and took her time and provided reassurance. She was kind and helpful to the patient during the tests and explained everything fully to the patient and the patient's daughter. The patient told us how happy they were with the way their appointment had gone and the way staff at the health centre had treated them.

We accompanied staff on home visits. Staff we observed consistently demonstrated kindness and compassion for patients and those close to them. We observed a nurse taking time to explain the care plan to a patient as well as involving the patient's family. The patient was also experiencing pain. The nurse reassured the patient and helped with medication and a fresh dressing. At one home visit we saw how dignity was observed during an intimate examination of pressure areas.

Another patient told us they looked forward to the community nurses' visit and that they were always cheerful and very good with their care. The trust was proud to tell us examples of where staff demonstrated compassionate care. For example, Portsmouth community nursing distributed Christmas presents to vulnerable and socially isolated patients, which staff in the community nursing service funded themselves. We were also told about a community nurse who helped a socially isolated patient attend a church service and meal at Christmas.

The trust provided examples of where staff had supported patients compassionately. For example, they outlined how therapists had helped a patient with a neurological condition secure suitable housing and equipment to help their rehabilitation. They also said that staff went 'above and beyond' to ensure patients received their care during a period of heavy snow, working in their own time and putting the patients first. We were also told about a compliment given to a healthcare support worker who had reassured a nervous patient attending a bladder and bowel service appointment.

Emotional support

Staff understood the impact that a person's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially.

The patients we observed at home and in clinic were listened to by staff and given time to ask questions. Patients were treated as individuals.

Another patient we saw on a home visit who was being treated for a COPD condition declined intervention. This was discussed fully with the patient with respect and dignity and the consequences clearly explained. This was a sensitive discussion which was clearly understood by the nurse and by the patient.

At another home the patient's husband told us that the nurses had not only `worked wonders for my wife's legs, but also for her mood.'

Understanding and involvement of patients and those close to them

Staff demonstrated that they understood the individual needs of patients and their families and involved them in decisions about their care. Most of the patients we saw in clinic and at home had members of the family present and they were involved along with the patient in decisions about current and ongoing treatment. For each interaction we saw that patients were fully involved and understood their care and treatment plans.

All of the services we inspected were fully patient focused with due importance given to family involvement. Services and teams such as the community stroke team, the rehabilitation and reablement team and the case management team in Southampton provided a comprehensive multi-disciplinary approach to patient care and treatment.

The hydrotherapy staff helped support a tracheostomy patient, who was a patient in the nearby hospital, access a hydrotherapy session. We saw from the video taken that staff demonstrated excellent care and respected the views of the patient. The trust told us that the community nursing had been commended by a local acute hospital service for their abilities to support people to die at home, by enabling rapid, sometimes same-day, discharges.
Staff provided patients and their families with printed advice and guidance and support documents published by the trust or by other statutory or voluntary agencies.

Is the service responsive?

Planning and delivering services which meet people’s needs

The service worked well with other health and social care providers to meet the needs of people in their area, particularly those with long-term or life-limiting conditions.

We observed strong multidisciplinary team working across community, acute and social services which was focused on supporting the patient through their health and social care pathway. Services were planned across teams to improve the care pathway for people in the community. These teams consisted of staff from health and from social care, including community nurses, occupational therapists, care co-ordinators, care managers, physiotherapists, rehabilitation staff and consultants in older persons care.

The urgent response team in Southampton and the rehabilitation and reablement team in Portsmouth accepted referrals from all parts of the health sector, which included the private sector. They accepted referrals for any adult who could benefit from intervention to be able to stay at home. The response time for referrals was two hours or, in the case of an ambulance or GP referral it was one hour. Any referrals deemed unsafe for any reason would be considered for an alternative form of admission (or location if it was a social care issue). All unsafe referrals were reported as an incident.

Staff worked closely with GP practices to address the needs of patients with complex needs. At the bladder and bowel clinic at Lymington the service was accessed by a referral from a range of healthcare sources, including GP’s, consultants, specialist nurses and community teams.

The trust had an in-house interpreting and translation service providing translation for most languages as well as interpretation provision through face to face and telephone support. Support for rarer languages was provided by an external company. There was support for accessing sign language translators for patients with hearing loss.

The trust told us that 100% of translation request were fulfilled in the 12 months between April 2017 and March 2018. 85% of those requests were fulfilled by the in-house service. The most common language supported was Polish, with the least common languages being Somalian, Amharic, Korean and Japanese.

Meeting the needs of people in vulnerable circumstances

Services were delivered, made accessible and coordinated to take account of and meet the needs of different people, including those people in vulnerable circumstances.

Teams held regular multi-disciplinary meetings to assess their patients and identify patients at risk. For example, the Southampton Urgent Response Team conducted a virtual ward meeting every morning and on a Wednesday afternoon. These meetings were multi-disciplinary and included a geriatrician or a registrar. Patients that presented with specific risks, which included patients living with dementia, were assessed daily. Upon receipt of a referral the screening process included identifying the patient's loss of skills and memory. If a decision was made that the patient's needs were related to a suspected cognitive impairment then the patient was allocated to the appropriate professional. The trust informed us of their work for community service to provide frailty support in acute trusts.

On home visits we observed instances of district nurses directly raising issues of concern with the patient's GP.

The trust had adopted the Accessible Information Standard (AIS) and we were shown a training package for staff which explained clearly what the AIS was, and what they and the trust needed to do. This was available on the trust's intranet. Training on Accessible Information had been provided in staff forums and an AIS card could be issued to a patient if they had AIS needs and would like one.

The electronic patient record system had a field on it with a template to record peoples' AIS needs All staff were required to complete the AIS assessment and completion rates were audited. We were shown an audit from August 2018 which had returns from community nursing, case management, neurological community teams, a number of specialist teams, urgent response and the community independence team. The audit showed a 40% compliance rate where the template was fully completed. The actions flowing from the audit included ensuring that staff were fully aware of AIS and recording the patient's needs on the template. The audit was to be redone in the fourth quarter.

Patients with learning difficulties were provided with a `hospital passport` which was a personalised document that described the specific needs of the patient including communication, eating and drinking, pain, allergies and medication. The trust had learning disability acute liaison nurses available to support colleagues and patients.

Access to the right care at the right time

According to the information provided to us by the trust people did not have timely access to initial assessment, test results, diagnosis, and treatment. However, during the inspection various teams showed us that they were meeting their specific targets for referrals.

Accessibility

The trust provided the following information about the largest ethnic minority groups in the two main catchment areas covered by the trust.

Portsmouth City	Ethnic minority group	Percentage of catchment population
First largest	Asian	6.1%
Second largest	Other White	4.3%

Third largest	Mixed Ethnicity	2.7%

The largest ethnic minority group within the Portsmouth City catchment area was Asian with 6.1% of the population.

Southampton City	Ethnic minority group	Percentage of catchment population
First largest	Asian	8.4%
Second largest	Other White	8.3%
Third largest	Mixed Ethnicity	2.4%

The largest ethnic minority group within the Southampton City catchment area was Asian with 8.4% of the population.

(Source: Universal Routine Provider Information Request – P48 Accessibility)

Referrals – IN RPIR

The trust had identified the services in the table below as measured on 'referral to initial assessment'.

A list of services and referral times against the median within community services for adults are provided in the table below. The trust met the referral to assessment target in 26 of the 41 targets listed.

Name of hospital site or location	Name of in-patient ward or unit	Days from referral to initial assessment	
		National / Local Target (days)	Actual (median) (days)
Cheviot Road Surgery	449 ADS 403008 Cheviot Road DN Team	2	2
Shirley Health Centre	449 ADS 403009 Shirley Health Partnership DN Team	2	2
Weston Lane Surgery	449 ADS 403018 South Shore DN Team East	2	3
Bitterne Health Centre	449 ADS 403250 Community Diabetes Service Southampton	40	15
Victor Street Surgery	449 ADS 403010 Victor Street DN Team West	2	2
Lordshill Health Centre	449 ADS 403011 Lordshill DN Team West	2	3
Western Community Hosp	449 ADS 403012 Community Independence West	20	38

Name of hospital site or location	Name of in-patient ward or unit	Days from referral to initial assessment	
		National / Local Target (days)	Actual (median) (days)
Westwood House	449 ADS 403014 Community Independence East	20	31
Royal South Hants	449 ADS 403030 Southampton SLT	90	38
Western Community Hosp	449 ADS 403082 Snowdon at Home	1	1
Western Community Hosp	449 ADS 403084 Community Neuro Rehab Team	90	38
Western Community Hosp	449 ADS 403086 Community Stroke Team	3	4
Bitterne Health Centre	449 ADS 403264 COPD	90	1
Royal South Hants	449 ADS 403020 Central DN Team	2	2
Westwood House	449 ADS 403022 Admiral Nursing	5	6
Adelaide Health Centre	449 ADS 403034 Tissue Viability	20	13
Bitterne Health Centre	449 ADS 403040 Bladder and Bowel West	30	63
Bitterne Health Centre	449 ADS 403044 Stoma Care	2	N/A
St James Hospital	449 ADS 403090 Community Neuro Service	10	36
Royal South Hants	449 ADS 403016 Community Independence Central	20	55
Rapid Response Team	449 ADS 403024 Urgent Response Team	1	1
St Marys Hospital	449 ADS 403042 Bladder and Bowel East	30	28
Queen Alexandra Hospital	449 ADS 403092 Neuropsychology	40	36
Bitterne Health Centre	449 ADS 403260 Cardiac Nurse Service	40	32
Adelaide Health Centre	Southampton Physiotherapy	42	25
Adelaide Health Centre	IMATs	28	24
St Mary's Hospital	Portsmouth Physiotherapy	28	20
Queen Alexandra Hospital	Portsmouth Specialist Physiotherapy (CPS)	10	18
Adelaide Health Centre	Pain Service	126	56
Gosport War Memorial	Specialist MSK Service (SMSK)	10	22
Stoneham Centre	Rheumatology	42	66

Name of hospital site or location	Name of in-patient ward or unit	Days from referral to initial assessment	
		National / Local Target (days)	Actual (median) (days)
Adelaide Health Centre	Podiatry	56	37
St James Hospital	449 ADP 403116 PRRT IC Rapid Response Team	1	1
St Marys Hospital	449 ADP 403120 DN Out of Hours Service	3	3
Millbrook Healthcare Ports. (Railway Triangle)	449 ADP 403124 Clinical Advisory Team CAT	1	9
Medina House - Cosham	449 ADP 403110 Portsmouth North Locality	3	2
Civic Centre Portsmouth	449 ADP 403112 Portsmouth Central Locality	3	3
Civic Centre Portsmouth	449 ADP 403114 Portsmouth South Locality	3	7
St James Hospital	449 ADP 403122 Heart Failure	10	1
St James Hospital	449 ADP 403182 Comm Oxy/Lead Respiratory	10	6
St James Hospital	449 ADP 403186 Pulmonary Rehab	126	40

The trust provided information that indicated that the data-collection systems did not capture referral to treatment times accurately. For example, the community neuro service showed a 36 day wait, and the trust said this measure included patients who had already seen a clinician and were waiting for a further referral. The trust stated the data for community independence teams was of poor quality since staff did not always capture the date of first contacts.

The trust had identified the services in the table below as measured on ‘assessment to treatment’.

A list of services and assessment to treatment times against the median within community services for adults are provided in the table below. The trust met the assessment to treatment target in two of the 38 targets listed.

Name of hospital site or location	Name of in-patient ward or unit	Days from assessment to treatment	
		National / Local Target (days)	Actual (median) (days)
Cheviot Road Surgery	449 ADS 403008 Cheviot Road DN Team	0	3
Shirley Health Centre	449 ADS 403009 Shirley Health Partnership DN Team	0	2
Weston Lane Surgery	449 ADS 403018 South Shore DN Team East	0	4

Name of hospital site or location	Name of in-patient ward or unit	Days from assessment to treatment	
		National / Local Target (days)	Actual (median) (days)
Bitterne Health Centre	449 ADS 403250 Community Diabetes Service Southampton	0	18
Victor Street Surgery	449 ADS 403010 Victor Street DN Team West	0	3
Lordshill Health Centre	449 ADS 403011 Lordshill DN Team West	0	4
Western Community Hosp	449 ADS 403012 Community Independence West	0	7
Westwood House	449 ADS 403014 Community Independence East	0	7
Royal South Hants	449 ADS 403030 Southampton SLT	0	9
Western Community Hosp	449 ADS 403082 Snowdon at Home	0	1
Western Community Hosp	449 ADS 403084 Community Neuro Rehab Team	0	10
Western Community Hosp	449 ADS 403086 Community Stroke Team	0	1
Bitterne Health Centre	449 ADS 403264 COPD	0	3
Royal South Hants	449 ADS 403020 Central DN Team	0	3
Westwood House	449 ADS 403022 Admiral Nursing	0	15
Adelaide Health Centre	449 ADS 403034 Tissue Viability	0	8
Bitterne Health Centre	449 ADS 403040 Bladder and Bowel West	0	65
Bitterne Health Centre	449 ADS 403044 Stoma Care	0	3
St James Hospital	449 ADS 403090 Community Neuro Service	0	11
Royal South Hants	449 ADS 403016 Community Independence Central	0	18
Rapid Response Team	449 ADS 403024 Urgent Response Team	0	1
St Marys Hospital	449 ADS 403042 Bladder and Bowel East	0	49
Queen Alexandra Hospital	449 ADS 403092 Neuropsychology	0	14
Bitterne Health Centre	449 ADS 403260 Cardiac Nurse Service	0	14
Gosport War Memorial	Specialist MSK Service (SMSK)	28	0

Name of hospital site or location	Name of in-patient ward or unit	Days from assessment to treatment	
		National / Local Target (days)	Actual (median) (days)
St James Hospital	449 ADP 403116 PRRT IC Rapid Response Team	1	1
St Marys Hospital	449 ADP 403120 DN Out of Hours Service	0	3
Millbrook Healthcare Ports. (Railway Triangle)	449 ADP 403124 Clinical Advisory Team CAT	3	21
Medina House - Cosham	449 ADP 403110 Portsmouth North Locality	0	3
Civic Centre Portsmouth	449 ADP 403112 Portsmouth Central Locality	0	4
Civic Centre Portsmouth	449 ADP 403114 Portsmouth South Locality	0	4
Queen Alexander Hospital	449 ADP 403118 Frailty Interface Team (FIT)	0	11
St James Hospital	449 ADP 403122 Heart Failure	0	9
St James Hospital	449 ADP 403182 Comm Oxy/Lead Respiratory	0	18
St James Hospital	449 ADP 403186 Pulmonary Rehab	0	18
St Marys Hospital	449 ADP 403252 Community Diabetes Services Portsmouth	0	-
St Marys Hospital	449 ADP 404150 Medicines Management Team	0	7
Civic Centre Portsmouth	449 ADP 403108 Care Home Team	0	14

(Source: CHS Routine Provider Information Request – CHS10 Referrals)

Referrals were accepted from all parts of the local health sector, including any clinician in the community or acute trust, social services and the local ambulance service. The referral was uploaded onto the trust's electronic patient record system and the relevant team triaged the patient.

There were referral to treatment targets across the services. For example, podiatry had a target of 95% to see patients with an active ulcer within 48 hours of referral (in accordance with NICE guidance). Their performance (at the time of the inspection) was 96%.

The clinical advisory team received daily requests for specialist equipment for patients, and referred to the appropriate specialist. Should the assessment require a visit from a clinical specialist the target was three working days from the referral. The team were achieving a 100% attendance rate of within one working day.

The case management team's role was to manage the more complex frequent users of services. These were principally patients who were frail with complex conditions and co-morbidities who required a range of services which included acute, GP and community. Accordingly, there were

multiple referral pathways. The case management team used a risk stratification tool to score the patient prior to referral; although, they also used clinical judgement. Having referred the patient to a service the aim was for them to be seen within four weeks, however at the time of the inspection there was a seven to eight week wait.

Learning from complaints and concerns

Complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

From April 2017 to March 2018 there were 70 complaints about community services for adults. The trust took an average of 29 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be dealt with within 30 working days.

A summary of complaints within community services for adults by subject is below:

Community Adults Total

Subject	Number of complaints
Patient Care	26
Integrated care (including delayed discharge due to absence of care package)	13
Communications	10
Appointments	6
Values & behaviours (staff)	5
Access to treatment or drugs	2
Other (specify in comments)	2
Admin/policies/procedures (including patient record)	1
End of life care	1
Privacy, dignity & well being	1
Staff numbers	1
Transport (ambulances)	1
Waiting times	1
Total	**70**

(Source: Universal Routine Provider Information Request (RPIR) – P52 Complaints)

Complaints and feedback from patients were discussed at the Assurance & Governance group meetings. Outcomes or actions were addressed by the appropriate team.

All of the staff we spoke with were familiar with the duty of candour process. One example was from the tissue viability team where a patient developed a pressure sore while in their care. The issue

was investigated and the reasons explained to the patient together with an apology and a revised care plan.

Compliments

From April 2017 to March 2018, the trust received 830 compliments. Of these, 458 related to community services for adults, which accounted for 55.2% of all compliments received by the trust.

(Source: Universal Routine Provider Information Request (RPIR) – P53 Compliments)

Community services for adults had very few complaints, and of those received just over a third related to patient care. Conversely, the service received many compliments in the form of cards and notes.

We observed questionnaires and patient satisfaction surveys in the clinics we visited and with patients at home. The patient record index, which was on the front of the patient 'at home' notes folder, had a patient survey indexed and enclosed. Staff were encouraged to ask patients to complete these. Staff were aware of the patient complaints process.

Snowden @ Home had held a Have Your Say event to which seven past patients and carers attended. This was a 'You Said, We Did' feedback session. Lessons from the event were shared across the team.

Is the service well-led?

Leadership

The trust had managers at all levels within community adults with the right skills and knowledge to provide a service delivering high-quality care.

All staff we spoke with knew who their managers were and told us they felt well supported. There was a clear leadership structure from operations managers and clinical leads to band 7 and band 6 nursing and team leads.

Community nurse Band 7's told us of a project to raise awareness within community adults of the leadership teams. The induction programme for all new staff had been updated to include a professional leadership page which introduced all of the senior team and their backgrounds. Senior staff also regularly attended all meetings for all bands of staff to improve visibility.

The trust had a leadership development programme, developed following staff feedback to support succession planning for Band 7 nurses. A Band 7 member of staff told us that they were part of this leadership programme, which was a 10-week course, funded by the trust and delivered away from clinical practice. Twelve community Band 6s had been on the programme and four had secured Band 7 positions.

Staff we interviewed spoke positively about their leaders and told us they were visible and approachable. Staff were positive about monthly governance meetings and the clinical supervision they received from their managers. Staff told us how much they enjoyed working in their teams.

Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The trust had a corporate strategy and a shared vision which was to deliver: `great care, be a great place to work and offer great value for money'. The trust envisioned the delivery of this vision by working to keep more people healthy, safe and independent in, or close to, their own home.

The trust had involved staff in developing shared values to support the delivery of the vision and strategy. These were referred to as the HEART values: an initialism for honesty, everyone counts, accountable, respectful and teamwork.

Staff we spoke with were aware of the trust values and how they underpinned the work in providing community services for adults. These values were visible on documents and bulletins within community adults, for example, on assurance and governance meeting minutes. Community adults were working on a strategy for community engagement which they recognised as being essential to the trust's shared vision. Staff who delivered the service were fully engaged with other services in delivering joined-up care to the patient. One team we spoke with told us their work was integrated and that "they work closely across the trust with colleagues".

In Portsmouth they were developing a fully integrated approach as a multi-speciality community provider. At the time of the inspection this was in early stages of development and only subject to a memorandum of understanding.

Culture

The culture within the trust focused on the needs and experience of patients and staff. Staff felt supported, respected and valued.

The culture was centred on the needs and experience of people who used the services, and placed "patients at the heart of the trust", as outlined in the vision and values.

Staff overwhelmingly felt positive and proud to work in the organisation. A tissue viability nurse told us they were "proud to be part of the service". Another therapist from the community stroke team told us how proud they were of their team and how everyone in the trust supported each other and focused on the patient.

The culture encouraged openness and honesty. Staff told us that the regular clinical supervision sessions were pivotal for issues and concerns to be raised and for colleagues to share learning from those discussions.

Staff told us they had opportunities for the development they needed. We were told by a range of staff about regular clinical supervision, either in a team or on a 1:1 basis.

The trust had implemented a continuous professional development support programme involving in-house and higher education institutions to improve staff skills. The trust provided a monthly clinical skills program for community staff (bands 3-7) and used Portsmouth university's clinical skills facility to support role play and training.

There was a strong emphasis on the safety and well-being of staff. The trust had an up-to-date lone workers policy on the intranet which set out the responsibilities of managers and of staff including the process of risk assessments. Staff told us they felt safe when they went out. Staff had personal alarm devices which were connected to the internet via mobile phone and satellite which gave a precise GPS location. Staff were also required to call in if they were not able to attend the daily midday safety meeting.

At one team meeting there was discussion about people loitering outside the premises which caused some staff members to feel unsafe. The manager reminded staff that when they left the building at end of work they must be with a colleague and wear their personal alarm devices. There was also discussion about the CCTV cameras and the manager said they would contact the council to get extra `you are being watched` CCTV signage put up.

The trust had a current Equality, Diversity and Human Rights policy which was available to staff on the intranet. Diversity and equality training was part of mandatory training and staff we spoke with were fully aware of the policy.

There were numerous examples of staff and teams working collaboratively across the trust and with other health care and social care organisations, as well as engagement with the public. One example was tissue viability who provided an advice line every afternoon for nursing homes, district nurses and practice nurse in both the private and public sectors.

Governance

There were effective structures, processes and systems of accountability to support the delivery of good quality services.

Although there were a range of different titles within the organisational structures for Southampton and Portsmouth there was a clear line of command and governance arrangements in place. All staff we spoke to were clear about who they were accountable to.

There were regular management meetings at all levels where staff escalated concerns and issues and where information and learning could be disseminated. We reviewed three sets of divisional assurance and governance meeting minutes which showed that topics discussed included incidents, risks and complaints as well as service lines and issues such as medicines management.

Management of risk, issues and performance

There were robust arrangements for identifying, managing and reviewing risks.

Southampton community adults risk register had eight open risks, none of them were rated higher than amber with a risk scoring of 12. Managers across adult community services told us what their local risks were. Most staff were aware of what the risks were for their service. We attended a team governance meeting which discussed risks and future risks, such as estate plans for their premises to move. An example of a local active risk was confusing information over the dosage of a corticosteroid medication. This had been identified, staff were made aware and informed to double check prescriptions and doses, and the information had been escalated to the medicines management meeting.

The trust had a winter resilience and cold weather plan already prepared for the forthcoming winter, and there were local operational versions for Southampton and Portsmouth. For the Portsmouth rehabilitation and reablement team there were plans, costed and agreed, to buy in six additional nursing staff, an additional 600 hours agency staff, and 4x4 vehicle hire.

Information management

The trust published monthly performance overview reports for community adults in both Southampton and Portsmouth. These reports covered a range of performance indicators including serious incidents, pressure ulcers, waiting times for patients, and responses from the family and friends test. This information was cascaded down through the meeting structure, such as assurance and governance meetings

Adult community services had comprehensive information technology systems and software which was used effectively to monitor and improve the quality of care, including the electronic patient records system. Managers or staff could show us information relating to appraisals and mandatory training, individual performance, staffing levels, patient waiting lists, team performance data, quality outcomes and so forth.

Engagement

People’s views and experiences were gathered and acted on.

The trust had a patient experience strategy for 2015 to 2018, “Ensuring patients are at the forefront of all we do”. This included four priority work streams for improving patient experience:

- Compassionate care
- Effective communication and to be listened to
- Being treated as an individual and being involved in their care
- Feeling safe in our care

Flowing from these work streams were a range of objectives to deliver the improvements in patient experience.

Staff were actively engaged with their managers and their views were reflected in the planning and delivery of services and in shaping the culture. All staff within adult services Southampton participated in a monthly staff survey, with an 80% to 100% return rate. This information alerted managers to the prevailing morale of staff and to any issues that needed addressing to improve the delivery of services. We were shown an action plan for community adults in Southampton which was developed from feedback by staff. The action plan was a workstream which ran over nine months intended to address issues of workload, local leadership, training, and patient safety.

The trust engaged well with patients, staff, the public and local organisations to plan and manage services. There were a range of positive and collaborative relationships with external partners to meet the needs of the population. Most of the teams we spoke with had collaborative partnerships with local GP services, local acute services, social services, council services, community organisations and private sector providers. In Portsmouth the overall strategy was to move the organisation to becoming a multi-speciality community provider.

Staff engaged with patients and carers and used feedback to improve services. We saw information displayed on actions taken in response to patient feedback using the `You said, we did` approach.

Learning, continuous improvement and innovation

Accreditations

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The trust did not provide information for any accreditation schemes relating to community services for adults.

(Source: Universal Routine Provider Information Request (RPIR) – P66 Accreditations)

The trust had participated in 31 clinical audits in relation to this core service as part of their Clinical Audit Programme.

The trust had an academy of research & improvement which integrated programmes of research, quality improvement, clinical effectiveness, innovation and patient involvement. The academy had a number of collaborations with local universities and had a clinical academic pathway supporting joint posts across organisations. The quality improvement training programme had trained over 200

staff and patients in improvement methods and hands on project delivery. The academy co-ordinated and monitored the trust's annual audit & evaluation plan.

The trust provided a range of examples of where staff had led local quality improvement programmes to improve care for patients. These included a programme to discharge inpatients in a safe and timely way and one to assess and implement better communication approaches on a ward.

The academy also ran a 'Dragon's Den' programme to give small scale funding to teams for innovation. There were over 20 projects underway at the time of the inspection.

A nurse in tissue viability told us how they had bid for a toe doppler in the last round and had been successful. This improved patient care as patients did not have to attend an acute hospital and could start therapy approximately six weeks earlier than they would have done.

Staff participated in internal and external reviews and brought the learning from those reviews back in to the trust. A member of staff from podiatry was involved in developing the World Health Organisation (WHO) report on Deprivation of Liberty Standards. The learning from that experience was brought back in to the trust to help improve awareness of the needs of patients.

Staff regularly took time out to work together to resolve problems and to review individual and team objectives, processes and performance at the monthly assurance & governance meeting and at team `huddles'.

Community health services for children, young people and families

Facts and data about this service:

Solent NHS trust provides a range of community based services to children, young people and families in the Portsmouth, Southampton and Hampshire areas. Care is provided in a variety of settings including schools, health clinics and home visits. Services provided include health visiting, school nursing, special school nursing, community children's nursing, children's continuing care nursing, community paediatricians, occupational therapy, physiotherapy, podiatry, orthotics, speech and language therapy, child protection nursing and medical services and Looked after Children nurses.

During the inspection we visited

- Adelaide Health Centre, Southampton.
- Civic Centre, Portsmouth.
- Battenburg Health Centre, Portsmouth.
- Child Development Centre, Horizons, Southampton.
- Thornhill Centre for Healthy Living, Southampton.
- Aldershot Medical Centre, Aldershot.
- Mary Rose School, Portsmouth.
- Cedar School, Southampton.
- Rosewood School, Southampton.
- Freemantle C of E Community Academy, Southampton.
- Somerstown Family Hub, Portsmouth.
- Family Point Sholing, Southampton.

The inspection was carried out because the children, young people and families service was rated as requires improvement at the previous comprehensive inspection in 2016. A focused inspection in 2017 judged that improvements had been made in the safe domain, which resulted in the rating changing from inadequate to requires improvement in that domain. The other domains (effective, caring, responsive and well led) were not inspected in 2017. At this current inspection we inspected all domains for this service. Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to were available.

Before carrying out the inspection, we reviewed a range of information submitted by the trust prior to the inspection. We carried out an announced inspection over three days between 9 – 11 October 2018. A further provider level well led inspection was carried out on 6 – 8 November 2018. During the inspection we spoke with 76 staff including community nurses, doctors, physiotherapists, speech and language therapists, occupational therapists, community matrons, administrators, specialist nurses and managers.

We accompanied staff on home visits, attended team meetings and handovers, observed clinics and staff interactions with patients. We viewed 10 sets of patient records and spoke with or interacted with 12 children or young people and 16 relatives.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff but could not evidence they made sure everyone completed it.

2018/19

The trust set target of 90% for completion of statutory & mandatory training in 2018/19. Compliance with this target was set and monitored for different staff groups. At the end of September 2018, the 90% target was met in 8 of 10 staff groups (not including bank staff). Information Governance (IG) was reset to zero at the start of April and carried a separate target of 95%, which was not due to be met until 31 March 2019.
Prior ot the inspection the trust provided data for mandatory training for the period April 2018 to June 2018. A breakdown of compliance for mandatory training courses for this period for qualified nursing staff in community health services for children, young people and families is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children (Level 4)	1	1	100%	90%	Yes
Non Clinical Resuscitation	258	262	98%	90%	Yes
Equality and Diversity	250	262	95%	90%	Yes
Moving and Handling	250	262	95%	90%	Yes
Safeguarding Children (Level 1)	243	262	93%	90%	Yes
Infection Prevention (Level 1)	238	262	91%	90%	Yes
Duty of Candour	237	262	90%	90%	Yes
Health and Safety (Slips, Trips and Falls)	227	262	87%	90%	No
Dementia Awareness (including Privacy & Dignity standards)	222	262	85%	90%	No
Safeguarding Children (Level 3)	190	225	84%	90%	No
Prevent Awareness	222	263	84%	90%	No
Fire Safety 2 years	221	262	84%	90%	No
Safeguarding Adults (Level 1)	221	262	84%	90%	No
Safeguarding Children (Level 2)	378	469	81%	90%	No
Hand Hygiene	164	244	67%	90%	No
Medicine management training	157	241	65%	90%	No
Mental Capacity Act Level 1	167	261	64%	90%	No

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Information Governance	143	262	55%	90%	No
Deteriorating and Resuscitation Training - Paediatric	58	112	52%	90%	No
Infection Prevention (Level 2)	100	244	41%	90%	No
Deteriorating and Resuscitation Training - Adults	2	6	33%	90%	No

In community health services for children, young people and families the 90% target was met for seven of the 21 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to June 2018 for medical staff in community health services for children, young people and families is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children (Level 4)	2	2	100%	90%	Yes
Equality and Diversity	26	32	81%	90%	No
Safeguarding Children (Level 1)	26	32	81%	90%	No
Fire Safety 2 years	25	32	78%	90%	No
Health and Safety (Slips, Trips and Falls)	25	32	78%	90%	No
Safeguarding Adults (Level 1)	25	32	78%	90%	No
Safeguarding Children (Level 2)	49	64	77%	90%	No
Duty of Candour	24	32	75%	90%	No
Infection Prevention (Level 1)	23	32	72%	90%	No
Dementia Awareness (including Privacy & Dignity standards)	22	32	69%	90%	No
Non Clinical Resuscitation	22	32	69%	90%	No
Prevent Awareness	22	32	69%	90%	No
Moving and Handling	21	32	66%	90%	No
Infection Prevention (Level 2)	20	32	63%	90%	No
Safeguarding Children (Level 3)	20	32	63%	90%	No
Mental Capacity Act Level 1	18	32	56%	90%	No

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Hand Hygiene	16	32	50%	90%	No
Medicine management training	14	28	50%	90%	No
Deteriorating and Resuscitation Training - Paediatric	10	28	36%	90%	No
Information Governance	7	32	22%	90%	No

In community health services for children, young people and families the 90% target was met for one of the 20 mandatory training modules for which medical staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to June 2018 for qualified allied health professionals in community health services for children, young people and families is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Non Clinical Resuscitation	180	182	99%	90%	Yes
Prevent Awareness	173	182	95%	90%	Yes
Moving and Handling	168	182	92%	90%	Yes
Infection Prevention (Level 1)	167	182	92%	90%	Yes
Equality and Diversity	166	182	91%	90%	Yes
Duty of Candour	164	182	90%	90%	Yes
Dementia Awareness (including Privacy & Dignity standards)	161	182	88%	90%	No
Health and Safety (Slips, Trips and Falls)	161	182	88%	90%	No
Fire Safety 2 years	147	182	81%	90%	No
Mental Capacity Act Level 1	145	182	80%	90%	No
Medicine management training	76	102	75%	90%	No
Hand Hygiene	130	182	71%	90%	No
Information Governance	123	182	68%	90%	No
Deteriorating and Resuscitation Training - Paediatric	115	173	66%	90%	No
Deteriorating and Resuscitation Training - Adults	1	2	50%	90%	No
Infection Prevention (Level 2)	91	182	50%	90%	No

In community health services for children, young people and families the 90% target was met for six of the 16 mandatory training modules for which qualified allied health professionals were eligible.

2017/18

The trust set a target of 85% for completion of mandatory training in 2017/18.

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for qualified nursing staff in community health services for children, young people and families is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children (Level 4)	1	1	100%	85%	Yes
Non Clinical Resuscitation	246	250	98%	85%	Yes
Equality and Diversity	240	250	96%	85%	Yes
Information Governance	236	250	94%	85%	Yes
Safeguarding Children (Level 1)	231	250	92%	85%	Yes
Moving and Handling	229	250	92%	85%	Yes
Infection Prevention (Level 1)	220	250	88%	85%	Yes
Duty of Candour	216	250	86%	85%	Yes
Health and Safety (Slips, Trips and Falls)	214	250	86%	85%	Yes
Fire Safety 2 years	206	250	82%	85%	No
Safeguarding Children (Level 3)	185	226	82%	85%	No
Prevent Awareness	203	250	81%	85%	No
Dementia Awareness (including Privacy & Dignity standards)	202	250	81%	85%	No
Safeguarding Adults (Level 1)	201	250	80%	85%	No
Safeguarding Children (Level 2)	353	463	76%	85%	No
Deteriorating and Resuscitation Training - Paediatric	138	239	58%	85%	No
Mental Capacity Act Level 1	141	250	56%	85%	No
Hand Hygiene	130	246	53%	85%	No
Infection Prevention (Level 2)	121	246	49%	85%	No

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Medicine management training	116	250	46%	85%	No

In community health services for children, young people and families the 85% target was met for nine of the 20 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for medical staff in community health services for children, young people and families is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children (Level 4)	2	2	100%	85%	Yes
Information Governance	30	33	91%	85%	Yes
Fire Safety 2 years	29	33	88%	85%	Yes
Health and Safety (Slips, Trips and Falls)	29	33	88%	85%	Yes
Equality and Diversity	28	33	85%	85%	Yes
Safeguarding Adults (Level 1)	27	33	82%	85%	No
Safeguarding Children (Level 1)	27	33	82%	85%	No
Moving and Handling	26	33	79%	85%	No
Safeguarding Children (Level 2)	49	64	77%	85%	No
Dementia Awareness (including Privacy & Dignity standards)	25	33	76%	85%	No
Infection Prevention (Level 1)	25	33	76%	85%	No
Non Clinical Resuscitation	25	33	76%	85%	No
Duty of Candour	24	33	73%	85%	No
Prevent Awareness	23	33	70%	85%	No
Safeguarding Children (Level 3)	21	32	66%	85%	No
Infection Prevention (Level 2)	20	33	61%	85%	No
Mental Capacity Act Level 1	16	33	48%	85%	No
Deteriorating and Resuscitation Training - Paediatric	14	33	42%	85%	No
Medicine management training	10	33	30%	85%	No

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Hand Hygiene	8	33	24%	85%	No

In community health services for children, young people and families the 85% target was met for five of the 20 mandatory training modules for which medical staff were eligible.

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for qualified allied health professionals in community health services for children, young people and families is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Deteriorating and Resuscitation Training - Adults	1	1	100%	85%	Yes
Non Clinical Resuscitation	177	179	99%	85%	Yes
Information Governance	175	179	98%	85%	Yes
Prevent Awareness	169	179	94%	85%	Yes
Equality and Diversity	166	179	93%	85%	Yes
Moving and Handling	165	179	92%	85%	Yes
Infection Prevention (Level 1)	160	179	89%	85%	Yes
Duty of Candour	159	179	89%	85%	Yes
Health and Safety (Slips, Trips and Falls)	159	179	89%	85%	Yes
Dementia Awareness (including Privacy & Dignity standards)	158	179	88%	85%	Yes
Fire Safety 2 years	147	179	82%	85%	No
Mental Capacity Act Level 1	129	179	72%	85%	No
Deteriorating and Resuscitation Training - Paediatric	125	174	72%	85%	No
Medicine management training	71	99	72%	85%	No
Hand Hygiene	112	179	63%	85%	No
Infection Prevention (Level 2)	78	179	44%	85%	No

In community health services for children, young people and families the 85% target was met for ten of the 16 mandatory training modules for which qualified allied health professionals were eligible.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)

The above data was provided by the trust in July 2018, the information provided showed that in the year period 1 April 2017 to 31 March 2018 nursing staff had met the trusts target of 85% for completion of mandatory training for nine of 20 required subjects. For the same period, allied health professional staff had met the target for 10 out of 16 required subjects and medical staff had met the trust's target for five of 20 required subjects.

The trust increased the target for completion of mandatory training to 90% for the year period 1 April 2018 to 31 March 2019. The information provided in July 2018 showed that between 1 April 2018 and 30 June 2018 nursing staff had met the 90% target for seven of 21 subjects, allied health professionals had met the target for six out of 16 required subjects, but medical staff had only met the target for one out of 20 required subjects.

At the time of inspection mandatory training completion rates, as described by staff, ranged between 85% to 100% indicating compliance with mandatory training had improved since the submission of the above information. Staff accessed mandatory training through an electronic system and most staff had sufficient time in their work load to complete mandatory training.

Following the inspection, the trust provided information that detailed on 30 September 2018, 90% of all staff across the whole trust had completed their annual mandatory training. Although the current mandatory training data showed an increase in completion of training from the previous business year, as the trust refreshed training completion data each new business year it was not clear if those staff missing training in each year had timely completion in the year after.

Systems for recording mandatory training were not always reliable. Some staff said that accurate recording of completed mandatory training was challenging. Although they completed training, the electronic systems did not always record the training that had been completed. This meant there was not full assurance statistics about mandatory training trust wide were accurate. Staff kept individual records, so they could demonstrate their compliance with mandatory training.

Some staff had difficulty locating and accessing mandatory training courses on the trust's electronic system. They said that although it was easy to find the page that listed the required mandatory training, finding the specific training package on the system was often challenging and time consuming.

The trust was aware of these two issues. They were included on the trust wide risk register which included actions the trust was taking to lessen the risk.

To support staff to identify sepsis in children and young people the mandatory training topic "Deteriorating and Resuscitation Training – Paediatric" included identification and management of sepsis.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff completed children's safeguarding training that was relevant to their role.

Safeguarding Training completion

Trust wide

2018/19

The trust set a target of 90% for completion of safeguarding training in 2018/19.

A breakdown of compliance for safeguarding training courses from April 2018 to June 2018 for

qualified nursing staff in community health services for children, young people and families is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children (Level 4)	1	1	100%	90%	Yes
Safeguarding Children (Level 1)	243	262	93%	90%	Yes
Safeguarding Children (Level 3)	190	225	84%	90%	No
Safeguarding Adults (Level 1)	221	262	84%	90%	No
Safeguarding Children (Level 2)	378	469	81%	90%	No

In community health services for children, young people and families the 90% target was met for two of the five safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding courses from April 2018 to June 2018 for medical staff in community health services for children, young people and families is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children (Level 4)	2	2	100%	90%	Yes
Safeguarding Children (Level 1)	26	32	81%	90%	No
Safeguarding Adults (Level 1)	25	32	78%	90%	No
Safeguarding Children (Level 2)	49	64	77%	90%	No
Safeguarding Children (Level 3)	20	32	63%	90%	No

In community health services for children, young people and families the 90% target was met for one of the five safeguarding training modules for which medical staff were eligible

A breakdown of compliance for safeguarding training courses from April 2018 to June 2018 for qualified allied health professionals in community health services for children, young people and families is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children (Level 1)	174	182	96%	90%	Yes
Safeguarding Children (Level 3)	162	176	92%	90%	Yes
Safeguarding Adults (Level 1)	165	182	91%	90%	Yes
Safeguarding Children (Level 2)	322	356	90%	90%	Yes

In community health services for children, young people and families the 90% target was met for all four of the safeguarding training modules for which qualified allied health professionals were eligible.

2017/18

The trust set a target of 85% for completion of safeguarding training in 2017/18.

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for qualified nursing staff in community health services for children, young people and families is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children (Level 4)	1	1	100%	85%	Yes
Safeguarding Children (Level 1)	231	250	92%	85%	Yes
Safeguarding Children (Level 3)	185	226	82%	85%	No
Safeguarding Adults (Level 1)	201	250	80%	85%	No
Safeguarding Children (Level 2)	353	463	76%	85%	No

In community health services for children, young people and families the 85% target was met for two of the five safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding courses from April 2017 to March 2018 for medical staff in community health services for children, young people and families is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children (Level 4)	2	2	100%	85%	Yes
Safeguarding Adults (Level 1)	27	33	82%	85%	No
Safeguarding Children (Level 1)	27	33	82%	85%	No
Safeguarding Children (Level 2)	49	64	77%	85%	No
Safeguarding Children (Level 3)	21	32	66%	85%	No

In community health services for children, young people and families the 85% target was met for one of the five safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for qualified allied health professionals in community health services for children, young people and families is shown below:

Name of course	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children (Level 1)	175	179	98%	85%	Yes
Safeguarding Children (Level 3)	163	173	94%	85%	Yes
Safeguarding Children (Level 2)	314	348	90%	85%	Yes
Safeguarding Adults (Level 1)	160	179	89%	85%	Yes

In community health services for children, young people and families the 85% target was met for all four of the safeguarding training modules for which qualified allied health professionals staff were eligible.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)

The trust wide risk register had identified that compliance with safeguarding training did not meet the standards described in the "Safeguarding children and young people: roles and competences for health care staff intercollegiate document, third edition March 2014." There was no clear action detailed in the risk register, and the last review of this risk in July 2018 detailed "the work to improve this position continues and it is hoped to see significant improvement by the end of Q2."

Information about staff training was provided by the trust in July 2018. All staff we spoke with said they were safeguarding children level 3 trained, indicating an improvement in the uptake for safeguarding children's level 3 training. Staff had a good understanding about safeguarding procedures. They gave examples where they had identified safeguarding concerns and appropriately alerted the local safeguarding authorities. Data provided by the trust following the inspection showed some improvements with meeting the safeguarding training targets.

At the previous inspection of the safe domain in 2017, it was identified that the service did not ensure all staff were trained to the appropriate safeguarding children's level for the job role they carried. We told the service they should ensure all staff were trained to the appropriate level for safeguarding children.

At the inspection of the children, young people and families service on 9 to 11 October 2018 we were not fully assured the service had fully considered the roles of all staff in relation to the level of children's safeguarding training they needed. We were not assured the service had fully considered the "Safeguarding children and young people: roles and competences for health care staff intercollegiate document, third edition March 2014" document.

The head of safeguarding who had commenced at the trust just a week before the inspection informed us that the current training position was being mapped against the recently published intercollegiate guidance for adult safeguarding and the same process will be followed when the updated guidance for children's safeguarding are published.

Following the inspection, we reviewed the job descriptions for both the head of children's safeguarding and the named nurse of children's safeguarding. The job descriptions indicated that both members of staff required children's safeguarding level 4 training to meet the national guidance in the 'intercollegiate document'.

At the well led inspection on 6 and 7 November 2018 the trust provided information that gave us assurance the service had fully considered staff training requirements against the intercollegiate document. For safeguarding children level 4 the service identified seven members of staff who needed this level of training. This was an increase of four members of staff from the information provided prior to the inspection. The service provided detail about the children's safeguarding level 4 training these members of staff had completed and future training they were booked to attend.

Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority had their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern was raised regarding a child or vulnerable adult, the organisation would work to ensure the safety of the person and an assessment of the concerns would also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Community health services for children, young people and families made 1,757 safeguarding referrals from 1 July 2017 to 1 June 2018, all of which concerned children.

(Source: Universal Routine Provider Information Request (RPIR) – P11 Safeguarding)

The trust had a safeguarding team that was headed by the newly appointed head of safeguarding for adults and children. There was a named nurse for children's safeguarding with a new internal interim appointment since September 2018. There were five whole time equivalent children's safeguarding nurses. However, staff said the safeguarding teams was less visible than previously and staff had limited knowledge of who the head of safeguarding or the named nurse for children's safeguarding was.

The National Health visiting service specification 2014/2015 states that health visitors (HVs) must receive a minimum of three monthly safeguarding supervisions of their work with their most vulnerable babies and children. These should include children on child protection plans, Looked after Children and children not in residential care and those for whom the health visitor had a high level of concern. Both health visitors and school nurses that we spoke with said they received group safeguarding supervision every six to eight weeks, this met the service specification.

Processes were followed to ensure staff were made aware if a child was on a child protection plan, was a Looked after Child or if there was a risk in the home. This included a flag system on the electronic notes and discussion at safeguarding supervision sessions.

The trust safeguarding team worked well with the local children's safeguarding boards. Due to integrated working on the Portsmouth side the health visitors, Family Nurse Partnership (FPN) team and school nurses were based in the same office as the social workers which aided effective and timely safeguarding communication. Southampton teams were integrated with the local authority with joint management and pooled budgets. They were not co-located with the social work teams, but some health visitor teams were co-located with city council early help and prevention staff. Solent NHS staff were part of the local authorities multi agency safeguarding hub (MASH) that coordinated children's safeguarding activities. The MASH desk received 1014 contacts in June 2018, 1238 in July 2018 and 1007 in August 2018. The safeguarding nurse, who had a role to link with the other professionals working with MASH, reviewed all these contacts.

Risk assessments for child sexual exploitation were completed for all Sexual Health patients under 18 years old. The service had developed a monthly risk assessment monitoring process, which was reported to the service line clinical governance meeting. The process involved reviewing the notes of all patients aged under 18 and any missing risk assessments were discussed with the clinician and learning shared across the service.

Staff received training about Prevent, a Government strategy about safeguarding people and communities from the threat of terrorism. Some staff gave examples where they had used the Prevent pathway when they had concerns about a child or a child's family.

Female genital mutilation (FGM) was included in the safeguarding training. Staff discussed the FGM assessment process, which included referral to counselling services for the child who had suffered FGM.

Health visitors and school nurses attended safeguarding child protection initial and review meetings. The health visitors and school nurses worked together to ensure that the most appropriate person attended the meeting and outcomes for the family were shared on the electronic database.

The trust followed an agreed process for child protection medicals that ensured the safety of children. There was a two doctor on call system to ensure there was always a medical practitioner available to carry out urgent child protection medicals. Child protection nurse specialists supported the medical assessment process. The service was developing a sibling clinic to provide support to siblings of children who were suspected as being subjected to abuse. Staff explained they worked with police, social workers and clergy to support children who had been subject to abuse.

Cleanliness, infection control and hygiene

Most areas of the service controlled infection risk well.

As a community trust, many of the clinic's and clinical spaces were shared with other organisations who had their own cleaning arrangements and staff. In most clinical areas cleaning schedules were followed by the relevant organisation. All clinical areas we visited were visibly clean and clutter free.

Across all the services we visited, staff washed with soap and water or sanitized their hands with alcohol gel before and after patient contacts. Staff, including staff delivering care to patients in their own homes, had access to and used personal protective equipment such as gloves and aprons. Most staff complied with the trust's policy and national guidance about being bare below the elbow when delivering care and treatment. However, two out of four staff in a clinic environment did not comply with the trust's bare below elbow policy.

Staff cleaned equipment before and after use, this included toys used for assessment purposes. In some areas, posters requested that parents washed their children's hands before and after playing with the toys. However, the waiting area for one clinic there were no toys available for children to play with. One of reasons given by staff was that toys would pose a risk of cross infection. Discussion with staff indicated there was no consideration to develop a schedule to clean toys after use, so they could be available for children.

In immunisation clinics, school nurses used alcohol gel to clean their hands before and after immunisation of children. Staff had specialised spill wipes to deal with any bodily fluid spills.

Clinical waste was managed safely. Appropriate clinical waste disposal bags and bins were used by staff at both trust owned sites, sites owned by other organisations and during home visits.

Staff adherence to infection prevention and control policies was monitored using audits. The trust carried out hand hygiene audits for the children, young people and family's service twice a year. Results showed the service consistently scored above the trusts 90% for compliance with the trust hand hygiene policy.

The trust carried out environmental audits of the clinical areas within the special school. We viewed a sample of these that evidenced where areas for improvement were identified, staff acted and re audits were carried out to measure the improvements.

Environment and equipment

Most of the service had suitable premises and equipment and looked after them well.

Many of the clinics and clinical spaces used by the service were shared spaces and located within GP practices or community settings.

Across the service, all rooms containing hazardous substances such as cleaning products such as the cleaner's cupboard were secured with a key code pad or had high handles small children would not be able to reach. All doors we observed were closed and secure.

The design, maintenance and use of facilities differed across each part of the service and mostly met the needs of the service being delivered. However, the school nursing team described incidents where the room allocated to them at a school was of an insufficient size to deliver the health screening programme. In these circumstances the health screening programme was cancelled and re booked for a later date in a room that met the needs of the service being delivered.

At one of the host sites, we found the environment, including waiting areas, was not child friendly. In the waiting area, there was no seating suitable for children, there were no toys other than a single bead frame, to occupy children whilst waiting for appointments. Staff explained the reason for this was because the site was used for other clinics as well as children's clinics and that because of risk of infection they could not have toys in the waiting areas. There were no toilet seats or steps to support young children to use the toilet facilities.

Staff, across the service, were provided with mobile phones and laptops. Staff reported there was improved connectivity and they rarely had problems connecting to the trust IT systems when working outside their bases.

Across the sites we visited, we saw clinic scales were routinely calibrated to ensure their accuracy. This was an improvement from the inspection in 2016. Equipment had servicing stickers attached to them, which identified when they were last serviced and when the next service was due. Servicing stickers on all equipment we looked at showed the equipment was up to date with servicing. This included equipment at the special schools which was an improvement since the inspection carried out in 2017.

Staff followed processes to ensure all emergency equipment, including child and adult resuscitation equipment was available and in date.

However, some staff reported difficulties with ordering equipment to meet the individual needs of children from an external equipment provider. The electronic equipment ordering forms required information, such as height and weight, that was not always required for the piece of equipment. Staff told us that if weighing and measuring the child was not needed for the piece of equipment and would cause the child distress, they omitted this information. However, despite explaining on the form why this information was not provided, the request form for equipment would be rejected, thus causing delay to acquiring equipment for children. Staff said they reported these cases as incidents, but were unsure if the trust was taking any action, such as working with the external provider, to influence improvements in the ordering process. Reviews of the trust risk register and the children, young people and family's risk registers showed staff had not formally raised this as a risk to the service and children who used the service. This meant we had no assurance the service was taking any action to reduce the level of risk to patients. However, there had been no reported incidents of harm to children and young people as a result in these delays in ordering processes.

Staff spoke about challenges associated with ordering equipment for children who attended schools located in Hampshire, but who lived in neighbouring counties or who lived in Portsmouth or Southampton. Staff could only order equipment from the Hampshire Equipment Service, not the Southampton, Portsmouth or neighbouring counties equipment services. This, they said led to delays in obtaining equipment for children who did not live in Hampshire. Despite staff describing this as a challenge and a risk to patients there was no detail about this on either the children, young people and families risk register or in the trust wide risk register. This meant we had no assurance the service was taking steps to address this risk. However, there had been no reported incidents of harm to children and young people as a result in these delays in ordering processes.

The service had long standing problems with accessing the wheelchair service that was provided by an external provider. This resulted in long delays for Solent NHS trust patients for new wheelchairs, adaptions and repairs to wheelchairs. This posed a risk to the physical and mental health and development of children who used wheelchairs.

This concern was identified at the previous comprehensive inspection of the service in 2016. At that time there was limited evidence the trust was acting to improve this situation and therefore we told the service they should review access to the wheelchair service to meet the needs of children in the community.

At this inspection the trust provided information on a serious incident review investigation completed with other agencies regarding the wheelchair provision across the trust that included awareness of the risk and a proposed action plan to improve the situation.

The trust had been working with commissioners and the wheelchair provider since 2016. Staff said they felt the service and the trust was beginning to work closer with the commissioners and the wheelchair service to make them aware of the impact the poor service had on children's lives. Changes had been made to the reporting of wheelchair service delays. All delays were incident reported and added to a data base that was being used by the trust to influence improvements to the wheelchair service. Special school nurses at Cedar school, described rather than their students having to attend appointments at the wheelchair clinic, the wheelchair clinic had been re-established within the school. They saw this an improvement to the wheelchair service.

Therapy staff reported due to a lack of a 'hub' base in Eastleigh and Southern parishes staff had long journeys to get to a 'hub' base where they could complete patient records. Despite having laptops, some of the staff said they preferred to complete the patent records at a 'hub' base. Review of the risk registers showed that the lack of a 'hub' base in this region was identified as a risk. However, the risk was identified as a risk to children having to receive therapy in suboptimal environments or having to travel long distances to a hub that had a suitable environment. It was not identified on the risk register that there was any impact on staff completing patient records, but it did detail there was an impact on the travelling staff had to do to deliver treatment to children.

Assessing and responding to patient risk

Risks to children, young people and families were assessed, monitored and generally managed appropriately.

The Healthy Child Programme (HCP) and National School Measurement Programme (NCMP) included assessment stages and tools to identify and respond to children, young people and families between 0 and 19 years of age who may be at risk of harm, disorder or ill health. The HCP meant that risks in relation to parental or child welfare or child development could be identified at routine checks carried out by, health visitors, community nurses, school nurses and the Looked after Children (LAC) teams.

The service had implemented and embedded the HCP and NCMP and used these as the key opportunities for assessing and monitoring the welfare of children, young people and families and responding to identified risks.

The Family Nurse Partnership provided an intensive and structured home visiting service for vulnerable first-time mothers under the age of 24. As part of their role, they used the opportunity to assess and monitor the welfare of children and young parents and respond to identified risks.

All staff were required to complete deterioration and paediatric resuscitation training as part of their mandatory training. The identification and management of sepsis was included in this training.

In the east region (Portsmouth) an established Children's Outreach, Assessment and Support team (COAST) worked to prevent unnecessary and avoidable admissions to hospital and facilitated early discharge from inpatient wards. The team were trained and managed the care and treatment of 10 specific conditions. GPs referred children to the COAST team. They carried out an initial telephone triage assessment with the child's parents or guardians. The team followed a process to identify whether the child's condition met their criteria for managing and whether they had the skills to manage the child's condition safely. If the child's condition did not meet the criteria for the COAST team or they were assessed as too ill for the COAST team to manage safely, the child was referred to their GP or admitted to the local acute NHS hospital either through the children's admission unit or if their condition was assessed as more serious, though the emergency department. The COAST team used the nationally recognised Paediatric Early Warning Score (PEWS) to support identification and management of a deteriorating child.

Children supported in special schools by the trust's special school nurses had a set of baseline clinical observations recorded at the beginning of each academic year. This meant if the school and nurses were concerned about a child's condition they would take another set of observations. These were compared to the baseline observations to support identification of changes in the child's condition.

Children supported in special schools by the trust's special school nurses had individualised care plans that detailed how to recognise if the child's condition was changing. For example, how to recognise how the child presented when they had an epileptic seizure or presented with altered blood sugar levels if they had diabetes. The child's care plan gave staff, including the teaching staff, individualised instructions about how to respond to these situations and ensure the safety of the child.

During immunisation clinics prefilled adrenaline syringes were accessible for staff to use in the event of a child having an anaphylaxis response to the immunisation.

At some health visitor clinics, a process for parents weighing their own babies, without being assessed by a health care professional, had been introduced. The service had not assessed the risk this practice might pose to some babies. This included health visitors not identifying babies losing weight, not identifying babies who had signs of being subject to harm and missing the opportunity to review babies under a child protection plan.

The service had introduced an Enhanced Child Health Visiting Offer (ECHO) which had been devised in partnership with the local authorities, commissioners, clients and public health consultants. The aim of this programme was to offer an intensive home visiting programme to vulnerable and complex families to reduce the risk of harm to both children and the families. Health visitors said because of resourcing ECHO commissioners had given the trust an extended target of 30 days to visit and assess new born babies. This was not in line with the national guidance of carrying out new born baby checks within 14 days of birth. It was common practice for midwives to discharge babies and families from their care at 10 days post-delivery, this resulted in a 12-day gap where new born baby's and their families were not being monitored by a suitable health care professional. Staff confirmed the nationally recommended targets were not being met, but that they were meeting the commissioner's targets. However, the service told us that potential risks posed by the extended target for new birth visits were lessened by improved antenatal assessments. All known pregnant mothers and families with identified risks were followed robustly in partnership with midwifery services during the antenatal period.

Staffing

The service mostly had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Where issues with staffing were identified, mitigating actions were taken to reduce risks to patients.

Planned v Actual Establishment

Year 1 section:

Details of staffing levels within community health services for children, young people and families by staff group as at March 2018 are below.

Community health services for children, young people and families total

Staff group	Actual Staff (WTE)	Planned staff (WTE)	Staffing rate (%)
Medical & Dental staff - Hospital	25.1	27.7	90.4%
NHS infrastructure support	40.3	84.1	48.0%
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	2.4	5.1	46.6%
Qualified Allied Health Professionals (Qualified AHPs)	140.1	143.0	97.9%
Qualified nursing & health visiting staff (Qualified nurses)	206.1	213.7	96.5%
Support to doctors and nursing staff	143.2	49.8	287.8%
Support to ST&T staff	5.4	38.4	14.2%
Total	**562.6**	**561.7**	**100.2%**

The staff group Support to doctors and nursing staff was noticeably over-established, whilst there was a low fill rate (14.2%) for Support to Scientific, Therapeutic & Technical staff.

(Source: Universal Routine Provider Information Request (RPIR) – P16 Total Staffing)

Vacancies

The trust set a target of 5.4% for vacancy rate. From June 2017 to May , the trust reported an overall vacancy rate of -0.3% in community health services for children, young people and families. This met the trust's target. Across the trust the overall vacancy rates for nursing staff were 4.3%, for medical staff they were 7.8% and for allied health professionals they were 3.8%.

A breakdown of vacancy rates by staff group in community health services for children, young people and families at trust level is below:

Community health services for children, young people and families total

Staff group	Total vacancies (12 months)	Total WTE establishment (12 months)	Annual vacancy rate

NHS infrastructure support	-279.3	1,007.7	-27.7%
Qualified Allied Health Professionals (Qualified AHPs)	67.7	1,761.3	3.8%
Qualified nursing & health visiting staff (Qualified nurses)	109.2	2,568.7	4.3%
Support to doctors and nursing staff	53.0	1,044.1	5.1%
Medical & Dental staff - Hospital	25.8	331.9	7.8%
No Staff group provided	4	4	100.0%
All staff groups	**-19.6**	**6717.8**	**-0.3%**

(Source: Universal Routine Provider Information Request (RPIR) – P17 Vacancy)

Turnover

The trust set a target of 12% for turnover rates. From April 2017 to March 2018, the trust reported an overall turnover rate of 14.7%in community health services for children, young people and families. This did not meet the trust's target. Across the trust the overall turnover rates for nursing staff were 18.0%, for medical staff they were 15.4% and for allied health professionals they were 9.6%.

A breakdown of turnover rates by staff group in community services for children, young people and families at trust level for the year ending March 2018 is below:

Community health services for children, young people and families total

Staff group	Turnover rate
Medical & Dental staff - Hospital	15.1%
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	86.9%
Support to ST&T staff	26.9%
NHS infrastructure support	7.5%
Support to doctors and nursing staff	14.9%
Qualified nursing & health visiting staff (Qualified nurses)	17.2%
Qualified Allied Health Professionals (Qualified AHPs)	9.5%
Total	**14.3%**

(Source: Universal Routine Provider Information Request (RPIR) – P18 Turnover)

Following the inspection, the trust provided the turnover rates for the 12 months preceding the inspection. This showed there had been changes with the turnover rates, with some staff groups having a smaller turnover rate, but others having an increased turnover rate.

Sickness

The trust set a target of 4 for sickness rates. From April 2017 to March 2018, the trust reported an overall sickness rate of 4.9% in community health services for children, young people and families. This did not meet the trust's target. Across the trust overall sickness rates for nursing staff were 5.2%, for 5.5% for medical staff and 1.6 % for allied health professionals.

A breakdown of sickness rates by staff group in community health services for children, young people and families at trust level is below:

Community health services for children, young people and families total

Staff group	Total available permanent staff (days)	Total permanent staff sickness (days)	Sickness rate
Medical & Dental staff - Hospital	511.1	9,329.4	5.5%
NHS infrastructure support	627.5	14,260.8	4.4%
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	0.0	660.1	0.0%
Qualified Allied Health Professionals (Qualified AHPs)	838.3	51,645.1	1.6%
Qualified nursing & health visiting staff (Qualified nurses)	4,030.0	77,539.3	5.2%
Support to doctors and nursing staff	4,212.1	54,490.3	7.7%
Support to ST&T staff	2.6	2,041.1	0.1%
All staff groups	**10,221.6**	**209,966.2**	**4.9%**

(Source: Universal Routine Provider Information Request (RPIR) – P19 Sickness)

Nursing – Bank and Agency Qualified nurses[1]

From April 2017 to March 2018, of the 479,461 total working hours available, 2% were filled by bank staff.

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Children's Services Portsmouth	222,662	4,374	2%	0	0%	0	0%
Children's Services Southampton	256,799	3,763	1%	0	0%	0	0%

[1] add link to source

Community children's total	479,461	8,137	2%	0	0%	0	0%

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)

Nursing - Bank and Agency Non-Qualified nurses

From April 2017 to March 2018 of the 190,626 total working hours available, 1% were filled by bank staff.

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Children's Services Portsmouth	66,956	1,010	2%	8	0%	0	0%
Children's Services Southampton	123,669	1,660	1%	0	0%	0	0%
Community children's total	190,626	2,669	1%	8	0%	0	0%

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)

Medical locums

From April 2017 to March 2018zero working hours were covered by locums to cover sickness, absence or vacancies in community health services for children, young people and families.

(Source: Universal Routine Provider Information Request (RPIR) – P21 Medical Locum Agency)

Discussion with health visitors indicated there were sufficient health visiting staff to meet the needs of the local populations. The community practitioners and health visitor's association recommend that each health visitor should hold a caseload of up to 300 families or 400 children. Health visitor caseloads in Southampton were roughly 350 children for each health visitor. Portsmouth health visitors were unable to give caseload numbers. They only knew the rough number of families that needed enhanced support, which were about 90 per each health visitor.

At the time of the inspection the Portsmouth health visiting team had a vacancy rate of three wholetime equivalent (WTE) staff. Bank and agency staff were used to cover health visitor vacancies. To reduce the risk posed to children and families due to a national shortage of health visitors, the trust had employed children's community health nurses who, with additional training, took on the role of children's community health nurses and relieved health visitors of some of their tasks.

The Family Nurse Partnership (FNP) had a maximum caseload of 25 and most were almost at capacity.

Most therapy staff reported recent recruitment had made improvements to their staffing numbers and in most areas, they were fully staffed. Therapists in Portsmouth were undertaking a time and motion analysis to evidence the need for more administration time so they could complete their essential documentation.

The children's community nursing (CCN) and children's continuing care (CCC) nursing teams in the east (Portsmouth) told us they had staff shortages. The clinical lead had implemented a risk rating for types of patient visited daily for CCNs to complete to show the type of work completed. It was hoped that information from this exercise would evidence to the trust the need for band 3 staff assistance with equipment deliveries and low risk visits.

The COAST team in the east of the region (Portsmouth) had a number of staff vacancies. This meant that since September 2018 the service was reduced from 10am to 10pm Monday to Friday and 9am to 6pm Saturday and Sunday to Monday to Friday 10 am to 8pm, and no service at the weekend. A risk based approach, determined by data gathered about the times of day and days of the week the service had the highest rate of use, were used to identify the core hours the service could reduce to whilst posing the least risk to children. The reduction in the service was communicated to GPs and the local NHS acute trust. There was no time frame for when the full COAST service would be able to resume.

The COAST team in Southampton had been de-commissioned due to the limited funding available to provide a safe service to children and their families. An equality impact assessment was completed and presented through commissioner governance routes. To address the challenges in recruiting to the community nursing teams, including the COAST team, the trust was in the process of restructuring this service. At the time of inspection, staff were not sure what the restructure would look like but were aware it would probably mean joined up working between the community nursing teams in the local regions to ensure children and families received the right care at the right time.

There were no band 6 school nurse vacancies at the time of inspection, which was better than the national picture, as nationally there were vacancies in this group of workers. However, there was a band 5 school nurse vacancy in the west of the region. This had an impact on the service meeting the key performance targets for meeting 10-day response times for requests for support from schools and carrying out vision and audiology re checks within eight weeks of the original screening. The service was following processes to recruit into this vacant post.

Suspensions and supervisions

During the reporting period from April 2017 to March 2018 community health services for children, young people and families reported that there were two cases where staff were placed under supervision.

(Source: Universal Routine Provider Information Request (RPIR) – P23 Suspensions or Supervised)

Quality of records

Staff kept detailed records of patients' care and treatment. Most records were clear, up-to-date and easily available to all staff providing care.

The trust's electronic record keeping system allowed community health practitioners to access records and have access as appropriate to child health information systems (CHIS) and access to GP records. Staff reported, the access to IT systems had improved and they could now access online electronic records when working in the community. This supported contemporaneous electronic recording of care and treatment provided to children and families. The system was secure and only accessed using secure links and password. The electronic records system contained a wide range of templates for assessment and care planning.

The Looked After Children (LAC) team effectively completed records. They showed the child or young person's health plans, treatments and results along with any interventions or conversations with the local authority.

However, not all staff used the laptops to make contemporaneous records and some routinely used paper records. Some staff expressed a reluctance to use lap tops in patients' homes or in clinics. They felt it was a barrier to communication between them and the patient, so instead they made paper records and transcribed them at a later point in the day to the electronic records. This increased the risk of staff recording inaccurate information onto the electronic records system. There was no information on the service or the trust wide risk register to show the service or the trust were aware of this risk.

The children's continuing care service used only paper records, but were developing templates on the trusts electronic recording system moving towards a paper light system. The COAST service completed initial records on paper and then entered the records onto the electronic recording system. The service was in the process of developing an integrated assessment within the electronic record system.

We observed that the Personal Child Health Record (PCHR Redbooks) were not completed at all clinics, even if parents spoke with a Health Visitor or Community Health Nurse. This meant there was a lack of information sharing with GPs and other relevant professionals. At some of the self-weighing clinics, there was no record kept of who attended and which children were weighed. This was a risk, for example if one of the scales were inaccurate it would be impossible to know who attended clinic that day.

To allow information to be shared with the school teaching team, the special school nursing teams, completed student's records electronically and printed out care plans. However, student's individual care plans did not always detail the care and support they currently required. At Cedar school, a care plan for a student described they needed a member of staff to support with managing their continence needs. Discussion with school staff, evidenced this student was now managing their continence needs independently. The care plan did not reflect the change in the student's care needs.

Students care plans did not always provide clear guidance about how to meet their individual continence needs. For example, for one student their care plan detailed that to meet their elimination needs they usually wore pads and that their pads were usually wet. There was no detail about the type of continence pad the student wore or how frequently pads needed to be changed.

The special school care plans provided opportunity to detail whether the student had an advanced care plan to inform staff about their priorities and wishes for end of life care. However, the form did not make it clear whether a student had an advanced care plan or not. The form allowed a yes or no answer, but the plans we looked at had both answers on the form, with one written in red and one in black. There was no code to detail what each colour meant.

We reviewed 10 sets of patient records. Records maintained by staff were detailed and appropriate. The electronic system had a facility to allow special markers on case notes, for example for known allergies and child protection concerns. All records reviewed had appropriate messaging to identify status and concerns.

Records were stored securely. Access to electronic records was password protected and permissions were required for staff to access records relating to their professional discipline. Paper records were secured in locked cupboards or offices or locked in practitioner's bags.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines.

All staff completed management of medicines training as part of their mandatory training. Nursing staff who were not prescribers administered medicine under Patient Group Directions (PGD). A patient group direction allows some registered health professionals, such as school nurses, to give specified medicines (such as immunisations) to a predefined group of patients without them having to see a doctor.

The trust had appropriate PGDs in place to allow staff to give vaccines. The trusts PGDs used a Public Health England template and each practitioner signed their own PGD for each vaccine given. These included; human papilloma virus (HPV) vaccine, measles, mumps and rubella (MMR) vaccine, diphtheria, pertussis (whooping cough), and tetanus (DPT) and Nasal Flu Vaccine.

School nurses followed a procedure to request student’s medicines from home. The nurses kept written records of all requests for medicines, the date requested and the date received. This was an improvement from the previous inspection.

Staff followed a process for monitoring and recording medicine fridge temperatures. We checked a sample of medicine fridges and temperature records and found only one out of range temperature at the immunisation storage fridge at Adelaide Health Centre. However, there was no evidence staff had followed trust processes to ensure the medicines in the fridge were safe to use on that occasion. The trust’s standard operating procedure for temperature management of medicines, dated July 2018, detailed in the circumstance of fridge temperatures outside the normal range, medicines must be quarantined and not used until a risk assessment had been completed and the medicines were judged by the ward/service manager or the pharmacy as safe to use. There was no evidence staff had followed this process which meant there was no assurance that action had been taken to ensure the vaccines were still effective.

Staff had obtained advice from the trust pharmacy team regarding how long a vaccine could be out of the ‘cold chain’ whilst using the vaccines in the community setting and had incorporated this into their protocols. For example, returned unused vaccines were marked when returned to the fridge. They would be the vaccines first used at the next vaccination session and if not used then would be discarded following the trust’s processes. Staff transported vaccines to clinics in cold storage bags which had continuous temperature monitoring.

During immunisation clinics staff had access to a spill kit and an anaphylaxis kit should anyone have an adverse reaction.

At the inspection of the children, young people and families service in 2016 we identified serious concerns with the trust’s management of medicines at the special schools. Inspection in 2017 identified the trust had started making improvements with the management of medicines at the special schools. At this current inspection we found the trust had sustained the improvements found at the previous inspection and had made further improvements. A pharmacy technician service was embedded in the specialist school service, with a minimum of weekly on-site visits and remote availability when needed for support and advice.

Parents or carers supplied medicines from home prescribed by GPs or specialist health practitioners. The pharmacy technician reconciled the medicines using as many sources of evidence as possible, for example the trust’s electronic recording system, consultant letters and the community children’s nursing team, to ensure staff administered the correct medicines in the correct doses to students. When a dose of an already supplied medicine was changed, this was reconciled by the pharmacy technician and over-labelled following the medicines policy to reflect the new dose. This was also checked by the pharmacist.

Staff followed processes to receive and return medicines from the student’s home and ensured an accurate record of the stock of medicines held at the school. Stock of medicines we checked matched details in the stock log book. This was an improvement from the previous inspection.

All medicines, at the three schools were stored safely and at the correct temperatures, including emergency medicines.

Each student had a medicines administration record (MAR) chart, that detailed the medicines they were prescribed, the dose, what time it should be administered and how it should be administered. To reduce the risk of errors, all MAR charts were transcribed by two members of staff. This could be two nurses or a nurse and a member of the pharmacy team. All MAR charts we looked at contained detail about allergies, a recent photo of the student to aid identification, weight (with date taken) and evidence of a pharmacy check.

Individual when required (PRN) protocols were written for all PRN medicines. These detailed when a medicine might be needed, the signs or symptoms a student might demonstrate, what to do, when to give emergency medicines and how many doses and when to call 999. Seizure care plans were in place for every student who was at risk of seizures. This was kept with the MAR chart and a copy with their emergency medicine.

Nurse discretionary, over the counter medicines (paracetamol, ibuprofen and chlorphenamine) were available for nurses to administer to students without a prescription. Consent to administer over the counter medicines was obtained from the student's parent or guardian at the beginning of each academic year. Nurses recorded the administration of over the counter medicines on the student's MAR chart and communicated the administration to parents or guardians both by telephone calls and letters.

Staff followed processes that ensured all medicines, including buccal midazolam and any controlled drugs were signed in and out of the CD register when children went out for day trips. This was an improvement from the previous inspection. All teachers and teaching assistants completed training and competency assessments carried out by the school nurses about epilepsy and administration of buccal midazolam. This ensured the school teaching staff had the appropriate skills and knowledge to administer medicines.

Some health visitors were non-medical prescribers and had completed a recent update concerning non- medical prescribing. Health visitors had prescribing FP10 pads which they kept in a locked bag or in the office in a locked drawer. The FP10 prescription was photocopied and sent to the GP, so they were aware of medicines prescribed to their patient.

Safety performance

The trust advised they did not care for physically acutely ill children in any of their services. Therefore, safety performance monitoring in relation to inpatient care did not take place. If a child presented acutely unwell emergency steps would be taken to transfer the child to hospital via ambulance.

Incident reporting, learning and improvement

The service managed safety incidents well.

Never events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From April 2017 to March 2018, the trust did not report any never events in community health services for children, young people and families.

(Source: Strategic Executive Information System (STEIS))

Serious Incidents

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include ‘never events’ (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported seven serious incidents (SIs) in community health services for children, young people and families, which met the reporting criteria, set by NHS England from April 2017 to March 2018.

Incident Type	Number of Incidents
Confidential information leak/information governance breach meeting SI criteria	1
Other	3
Medical equipment/ devices/disposables incident meeting SI criteria	1
Apparent/actual/suspected homicide meeting SI criteria	1
HCAI/Infection control incident meeting SI criteria	1
Total	**7**

(Source: Strategic Executive Information System (STEIS))

Serious Incidents (SIRI) – Trust data

From April 2017 to March 2018 trust staff within community health services for children, young people and families reported seven serious incidents.

The number of the most severe incidents recorded by the trust incident reporting system is identical with that reported to Strategic Executive Information System (STEIS). This gives us more confidence in the validity of the data.

Incident Type	Number of Incidents
Confidential information leak/information governance breach meeting SI criteria	1
Other	3
Medical equipment/ devices/disposables incident meeting SI criteria	1

Apparent/actual/suspected homicide meeting SI criteria	1
HCAI/Infection control incident meeting SI criteria	1
Total	**7**

(Source: Universal Routine Provider Information Request (RPIR) – P29 Serious Incidents)

Prevention of Future Death Reports (Remove before publication)

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

Within the last 12 months, there have not been any prevention of future death reports sent to Solent NHS Trust.

(Source: Universal Routine Provider Information Request (RPIR) – P76 Prevention of future death reports)

All staff we spoke with knew how to report incidents, using the trust electronic reporting system, and gave examples of what incidents they had recently reported. Staff reported that connectivity to the internet and the trusts electronic recording systems had improved which meant they could report incidents in a timely manner whilst working in the community.

Staff confirmed and gave examples where changes in practice had occurred as result of learning from incidents. This included following a medication error, mobile telephones now being switched on to silent when attending to patients, to avoid distractions and reduce the risk of errors. A second change in practice included a change in the screening forms for child immunisations. Forms had been revised and were written to be clear whether the child had asthma or not. This meant triaging for immunisations was a swifter process without the need to contact parents for further information.

Staff gave examples where changes in practice had occurred from incidents and learning with partner agencies. This included a review of pathways, a reflective feedback group with partner agencies and strengthened supervision levels following the multidisciplinary team failing to identify and thus provide relevant support and guidance for an obese child. A second example of learning from incidents involving other agencies, included the Looked after Children's (LAC) service. There had been an incident where a third-party agency did not send patient information using the secure email address. The LAC team worked with the third-party agency to remind them about the requirement to send information securely.

Staff were aware of serious incident investigations that had occurred trust wide and knew the actions being taken as a result. This included any issues relating to the wheelchair service provided by an external provider being added to a data base as well as being reported on the trust's incident reporting system. Staff said more detail was required in the database and they believed the information was being collated, so the trust could demonstrate to the wheelchair providers and commissioners of the service the negative impact it was having on their patients.

Is the service effective?

Evidence-based care and treatment

The service mostly provided care and treatment based on national guidance and evidence of its effectiveness. The health visiting service did not adhere to Healthy Child Programme for timeliness for reviews of babies and children. This was a similar finding to the inspection carried out in 2016.

The policies and procedures used by children, young people and families (CYPF) services were developed around national guidelines. Policies were available on the trust intranet system. However, staff found they were difficult to navigate to on the trust intranet.

The health visiting and school nursing services followed the Department of Health's national initiative called The Healthy Child Programme (HCP). The programme required the early intervention of health visitor contacts with babies and children. It offered regular contact with every family and included a programme of screening tests, developmental reviews and information, guidance and support for parents. We saw that health visitors gave information to parents in line with the Healthy Child Programme. Staff followed the World Health Organisation guidance about Baby led Weaning. Staff followed the Lullaby Trust guidance for safe sleeping advice for babies and reduction of risk of Sudden Infant Death.

The Family Nurse Partnership (FNP) followed national guidance to provide intensive support for vulnerable first-time mothers under the age of 24. The Portsmouth FNP was part of an eleven-site trail for ADAPT, a trial to improve outcomes for clients and how the programme is delivered.

The National Child Measurement Programme (NCMP) measured the weight and height of children in reception class (aged 4 to 5 years) and year 6 (aged 10-11 years) to assess overweight and obesity levels. This is a government initiative, supported by NHS England. Currently Children's Services only send leaflets to 'out of range' children – underweight, overweight and very overweight. Children categorised as very overweight received an additional leaflet entitled 'Let's get going'. This was an activity leaflet with a 10-week programme for ages 7-12 years and was run by the local authority. Staff entered health screening information onto the NCMP database which indicated in to which category a child falls.

Therapy services for children with cerebral palsy was delivered in accordance with national standards (Cerebral Palsy treatment in under 25's (Nice 2018). Therapy and care was adapted to meet the needs of the individual, with management of the delivery of care very inclusive of the parents and child.

Health Visitors caseloads were set in accordance with the national 4-5-6 Health Visiting Model. This is an integrated 4-5-6 model for health visitors and school nurses, which identifies high impact areas for early years (health visiting) and high impact areas for school aged years (school nursing), so caseloads can be set to address the high impact areas. The high impact areas for health visiting were transition to parenthood, maternal mental health, breast feeding, healthy weight, minor illness and accidents and healthy two-year olds and getting ready for school.

The continuing care nursing team followed a competency framework based on the Coventry and Warwickshire children and young people's interactive framework. This was a framework developed by NHS trusts and a voluntary organisation that works to ensure that the UK's children's nursing workforce have the right skills, knowledge and experience to provide palliative care to babies, children and young people with life-limiting conditions across the UK.

The service was accredited at level three under the UNICEF UK Baby Friendly Initiative. This meant the service had demonstrated staff supported mothers with breast feeding, staff gave them useful and accurate information and staff supported parents to recognise the importance of relationships and how to build these. It also meant the service had demonstrated breastfeeding was protected and supported in all areas of the service.

There was minimal evidence of telemedicine or staff carrying out telephone follow up's. However, health visitors said they often called families where children were not meeting their developmental milestones in their reviews to see if they need extra support The COAST team carried out telephone

triage assessments and provided advice and support in telephone conversations if assessment showed the child did not require a visit from the COAST team. The service had commenced a new SMS text service called Solent Pulse, to provide responses to queries asked through text messages. This service enabled young people and parents to text with a qualified nurse and receive timely text responses to queries.

However, the health visiting service did not meet the national best practice guidance about when health visitors should carry out visits and reviews for babies and children. Best practice guidance details that new born babies should receive a visit from health visitors within 14 days of birth. The service's Enhanced Child Health Visiting Offer (ECHO) which had been devised in partnership with the local authorities, commissioners, clients and public health consultants. The service told us that potential risks posed by the extended target for new birth visits were lessened by improved antenatal assessments. All known pregnant mothers and families with identified risks were followed in partnership with midwifery services during the antenatal period.

Nutrition and hydration (only include if specific evidence)

Staff in health visiting and school nursing, educated families and carers about nutritional health.

A healthy weight team had been developed to provide advice and guidance to families and children in response to rising obesity rates

Promotion of breast-feeding was seen across the services. Health visitors could refer mothers to specialists such as dieticians and the speech and language therapy teams for advice about eating and drinking and swallowing difficulties, as well as dietary concerns.

Following identification of children who were underweight or very over weight from the NCMP, school nurses made timely referrals to dieticians and paediatricians who provided healthy eating education within schools as well as through home visits.

Pain relief (only include if specific evidence)

The service used nationally recognised tools to identify levels of children's pain and whether the current pain relief was effective. This included tools to assess pain in children who were unable to communicate their needs. This was an improvement since the inspection in 2016. We observed special school nurses administered pain relieving medicine to students and followed processes to monitor, record and inform the student's parents or guardians that pain relief had been administered during the school hours.

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them.

Audits – changes to working practices

The trust has participated in eight clinical audits in relation to this core service as part of their Clinical Audit Programme.

Audit name	Area covered	Key Successes	Key actions
Re-audit: Patient Care Plans (CCN - West) benchmarked against Government Policies and NMC Code of Conduct	Children's Community Nursing	There was evidence of well written and individualised care plans; the team had started to create care plans through the use of templates which improves care planning.	1. Ensure all staff are aware of audit findings by sharing with Team Leads, Clinical Matron, Managers across Solent; 2. Develop a standardised approach to recording care plans on S1; 3. Identify teams that require support with creating care plan templates on S1; 4. Ensure all children within CCN West have a clear care plan attached to their records; 5. Set up S1 working group to review processes and develop flow guideline for each team regarding care plan recording and record keeping in partnership with CCN East; 6. Review record keeping training needs of the CCN team.
Initial Health Assessment of Child / Young person entering care within statutory time frame (20 working days of entering care)	Community Paediatrics	Compliance is at 88%.	Improvements to informatics - databases and interface with SystmOne with support from appropriate IT teams; increased responsibility to be placed on our social care partners on notification, information and consent provision ahead of IHA; improved processes for Portsmouth children placed out of area.
Medical Surveillance of Children with Down Syndrome	Community Paediatrics	Compliance with monitoring is 89-100%, although it must be recognised that some monitoring is reliant on other services and children successfully being brought to appointments.	Update Audit proforma including Blood tests and Sleep difficulties; request a Down Syndrome Recording Template be added to System 1; request a letter template to report appointments for children with Down syndrome on System 1.
Adoption Medical Reports (Portsmouth City 2015/2016)	Community Paediatrics	Of the 27 standards examined, more than half were met in all of reports, including the standards of greatest importance with respect to adoption medical assessments. Comments about vision and hearing were	Amend adoption medical reports to include additional headings; look at ways to encourage Social Workers to supply the necessary information in a timely fashion; present the audit findings at a CPD meeting of

Audit name	Area covered	Key Successes	Key actions
		absent from a small percentage of reports.	Community Paediatricians, prior to re-audit taking place in December 17.
Audit of Family Nurse's use of Ages and Stages Questionnaires (ASQ) and Family Nurse Partnership (FNP) tools with evaluation of training needs.	HV West	The majority of cases audited followed the guidelines currently in place.	Hold a meeting with nurses to provide them with the FNP guidelines and a quick start guide provided to use whilst administering ASQs; order the most up to date ASQ 3rd edition resources; arrange for NHS Digital to amend FNP Information System cut-off scores, to reflect those shown on paper assessments; provide training to nurses to ensure they are aware how to implement the ASQ alongside FNP guidance; establish an ASQ Pathway to ensure consistency within the unit on recording ASQs.
Clinical Record Keeping in Health Visiting and School Nursing Service	Health Visiting & School Nursing East	Audit criteria were divided into 7 sections, 5 of which scored acceptable compliance and 2 sections scored partially acceptable. School Nursing - overall compliance of 87%; Health Visiting 90% (combined rate 89%).	Share updates of the template with all staff members at the Professional forum; inform clinical managers that updates of the template should be shared with staff members during clinical supervision; discuss Lone Worker Policy and use of electronic diaries in next available team meetings; arrange a question and answer session on System One templates for staff, to help in using System One correctly, e.g. inputting clients into the correct caseload and using the correct templates.
Does the summary and Health Care Plan meet the criteria of Annex H (Health Assessment for Looked After Children Checklist Tool) - Looked After Children (LAC) West	Community Paediatrics (LAC)	Overall the audit shows clinicians formulate high quality, child-focussed reports, with clear recommendations and timescales, that meet the standards of Annex H for both Initial Health Assessments (IHA) and Reviews (RHA), as follows: the Summary report should be typed and include: pre-existing & newly identified	Discuss requirement to write to GPs, to release summary records for over 16's; discuss whether need to: gain Social Worker input prior to all assessments, add family history to the RHA, see children & YP alone as part of assessment; provide Foster Care Training to emphasise

Audit name	Area covered	Key Successes	Key actions
		health issues; recommendations with clear time scales and identified responsible person; evidence that referrals to appropriate services have been made; up to date Immunisation summary; Child Health Screening summary; IHA consent gained overall; evidence that child / young person's (YP) and carer's comments have been sought / recorded; evidence that information has been gathered to inform the Assessment from the placing Social Worker; child / YP is registered with a Dentist & date of most recent Dental check; child / YP has been seen by an optician & date of most recent eye test; any development or learning needs have been assessed; emotional, behavioural needs have been assessed and any identified concerns documented; lifestyle issues discussed and health promotion information given; recommendations have clear time scales and identified responsible person(s); all reports were signed and dated.	importance of health assessments.

(Source: Universal Routine Provider Information Request (RPIR) – P35 Audits)

The service told us their rate for take up of the National Child Monitoring Programme was 97.1%, which was better than the national average of 90%.

The Looked after Children team audited their service. We saw they developed and followed action plans and re audited the service to promote continued improvements. The team had worked with the local authority to improve the timeliness of referrals for children in care health assessments to improve on the 88% compliance by carrying out health care assessments within 20 working days of entering care.

An audit about how practitioners asked about domestic violence resulted in the trust amending templates for asking about domestic violence and providing guidance for staff about the action they needed to take if the question could not be asked.

Both Health Visiting and School Nursing teams were focusing on an 'eyes on practice' approach where an auditing approach was being introduced. They asked families for feedback, reviewed records for completeness and observed peer visits to improve feedback.

Teams shared completed internal audits and changes were made in the delivery of service because of audits. For example, the children's occupational therapy services in Aldershot Centre for Health had removed 'jargon' from their record keeping because of findings from a notes audit completed in summer 2018.

Competent staff

The service made sure staff were competent for their roles

Clinical Supervision

The trust provided the following information about their clinical supervision process:

"All services follow the Solent NHS Trust Policy for Clinical Supervision.

Clinical supervision compliance is recorded and monitored at clinical governance meetings and through the individual care group performance meetings. It was also considered as a discussion point as part of management supervision to ensure direct reports were receiving regular clinical supervision as per trust policy. Clinical supervision was actively encouraged and open to all grades of staff working clinically. The trust-wide clinical supervision policy required clinical supervision at least every six to eight weeks.

Individual services agreed the model of supervision with the clinical director and supervision could be provided in a number of different ways for example: individual, group, peer and observational supervision of practice. The service had recently agreed the implementation of an IT solution which would enable staff to centrally monitor compliance more easily. Service leads ensured compliance is followed and staff are realising the value of such practice."

(Source: CHS Routine Provider Information Request (RPIR) – CHS4 Clinical Supervision)

Discussions with staff of all professions indicated they received regular supervision sessions. Some staff demonstrated how they monitored compliance with the supervision using the trust's IT solutions as detailed above.

Appraisal rates

Prior to the inspection, as part of the routine provider information request, the trust provided information about appraisal rates for the previous year (April 2017 to March 2018). The information showed very low completion of annual appraisals across all staff groups and professions.

Community health services for children, young people and families total

From April 2017 to March 2018, 31% of permanent non-medical staff within the community health services for children, young people and families core service had received an appraisal compared to the trust target of 95%. However, appraisals across the trust were reset to 0% on April 1 each financial year. This meant the target of 95% completion of appraisals was not due to be achieved until 31 March 2019.

Staffing group	Number of staff appraised	Sum of Individuals required	Appraisal rate (%)	Trust target (%)	Target met (Yes/No)
NHS infrastructure support	11	37	30%	95%	No
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	1	4	25%	95%	No
Qualified Allied Health Professionals (Qualified AHPs)	80	182	44%	95%	No
Qualified nursing & health visiting staff (Qualified nurses)	87	262	33%	95%	No
Support to doctors and nursing staff	33	202	16%	95%	No
Support to ST&T staff	5	8	63%	95%	No
All staff	**217**	**695**	**31%**	**95%**	**No**

Medical staff

Staffing group	Number of staff appraised	Sum of Individuals required	Appraisal rate (%)	Trust target (%)	Target met (Yes/No)
Medical & Dental staff – Hospital	18	23	78%	95%	No

None of the staff groups within the community health services for children, young people and families core service met the appraisal target.

(Source: Universal Routine Provider Information Request (RPIR) – P39 Appraisals)

All staff, (medical, nursing, allied health professionals and administration staff), we spoke with during the inspection confirmed they received annual appraisals, despite information provided by the trust prior to the inspection indicating not all staff received an annual appraisal.

Information provided by the trust following the inspection showed that 80% of staff, (medical, nursing, allied health professionals and administration staff), across the trust had received an appraisal during the period 1 April 2018 to 31 September 2018. Additional information provided by the trust showed that 73% of staff working in the CYPF service had completed an annual appraisal in this same time period. However, as the trust refreshed appraisal completion data each new business year it was not clear if those staff missing appraisal in a given year had timely completion in the year after.

The trust and the children's, young people and family's services was committed to supporting their staff to become competent practitioners. All new staff completed a trust, local induction and role based induction. Newly qualified health visitors and school nurses had preceptorship programmes to follow.

The well-being of staff was always considered during supervision sessions. Supervision frequency was increased, if needed, to meet the individual needs of the member of staff.

The health visiting team was looking at introducing multiagency supervision with social services and the 5-19 services. If needed, staff had access to additional supervision from the safeguarding team and the children's and adolescent mental health service colleagues. Staff used nationally recognised reflective models such as Johns or Driscolls model of reflection to help identify areas of good practice and areas for improvement.

Across the service, all staff had specialist knowledge and the right skills to treat children, young people and their families. Staff had completed competency assessments to ensure they had the appropriate skills and knowledge to deliver care and treatment. This included competency assessments for non-clinical staff in special schools who under took clinical tasks. This was an improvement from the findings at the inspection in 2016.

Staff told us the trust supported continuous professional development and they felt supported by the trust to undertake any further university degrees if they chose too. We spoke with several staff, across the range of children, young people and family services, who had been supported by the trust to complete graduate and post graduate degrees.

Multidisciplinary working and coordinated care pathways

Staff of different kinds worked together as a team to benefit patients.

Multidisciplinary working was used effectively throughout the service. Staff of different kinds worked together as a team to benefit patients. We saw many examples of multidisciplinary working and integrated care throughout the trust, although these were not the same in the east (Portsmouth) and west (Southampton) of the service.

All children who received support from the continuing care service (CCS) had joint annual reviews with the CCS and children's social care. The service worked with education partners to review and amend children's education and health care plans (EHCP) annually.

In Portsmouth the Health Visiting team was integrated with social services. Working closely with social workers had strengthened relationships between the different health and social workers and reduced the number of onward referrals experienced by children and families. We saw coordinated care pathways, that included both the trust and the local authority. Although the health visiting service in the west (Southampton) of the trust was not integrated with the local authority, we saw evidence of effective working with the local authority. Trust safeguarding nurses sat within the Multi Agency Safeguarding Hub (MASH) team in Southampton to support joined up working.

The service had introduced a 'Team around the Worker' model. This aimed to create a confident, engaged, knowledgeable and properly skilled workforce at the heart of any service and practice change. This was done by creating a support and learning environment that offered a variety of opportunities to support new relationships with external providers, such as social services, to develop new ways of working.

The Looked after Children's (LAC) team in the east of the trust worked closely with the local authority. This had resulted in improved and more timely referrals to the LAC team. The LAC team worked across and liaised with other LAC teams outside the border of the Solent NHS. This supported timely reviews of children who were looked after in areas outside the Solent NHS region.

In the west (Southampton) school nurses worked closely with a local authority service that helped with children's emotional wellbeing at schools. The local authority staff joined the trust staff for 'cluster' meetings where they triaged referrals together, making decisions regarding which service would provide the most appropriate support to children and families. We observed the local authority staff sharing concerns about children with trust staff and develop a mutually agreed plan of care. There was no similar provision in the east (Portsmouth) of the service.

Health Visitor clinics were held in Sure Start centres or Family hubs. Both these services gave help and advice on child and family health, parenting, money, training and employment and ran 'stay and play' sessions. Health visitor clinics were held at the same time as 'stay and play' sessions. This encouraged joint working between the health visitors and play workers to meet the health and social needs of children and families and an integrated approach to deliver the Healthy Child programme.

Therapists, across all areas, worked together to provide effective care and treatment. This included joint delivery of treatment sessions to meet the child's agreed care plan. The podiatrist in the north of the region had developed links with a local shoe shop who measured children for podiatry insoles. The children's podiatry service had started linking with the adult podiatry service to carry out peer reviews of their services.

Children's therapy services in the north of the region worked closely with local schools. Therapists had developed link roles and training within local schools. The service had worked with local paediatricians to reduce the number of inappropriate referrals to the therapy service.

The service worked with local children's hospices to deliver shared care to children with life limiting conditions.

Health promotion

The service effectively promoted and empowered service users to manage their own health, care and wellbeing to maximise their independence.

There were health education leaflets available in most of the clinical areas where the trust delivered services. This included information about obesity, positive weaning advice and 'Change for life' leaflets.

Breast feeding health promotion was evident across the trust. Health Visitors ran breast feeding support groups. They promoted the role of the infant feeding team and how parents could access them to receive further support with feeding their baby. There was a healthy weight group which focused on bottle and breast feeding, following research that showed obesity could begin when bottle fed babies were overfed.

The trust had introduced the 'Baby Buddy App' to their service. This is an app developed by an external organisation that parents and professionals can access for support and advice across a wide range of issues, such as how to maximise their child's physical, emotional and language development.

The school nurse for home educated children ran health promotion groups with a home educated parents group.

Staff said that at all contacts with children and parents, they offered health promotion advice. We observed advice given in a variety of clinics about healthy eating, potty training and management of asthma. Health visitors provided healthy child clinics and the school nurses promoted healthy eating.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Capacity Act and Gillick competency framework with respect to issues of consent and capacity.

Mental Capacity Act and Deprivation of Liberty training completion

2018/19

The trust set a target of 90% for completion of Mental Capacity Act training in 2018/19. Compliance with this target was set and monitored for different staff groups.

From April 2018 to June 2018 the trust reported that Mental Capacity Act (MCA) training had been completed by 68% of staff within community health services for children, young people and families.

A breakdown of compliance for Mental Capacity Act Level 1 training from April 2018 to June 2018 for all staff in community health services for children, young people and families is shown below:

Staff Group	Staff trained	Eligible staff	Completion (%)	Target (%)	Target met (Yes/No)
Qualified Allied Health Professionals (Qualified AHPs)	145	182	80%	90%	No
Support to ST&T staff	6	8	75%	90%	No
Qualified nursing & health visiting staff (Qualified nurses)	167	261	64%	90%	No
Support to doctors and nursing staff	61	102	60%	90%	No
Medical & Dental staff - Hospital	18	32	56%	90%	No
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	2	4	50%	90%	No
Public Health & Community Health Services		1	0%	90%	No
All staff groups	**399**	**590**	**68%**	**90%**	**No**

The trust did not meet the target for Mental Capacity Act level 1 training for any of the staff groups in community health services for children, young people and families.

2017/18

The trust set a target of 85% for completion of Mental Capacity Act training in 2017/18.
From April 2017 to March 2018 the trust reported that Mental Capacity Act Level 1 training had been completed by 62% of staff within community health services for children, young people and families.

A breakdown of compliance for Mental Capacity Act Level 1 training from April 2017 to March 2018 for all staff in community health services for children, young people and families is shown below:

Staff Group	Staff trained	Eligible staff	Completion (%)	Target (%)	Target met (Yes/No)
Support to ST&T staff	7	8	88%	85%	Yes

Qualified Allied Health Professionals (Qualified AHPs)	129	179	72%	85%	No
Support to doctors and nursing staff	63	105	60%	85%	No
Qualified nursing & health visiting staff (Qualified nurses)	141	250	56%	85%	No
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	2	4	50%	85%	No
Medical & Dental staff - Hospital	16	33	48%	85%	No
Public Health & Community Health Services		1	0%	85%	No
All staff groups	**358**	**580**	**62%**	**85%**	**No**

The trust met the target for Mental Capacity Act level 1 training for one of the staff groups in community services for children, young people and families.

Deprivation of Liberty training was covered within the Mental Capacity Act training
(Source: Universal Routine Provider Information Request - P38 Training)

Deprivation of Liberty Safeguards

From April 2017 to March 2018 the trust reported that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for community health services for children, young people and families.

(Source: Universal Routine Provider Information Request (RPIR) – P13 DoLS)

The DoLS legislation is not applicable to children under the age of 18, so there would be very few occasions when DoLS would be applicable to the children, young people and family's service.

Staff spoken to from across the services understood the Mental Capacity Act, DoLS and Gillick awareness.

Data provided by the trust following the inspection showed improvements with the uptake of Mental Capacity Act level 1 training, but this did not yet fully meet the trust's targets for completion of this training School nurses had a clear process for managing consent for the national measurement programme. Children's services provided health screening for children in Reception and Year 6. Schools sent out letters to parents/guardians regarding consent to this programme. Letters were returned in a set time frame, with parents either consenting or declining to the national measurement programme.

Before each immunisation session, parents completed hard copy consent forms which were checked by the nursing team. Checks included whether there were any additional health needs that needed to be considered.

Consent regarding the sharing of information was discussed with parents/guardians/young people and recorded on the trusts electronic record keeping system.

Special school nurses obtained consent from parents/guardians for administration of prescribed medicine, over the counter medicines and for information sharing with relevant professionals, family members or carers.

We observed staff sought consent from parents before making onward referrals to other professionals.

Is the service caring?

Compassionate care

Staff cared for patients with compassion.

All staff we observed introduced themselves to the children and families.

Across all services we witnessed kind interactions with the children and families. During a school immunisation clinic, we observed kind interactions with the children and encouragement such as "you're doing well, well done". 'Flu fighter award' certificates were issued to children who had the flu vaccination. For one child who was reluctant to have the vaccine, the nurse encouraged the child to have the vaccine in a caring and gentle manner.

At one of the special schools we observed kind interaction from the nurse with a teenage student giving options about their medicine.

For most consultations and clinics, the child was at the centre of the activity. We observed a children's therapy service where the speech and language therapist was extremely engaged with the child and devised lots of novel games to support the session. They praised the child and offered lots of encouragement which helped keep the child's focus. We observed a home visit, where therapy staff were delivering and fitting new equipment. Staff interacted well with both the parent and the child, making them feel comfortable with the process.

Staff described an example where they had delivered compassionate care and support to a family and their child who was in the end stages of life. This had extended to providing care and support to the school so school staff felt comfortable with the situation and in turn could support all the children at the school.

The service received positive feedback from parents. Compliments were recorded electronically and shared with the teams.

Most parents we spoke with commented positively about the service provided. One set of parents spoke highly about the support and guidance provided by the children's medical services in the care of their child who had autism. They commented this was the only medical service, across the contacts they had had, who understood the needs of a child with autism and made the necessary adjustments to communicate with and support their child.

In most observations the privacy and dignity of children and their family was respected and promoted. For example, staff asked parents if we could observe while with them. The health visiting teams also had access to additional rooms, within the bases where they held clinics, which could be used if parents wanted conversations in private.

Emotional support

Staff provided emotional support to children, young people and families to minimise their distress.

We observed interactions between staff and patients or children in a range of environments, including at children's health clinics, schools and during home visits. Care and support provided was in a non-judgemental way. One parent explained that they had not been able to complete all the set therapy exercises with their child at home. The therapist was supportive, listened to the parent and acknowledged the contributory factors that had affected the parent's ability to complete all therapy exercises at home.

At health visitor clinics we saw emotional health of the parents addressed as well as the physical health of the child. Six to eight-week reviews focussed primarily on the mother and/or father's emotional wellbeing.

Services were flexible, and changes were made to emotionally support parents at times of need. We saw this during the inspection when clinics were rearranged to allow a community children's nurse to support a bereaved family.

Parents spoke about the support the health visiting service provided by helping them with their emotional wellbeing. Examples included providing extra home visits to weigh, support and signpost to other services such as counselling and arranging debriefs with the hospital consultant.

The trusts collaboration with the local authority in Southampton, provided children and young people with access to emotional wellbeing support. This included counselling services, drop in sessions at schools and an instant text messaging support service.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

School nurses explained the immunisations given in school in a clear, friendly and age-appropriate way to school children. Health visitors talked to parents in language they could understand, explained decisions about care and answered questions raised by parents in a thoughtful way, checking they understood the answers.

Parents could access further information and ask questions about their child's care and treatment. Staff were available to answer any questions about the care provided and responses were open and honest. Parents told us if they had any questions they could discuss them with staff.

Children were involved in decisions about their care and treatment. For example, we observed a child had the opportunity to choose the colour of their new piece of equipment.

Staff described an example of how they had supported a family and their child in the final stages of the child's illness to set their own goals and plans and achieve them. This included the child starting school with their peers and accessing the local children and young people's hospice.

Care plans at special schools evidenced the inclusion of parents' wishes about the management of their child's conditions.

The trust had developed links with external organisations that provided up to date guidance and information on external websites. All services promoted this facility to parents, and the website could be translated into numerous languages.

Is the service responsive?

Planning and delivering services which meet people's needs

The service planned and provided services in a way that mostly met the needs of local people

Clinics to support the healthy child programme were mostly set up in suitable and accessible locations to meet people's needs. Clinics were often held in children's centres with a range of additional facilities available for children and families including café's, play areas and rooms for confidential conversations. However, a lack of a hub centre in one of the areas of the service, meant there was a lack of suitable clinical areas to deliver therapy treatment to children. This issue was included on the children, young people and families risk register and the trust wide risk register that detailed the service was working with the commissioners to find a suitable venue for a hub in this region.

Therapy services had limited clinical area resource in the northern areas of Hampshire. One parent said that to attend therapy sessions, they and their young child had to travel to the clinic by two buses. This created anxiety that the transport system would fail and they would be late or miss

appointments. This contrasted with other areas of the service where parents had a choice of location that suited them best.

Joint clinics between paediatricians, nurses and therapists were held at special schools. This reduced the need to take students out of school for multiple appointments. Joint therapy clinics meant parents and their children did not have to attend multiple appointments, which parents said was beneficial to their family life and wellbeing.

Services were aligned to national programmes such as the healthy child programme and the national child measurement programme, with set key performance indicators to monitor progress. At a local level, these had been adapted to meet local need.

The children's therapy service in Aldershot Centre for Health had set up a 'reach up reach out' group session advertised for children with additional needs, parents and carers. Parents could get information on stammering, speech, sound difficulties and eating and drinking difficulties.

The aim of the service's Enhanced Child Health Visiting Offer (ECHO), was to provided intensive support to expectant mothers, children and families who were assessed as at high risk of harm or ill health. However, there were examples where children and families received differing services dependant on where they lived. The service worked with seven commissioning teams across Hampshire, which resulted in some differences in service provision in different geographical areas.

The Children's Outreach, Assessment and Support team only worked in the east (Portsmouth) region. The service in the west (Southampton) region of the trust was disbanded because sufficient resource had not been commissioned.

Therapy staff reported some children had delayed access to equipment. This was due to the home address of the child. Solent NHS trust staff could only order equipment from the Hampshire equipment store. If a child lived in Portsmouth, Southampton or in a neighbouring county but received service from Solent NHS trust therapists did not have the authorisation to order equipment from those equipment stores. Despite staff telling us this had an impact on the delivery of service to children and young people there was no detail about this on either the children, young people and families risk register or the trust wide risk register. We had no assurance the service was addressing this issue.

Staff told us the asthma specialist service was only commissioned to deliver the service in Southampton. One parent, whose child received support from this service but attended school outside Southampton, said they would not move closer to their child's school because that would mean they would lose this service. However, the trust told us this service was offered in both Portsmouth and Southampton cities.

Meeting the needs of people in vulnerable circumstances

The service took account of patients' individual needs.

During the inspection we found the trust had taken steps to ensure vulnerable people were supported to use the service. Staff demonstrated a good understanding of the needs of the local population where they worked.

The service had a range of support networks available. For example, there was a duty health visiting line which could be accessed by professionals and parents. Staff informed parents of external resources where they could access urgent help and support.

The health visiting team had a duty health visitor on call who took calls from parents and triaged visits in accordance to the need and vulnerability of the child and family.

The school nursing team in Southampton had a dedicated school nurse for children not in education or employment and home-schooled children. The current number of home schooled children was 150, although not all these children were on the school nurse's case load.

The Looked after Children service in the east (Portsmouth) was responding to the increase of unaccompanied minors entering the country through the local ports. Many of the looked after children were homed in areas outside the trust's geographical boundaries, but the welfare of these children remained under the care of the trust's Looked after Children's service. An increase in the number of LAC nurses and improved coordination of services between the local authority and the LAC team meant initial health reviews were carried out within the required time scale. The LAC service liaised with LAC teams where children were homed, to coordinate the required ongoing health reviews.

The LAC team had identified there would be a significant increase in annual health reviews due during the spring of 2019. However, we did not receive any assurance that systems had been put in place to ensure this group of vulnerable children received their annual health review in line with the national guidelines. Although there was reference to challenges meeting the initial health assessment for children entering care on the services risk register, there was no entry about the risk that national targets for looked after children receiving ongoing health reviews might not be met.

Although access to face to face interpreters for children and families using the trust services in the east and west of the trust posed no challenges, therapy staff working in the north region (for example Aldershot) expressed there were challenges in accessing face to face interpreting services. They said the only translation service was via a telephone translation service. This was difficult as the translator was unable to see what the therapists were doing or requested the child to do; such as for physiotherapy We were not assured the challenge in accessing face to face interpretation facilities in the north of the region had been escalated to senior management. The risks to patients because of the lack of interpreting services was not detailed on either the children, young people and families risk register or the trust wide risk register and when discussed with senior trust managers, they were not aware of this issue. The therapists said they had managed to get reports translated from English into the patients' preferred language but this was a challenge as no regular translation source for this had been identified.

Access to the right care at the right time

Accessibility

The trust provided the following information about the largest ethnic minority groups in the two main catchment areas covered by the trust.

Portsmouth City	Ethnic minority group	Percentage of catchment population
First largest	Asian	6.1%
Second largest	Other White	4.3%
Third largest	Mixed Ethnicity	2.7%

The largest ethnic minority group within the Portsmouth City catchment area is Asian with 6.1% of the population.

Southampton City	Ethnic minority group	Percentage of catchment population
First largest	Asian	8.4%

Second largest	Other White	8.3%
Third largest	Mixed Ethnicity	2.4%

The largest ethnic minority group within the Southampton City catchment area is Asian with 8.4% of the population.

(Source: Universal Routine Provider Information Request – P48 Accessibility)

Referrals – IN RPIR

The trust has identified the below services in the table as measured on 'referral to initial assessment'.

A list of services and referral times against the median within community services for children are provided in the table below. The trust met the referral to assessment target in both targets listed.

Name of hospital site or location	**Name of in-patient ward or unit**	**Days from referral to initial assessment**	
		National Target (days)	**Actual (median) (days)**
Battenburg Avenue	COAST Portsmouth	0	0
Adelaide Health Centre	Looked after Children West	28	27

The trust has identified the below services in the table as measured on 'assessment to treatment'.

A list of services and assessment to treatment times against the median within community services for children are provided in the table below. The trust met the assessment to treatment target in eight of the nine targets listed.

Name of hospital site or location	**Name of in-patient ward or unit**	**Days from assessment to treatment**	
		National / Local Target	**Actual (median)**
Civic Centre Portsmouth	Paediatric Therapy Portsmouth Central	90	0
Battenburg Avenue	COAST Portsmouth	1	1
Fort Southwick	Paediatric Therapy SE Hants FG	90	0
Battenburg Avenue	Community Paediatric Medical Portsmouth	90	35

Adelaide Health Centre	Paediatric Therapy Southampton SW Hants	90	0
Adelaide Health Centre	Enuresis	90	35
Adelaide Health Centre	Paediatric Medical Southampton	90	91
Adelaide Health Centre	Paediatric Therapy Southampton Central	90	0
Adelphi House	Paediatric Therapy North Hants	90	0

(Source: CHS Routine Provider Information Request – CHS10 Referrals)

Therapy services had worked with partner organisations to improve the referral process, so only children who needed to be seen by therapists were referred. This supported them in meeting their referral to treatment targets. Therapy staff in Aldershot said they were very proud that their service met the referral to treatment timescales. However, they were concerned that with staff leaving employment, this would no longer be achievable.

Staff followed the trust's 'Was not brought' policy if appointments were missed. Text messages and reminders were sent regarding appointments where the original one was not attended. The trusts electronic record system allowed staff to view all appointments attended or not attended. They could identify parents who persistently did not bring their children to appointments and escalate using the 'was not brought' policy.

The service had an on call rapid response team to deal with unexpected child deaths which included a safeguarding nurse, social worker and police. If the child died at home the nurse attended the home and offered support to the family.

Each health visiting team had a duty worker for each day. This practitioner was available in the office during the day to deal with any issues that arose rather than having to wait until the named practitioner returned to the office. This meant parents, social workers and other practitioners calls were dealt with straight away.

The service monitored the health visiting service against best practice guidelines published by Public Health England. Staff told us they were meeting these guidelines, but did explain that commissioners did not require them to meet the best practice guideline of new birth visits within 14 days of birth as commissioners had extended this to 22 days post birth.

When we reviewed information provided by the trust for the period 1 July 2018 to 31 September 2018 and compared it to the national guidance and the national average compliance with the guidance for the year 2017 to 2018, we found the trust was performing below the national average. However, the trust explained that with the introduction of the ECHO programme, the commissioners had set different targets, that were not in line with national targets, for them to achieve.

The Family Nurse Partnership (FNP) for both Portsmouth and Southampton reported that client engagement for the duration of the programme was above the national FNP average. Southampton FNP reported successes with clients who took illegal drugs. They reported 7.9% of their clients took illegal drugs at the beginning of the programme, but this reduced to 2.1% at 36 weeks of pregnancy. Portsmouth FNP. reported 99% of their clients were up to date with childhood vaccinations compared to the national FNP of 96.7%.

The COAST team in Portsmouth monitored the effectiveness of the service. Information provided for the year 1 April 2017 to 31 March 2018 showed they received a total of, 1515 referrals from GPs who would have otherwise sent the child to hospital. Out of this number, 1,352 children were managed at home by the COAST team and successfully discharged from the service. The remaining 163 children were treated at the local acute NHS hospital, either through admission to the children's assessment unit or the emergency department.

Parents commented they did not have to wait long for appointments. For example, one parent told us they only had to wait four weeks for a therapy appointment, which was below the 18-week national waiting target.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Complaints

From April 2017 to March 2018 there were 13 complaints about community health services for children, young people and families. The trust took an average of 48 days to investigate and close complaints, which is not in line with their complaints policy, which states complaints should be dealt with within 30 working days.

A summary of complaints within community health services for children, young people and families by subject is below:

Community health services for children, young people and families total

Subject	Number of complaints
Patient Care	8
Communications	2
Appointments	1
Integrated care (including delayed discharge due to absence of care package)	1
Values & behaviours (staff)	1
Total	**13**

(Source: Universal Routine Provider Information Request (RPIR) – P52 Complaints)

All staff we spoke with across the service said the sharing of and learning from complaints and compliments was done through their team meetings. We saw evidence of these discussions within the team meeting records.

Staff gave examples of changes in practice made because of learning from complaints. This included changes to how school nurses responded to school entry forms that detailed a child had continence problems. Previous practice was that these parents were automatically sent incontinence pads. After a parent complained that this was not the support their child needed, the

practice was altered, so the school nurse rings the parent to discuss the individual support the child needs.

Parents receiving support from the children's continuing care nursing team in Portsmouth had complained that they were not informed when there were staff absences and shifts could not be covered by the trust or agency staff. This left them unsure if a nurse was going to arrive to support them with their child's care. The service now contacts parents as soon as they know staff are not available to carry out a care visit.

Staff told us the trust had recently appointed a family liaison manager to support patients and families through the complaints and investigation processes. This role was trust wide and at the time of the inspection there was no evidence presented about the impact it was having on the children, young people and families service. This member of staff linked in with the patient experience group.

Compliments

From April 2017 to March 2018 the trust received 830 compliments. Of these, 123 related to community health services for children, young people and families, which accounted for 14.8% of all compliments received by the trust as a whole.

(Source: Universal Routine Provider Information Request (RPIR) – P53 Compliments)

Is the service well-led?

Leadership

The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

All managers and staff we spoke with reported the chief executive officer (CEO) and the executive team were visible and accessible.

The senior management structure for children, young people and family's services included a clinical director for the whole service, an operations director for the east of the region, an operations director for the west of the region and a professional lead for quality governance and standards.

There were service and quality managers for physical wellbeing, integrated therapies, emotional health and wellbeing, and special educational needs and a Head of Integrated Prevention & Early Help Services.

We observed effective leadership at a local level, team meetings were professionally managed with engagement from staff attending. Staff told us they could raise different viewpoints in meetings and have professional debate. All staff we spoke with said their local team leaders were very good, supportive and visible.

Management training programmes were provided to support the development of new managers.

Vision and strategy

The trust had a vision for what it wanted to achieve.

The vision set out by the trust was "to deliver great care, make Solent a great place to work, deliver value for money and quality". The trust had developed "HEART" values, which were honesty,

everyone counts, accountable, respectful and teamwork. Staff we spoke with were aware of the trust’s vision and values.

When asked about their own services vision and values, there were differing responses from different teams. Some staff said their team’s values and visions were the same as those of the trust and they had not developed any specific goals or visions for their services. Other teams had developed their own measurable goals and visions for their service based on the trust’s visions and values.

Recruitment and appraisals were based on the trusts values.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff spoke about a culture across the organisation that supported staff development, staff wellbeing and was a no blame culture.

The wellbeing of staff was considered by all working in the trust. Staff described teams that were very supportive, supported training opportunities with protected time and looked after the wellbeing of staff. Wellbeing was considered during supervision and one to one sessions. Team wellbeing lunches were arranged where the team met for a short social occasion rather than work related issues. Staff spoke about the positive effect this had on their wellbeing.

Staff spoke positively about the support provided by the trust’s occupational health service. Many commented this service enabled staff to remain in work rather than be on sick leave and provided good support to staff returning to work from extended sick leave. One member of staff gave the example that the occupational health service had arranged a physiotherapy appointment for them within one week of request. Staff had access to counselling and psychotherapy services.

The trust had an up to date lone worker policy that all staff were aware of. However, there were some discrepancies about how the safety of lone workers was supported. Staff in some services had devices that tracked their position and enabled them to call for urgent assistance without the patient being aware of this. Information provided by the trust showed that this piece of equipment was being rolled out to all staff who were exposed to lone working. However, not all staff were aware of this.

All staff knew who to raise concerns about poor practices via the trust’s whistle blowing process. However, there was limited knowledge about the Freedom to Speak up Guardian role. For some staff, our conversations with them during the inspection, was the first time they heard about the Freedom to Speak Up Guardian role. However, we did observe in some team ‘huddle’ meetings, the role of the recently appointed trust Freedom to Speak up Guardian was discussed.

Discussion with staff showed there was a culture within the trust of being open, honest and transparent with people who used the service and their families. However, when we asked staff about their understanding of their responsibilities towards the Duty of Candour legislation, there was a gap is their knowledge about his specific and important piece of legislation.

Governance

The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. This was an improvement from the findings of the inspection in 2016 where

governance processes were found to be immature and did not provide appropriate methods of assurance.

The governance structure of the trust and the children, young people and family's service supported effective monitoring of performance and cascade of information. Review of records of governance meetings showed performance and risks across the service were monitored. The governance structure provided a process for individual services to provide detail and assurance to the senior management about the performance of their individual services.

In all services, there were regular team meetings where local performance was discussed and included decisions about actions to improve performance. Performance and decisions about actions to improve performance differed in the different geographical regions of the service. Meetings were recorded, so the detail could be reviewed. Performance and decisions about actions to improve performance differed in the different geographical regions of the service.

The team brief was sent out weekly to all teams with information regarding the current service changes. Matrons held weekly briefings with team leads who disseminated the information down to their individual teams. Learning events were held to share learning from Serious case reviews or incidents.

The Southampton school nursing team held weekly cluster meetings with the local authority provision where management updates, wellbeing checks, safeguarding concerns, cases for discussion and allocation of work was discussed.

The Family Nurse Partnership team lead attended regulatory advisory board meetings with commissioners to provide evidence of the service and face challenge.

Services had consistent, systematic audit programmes to monitor the quality of care and identify areas of improvement.

Management of risk, issues and performance

Although the service had systems for identifying risks, not all risks were formally identified which meant there was no plan to eliminate or reduce them. There was no assurance that senior management were made aware of all risks relating to the children, young people and families service.

Managers and staff we spoke with were aware of risks in their area of responsibility and told us risks had been escalated. However, the service's risk register did not include all the risks staff spoke about.

For risks that were included on the risk register, detail showed the risks were reviewed and the service acted to reduce the level of risk. However, there was no assurance the service acted to reduce the level of risk to children, young people and families in relation to the difficulties of ordering equipment to meet the individual needs of children and the challenges of carrying out ongoing health reviews for looked after children. These risks were not detailed in the risk register.

Review of the trust wide risk register showed some of the identified risks for the children, young people and families service (CYPF) service were included. However, we were not assured the risk management processes ensured the trust senior management team had awareness of significant risks to the CYPF service. Review of the trust wide risks register showed some risks rated a low risk were included on the trust risk register, but risks rated as medium of the CYPF risk register were not included in the trust wide risk register. The risks not detailed on the CYPF risk register, were not escalated to the trust wide risk register, which meant there was no assurance the trust senior management were aware of these risks

The service monitored performance with the use of performance dashboards. These monitored the number of complaints received by the service, incidents, how many people waited over 52 weeks for appointments, training compliance, sickness rates, vacancies, freedom to speak up concerns and financial position. Results from performance dashboards were shared at team meetings, so staff could influence the actions needed to make any improvements and celebrate improvements in performance.

There were processes for staff to follow to ensure the service delivered at times of pressure. To deliver the flu vaccine programme, school nurses and managers worked together flexibly to ensure all clinics were covered.

There was a trust wide business continuity plan which detailed how the trust would meet its legal responsibilities as a Category 1 Responder under the Civil Contingencies Act 2004 (CCA). This required the trust, including the CYPF services to have systems in place so they could respond to a wide range of incidents and emergencies and maintain key services, when faced with disruption such as severe weather, fuel or supply shortages or industrial action. The business continuity plan detailed that all services must have their own service recovery plan.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

All the services used their local service dashboards, which covered incidents, complaints, staffing and key performance indicators. Information was shared with the team through team meetings, which ensured all staff were aware of areas requiring improvement. Therefore, we saw evidence of technology systems being used effectively to monitor and improve the quality of care and staff at all levels could challenge the information if required.

The trust had an electronic patient record keeping system. Most services used this system to record patient assessments, care plans and outcomes. However, not all teams used electronic records and some used both electronic and paper records. This increased the risk of inaccuracy of records. The system was password protected and each member of staff had their own individual login. Staff, except for one member of staff, were seen to lock their computer screens when leaving their work station.

The process for recording and monitoring staff training did not support accurate detail of staff compliance with mandatory training.

We observed that accountability to the European Union General Data Protection Regulation (GDPR) was discussed at home visits and clinics. This meant people who used the service were advised about what staff could and could not do with their personal information.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Many of the partner organisations that the service worked with to deliver the service were included in team briefings and huddles. Staff from partner organisations said their views and opinions were considered and they felt the trust engaged well with them.

The trust told us they believed they had a strong focus on employee engagement and had put in place a range of innovative interventions to effectively involve and engage with teams based across all our locations. Staff reported they had good engagement from the senior management and

executive team. Staff received monthly invitations to 'skype' and face to face group sessions with the chief executive, who also communicated to staff with regular emails. There was a rolling programme of executive and non-executive board members visits to clinical areas. We reviewed these and saw dates were arranged for visits to a sample of the children, young people and family's services.

The trust told us one of their initiatives to ensure staff could engage with the organisation was through the Freedom to Speak Up Guardian network. A Freedom to Speak up Guardian is a member of staff appointed to support staff in a confidential and non-judgemental manner who want to raise a concern about poor or unsafe care practices or about the behaviours of other members of staff. However, our conversations with staff showed there was very little knowledge or awareness about the Freedom to Speak up Guardian programme. For some staff, the first awareness they had about this programme, was when we explained it to them. There was no knowledge of who the trust's freedom to speak up guardian was.

The trust gathered feedback from parents and children with feedback forms in clinics and through parent carer networks in the local areas. Staff gave examples where changes had been made in response to feedback. This included taking into consideration the views of parents in the trust's redesign of the neurodevelopmental service. We saw there were age appropriate feedback forms, that children could complete.

In partnership with an external organisation, the CYPF service had set up a service user group for young people called "Solent Young Shapers." This was to enable young people who used the trust's service influence how services were developed. Discussion with the CYPF leaders and review of information provided showed that, although the forum was for all young people who used the trust's services, it was predominantly used by young people who had mental health conditions.

The service had also introduced the '15 steps challenge' programme. This programme focused on seeing care through a patient or carer's eyes, and exploring their first impressions of a service. The service provided details and findings from '15 steps challenges' that had been completed by young people. The findings detailed the young people had identified some areas for improvement in clinic environments to meet their needs.

The views and opinions of young people supported the underwriting of a capital bid for some minor works to the Horizon waiting area to make it more friendly and inviting to new users of the service and shaped the development of the service's digital programme.

We observed a parent engagement meeting where parents could raise their concerns about the service and offer solutions. We found mixed experiences of parents being included in the recruitment process for staff. Young mothers were invited to be part of the interview panel for the recruitment of family nurse partnership staff. However, we also heard from a parent, that despite being asked by trust staff at several meetings and declaring she would like to be included in the recruitment of community continuing care nurses, they had not been given the opportunity to be involved in this.

We saw from the development of new methods of working, the service worked with partner organisations to deliver care and treatment for children, young people and families.

Learning, continuous improvement and innovation

Accreditations

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The trust did not provide information for any accreditation schemes relating to community health services for children, young people and families.

(Source: Universal Routine Provider Information Request (RPIR) – P66 Accreditations)

Staff told us and we saw evidence that the service was accredited at level three under the UNICEF UK Baby Friendly Initiative.

The trust encouraged and supported innovation and improvement.

The Dragons Den approach was used by staff to secure funding for small improvement projects. Staff gave examples including a speech and language therapy led eating and drinking project.

Some innovations and changes were made in response to the demands of the service, this included the ECHO service. This had been developed in response to a reduction in funding from local government for the health visiting service, to ensure patients' needs continued to be met, the health visiting teams in Southampton and Portsmouth were reshaped leading to the introduction of the ECHO service. This delivers intensive health care to the most vulnerable families and is supported by text messaging, apps, and a new website.

The school nursing team had developed a programme to try and reduce school absences. Band 5 Health Related Absence nurse roles were established and worked with local primary and secondary schools to support improvements in school attendances.

The service had introduced a 'Team around the Worker' model. This aimed to create a confident, engaged, knowledgeable and properly skilled workforce at the heart of any service and practice change. This was done by creating a support and learning environment that offered a variety of opportunities to support new relationships with external providers to develop new ways of working.

The service provided an example where they used a nationally recognised reflection tool to learn and enhance care delivery for children with life limiting diseases or at the end stages of their life.

There were examples when the service had worked with partner organisations to improve services. This included working with a local hospice to ensure coordinated care to a young person at the end of their life. This has led to a formal working arrangement between the Solent NHS and hospice teams.

The provision of pastoral and spiritual support for patients and staff had improved with joined up working with the clergy of a neighboring community NHS trust.

There were examples where innovations by the trust had been adapted by national programmes. The Family Nurse partnership team as part of the national ADAPT research into neglect had developed their own tool for neglect. This tool was adapted for use by the national ADAPT programme.

Some of the improvements to services were at a more individualised or local level, but still had a positive impact on the service. A school nurse had started an emotional first aid course for colleagues. This provided the staff and team with the skills and tools to support each other and improve communication.

Mental health services

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

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
St James Hospital	Hawthorn Ward	20	Mixed
St James Hospital	Maple Ward (PICU)	10	Mixed

Is the service safe?

Safe and clean care environments

Staff members in both wards ensured that the premises, including the seclusion room were safe for patients. The managers in all teams had completed ligature and environmental risk assessments on the premises in 2018. Ligature risks identified at the last inspection in 2016 had been completed. In the main corridor on Hawthorn ward there was a phone booth that was not in line of sight, in a blind spot. However, this was mitigated by the introduction of a dedicated staff member that walked around in the corridors and the staff on 15 minute observations. There was no unsupervised access to areas with ligature points.

The service had premises that were well maintained. Nurses had hand held alarms so staff could alert others if they needed assistance. Patients had nurse call alarms in their bedrooms.

Therapy rooms and all communal areas were clean and appeared well maintained. We reviewed the most recent cleaning records and they were up to date, complete, and filled in correctly.

Safety of the ward layout

Same sex accommodation breaches[2] (Remove before publication)
Over the 12 month period from 1 April 2017 to 31 March 2018 there were no mixed sex accommodation breaches within this core service.

Since the last inspection the trust had reorganised the Hawthorn ward so the male lounge was now located next to the male bedroom corridor.

Maintenance, cleanliness and infection control
Staff members from both the teams controlled infection risk well. Staff adhered to infection control principles including hand washing. There was signage on the premises instructing how to wash hands correctly.

[2] 20180703 Universal RPIR - Mixed sex breaches

Patient-Led Assessments of the Care Environment (PLACE)[3] (Remove before publication)
For the most recent Patient-Led Assessments of the Care Environment (PLACE) assessment (2017) the location scored better than the similar trusts for all four aspects overall.

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
St James Hospital	CHS – Adult community CHS – Children, young people and families Acute wards for adults of working age and psychiatric intensive care units Community based mental health services for older people Long stay/rehabilitation mental health wards for working age adults Wards for older people with mental health problems Community based mental health services for learning disability and autism	99.1%	97.9%	95.7%	96.5%
Trust overall		**99.3%**	**96.8%**	**91.9%**	**92.9%**
England average (Mental health and learning disabilities)		**98.6%**	**92.7%**	**80.6%**	**86.1%**

Seclusion room (if present)

The seclusion room on Maples allowed clear observation, two-way communication, had toilet facilities and a clock.

Clinic room and equipment

Both teams ensured that clinic rooms were well- equipped. In both clinic rooms the medications in the medicine cabinets were checked by the nurse in charge weekly and the pharmacist. Emergency grab bags for emergency medication were available in all clinics room and fridge temperatures recorded appropriately.

Safe staffing

Nursing staff

Staffing overview at a glance[4]

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

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[3] PLACE 2017 data report
[4] 20180801 R1C Vacancy analysis ; 20180802 R1C Sickness analysis ; 20180802 R1C Turnover analysis ;20180802 R1C Bank and agency analysis

Substantive staff figures			Trust target
Total number of substantive staff	31 March 2018	63.1	N/A
Total number of substantive staff leavers	1 April 2017 – 31 March 2018	6.4	N/A
Average WTE* leavers over 12 months (%)	1 April 2017 – 31 March 2018	9%	12%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	31 May 2018	16.3	N/A
Total vacancies overall (%)	31 May 2018	22%	5.4%
Total permanent staff sickness overall (%)	Most recent month (31 March 2018)	5%	4%
	1 April 2017 – 31 March 2018	6%	4%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	31 May 2018	34.9	N/A
Establishment levels nursing assistants (WTE*)	31 May 2018	39.5	N/A
Number of vacancies, qualified nurses (WTE*)	31 May 2018	8.4	N/A
Number of WTE vacancies nursing assistants	31 May 2018	11.7	N/A
Qualified nurse vacancy rate	31 May 2018	24%	5.4%
Nursing assistant vacancy rate	31 May 2018	30%	5.4%
Bank and agency Use			
Bank staff hours filled to cover sickness, absence or vacancies (qualified nurses)	1 April 2017 – 31 March 2018	324(<1%)	N/A
Agency staff hours filled to cover sickness, absence or vacancies (Qualified Nurses)	1 April 2017 – 31 March 2018	23018 (34%)	N/A
Hours NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 April 2017 – 31 March 2018	887 (1%)	N/A
Bank staff hours filled to cover sickness, absence or vacancies (Nursing Assistants)	1 April 2017 – 31 March 2018	16784 (27%)	N/A
Agency staff hours filled to cover sickness, absence or vacancies (Nursing Assistants)	1 April 2017 – 31 March 2018	12271 (20%)	N/A
Hours NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 April 2017 – 31 March 2018	1392 (2%)	N/A

*Whole-time Equivalent

Establi***shme***nt, Vacancy, Levels of Bank & Agency Usage[5]

This core service reported an overall vacancy rate of 24% for registered nurses at 31 May 2018.

This core service reported an overall vacancy rate of 30% for registered nursing assistants.

This core service has reported a vacancy rate for all staff of 22% as of 31 May 2018.

[5] 20180801 R1C Vacancy analysis

Ward/Team	Registered nurses			Health care assistants			Overall staff figures		
	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
The Orchards PICU – Maples	6.2	19.4	32%	6.0	19.8	30%	10.6	39.2	27%
The Orchards Acute – Hawthorn Ward	2.1	15.6	14%	5.6	19.7	29%	5.8	35.3	16%
Core service total	**8.4**	**34.9**	**24%**	**11.7**	**39.5**	**30%**	**16.3**	**74.4**	**22%**
Trust total	**68.1**	**846.4**	**8%**	**53.9**	**747.4**	**7%**	**166.3**	**3083.4**	**5%**

NB: All figures displayed are whole-time equivalents

Between 1 April 2017 and 31 March 2018, bank staff filled <1% of hours to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 34% of hours for qualified nurses. One percent of hours were unable to be filled by either bank or agency staff.

Ward/Team	Available hours	Hours filled by bank staff	Hours filled by agency staff	Hours NOT filled by bank or agency staff
Maples PICU Ward	34,028	113 (<1%)	12,783 (38%)	260 (1%)
Hawthorn Ward	33,384	212 (1%)	10,236 (31%)	627 (2%)
Core service total	**67,412**	**324 (<1%)***	**23,018 (34%)***	**887 (1%)***
Trust Total	**1,123,704**	**39,989 (4%)***	**60,916 (5%)***	**8,701 (1%)***

*Percentage of total shifts

Between 1 April 2017 and 31 March 2018, bank staff to cover sickness, absence or vacancy for nursing assistants filled 27% of hours.

In the same period, agency staff covered 20% of hours. Two percent of hours were unable to be filled by either bank or agency staff.

Ward/Team	Available Hours	Hours filled by bank staff	Hours filled by agency staff	Hours NOT filled by bank or agency staff
Maples PICU Ward	30,576	9,857 (32%)*	7,365 (24%)*	732 (2%)*
Hawthorn Ward	31,844	6,927 (22%)*	4,906 (15%)*	660 (2%)*
Core service total	**62,420**	**16,784 (27%)***	**12,271 (20%)***	**1,392 (2%)***
Trust Total	**750,079**	**64,940 (9%)***	**35,565 (5%)***	**5,016 (1%0***

* Percentage of total shifts

Turnover[6]

This core service had 6.4 (9%) staff leavers between 1 April 2017 and 31 March 2018.

[6] 20180802 R1C Turnover analysis

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
The Orchards PICU – Maples	28.1	2.6	10%
The Orchards Acute – Hawthorn Ward	35.0	3.8	9%
Core service total	**63.1**	**6.4**	**9%**
Trust Total	**2,908.4**	**422.3**	**13%**

The trust provided refreshed turnover data following the inspection for the period 1 April 2018 and 30 September 2018:

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
The Orchards PICU – Maples	8.9	1.9	21%
The Orchards Acute – Hawthorn Ward	13.1	2.2	17%

Both teams had enough staff with the right qualifications, skills, training, and experience to keep patients safe and provide the right care and treatment. The current staff complement included mental health nurses, nurse practitioners, occupational therapists, psychologists, junior doctors, pharmacist and consultant psychiatrists.

Patients had good access to psychology services, with a full-time psychologist, feedback from patient groups was positive about the level of psychology input.

Patients also had consistent access to a psychiatrist in both wards. Patients who were assessed as higher risk were seen daily by the consultant psychiatrists.

Both the teams had an overall high vacancy rate, particularly for qualified nurses. The managers actively tried to recruit staff. For example, they have developed their relationship with a local university and attended recruitment drives. The staff acknowledged that they were understaffed but recognised the managers were doing everything to recruit new staff. The staff vacancies were on the trust risk register and there was an ongoing recruitment drive.

The service used regular bank staff and agency staff to fill any vacancies. The majority of agency staff used were block booked staff who were treated as substantive staff, had a full induction, appraisal, supervision and full access to training and staff support sessions. Manager’s risk assessed each ward at the daily meeting. They discussed the staffing needs of the inpatients wards and allocated staff across the teams to ensure patients were cared for safely. Managers could adjust staffing levels if they needed. For example, they had additional staff for patients on one to one observations or to facilitate leave.

Staff members ensured that a qualified nurse was present in communal areas of the ward at all times. Staff members spoke positively of the new role for staff that included walking around the corridors every 15 minutes. They gave us several examples were incidents had been diffused quickly as these staff were quick to attend.

Staff members and patients told us that escorted leave or ward activities were sometimes cancelled because there were too few staff. Although they said every effort was made to reschedule.

Most staff, including managers, told us that there was enough staff to carry out physical interventions such as restraint and seclusion. This often involved utilising trained staff from other wards. This was always risk assessed to ensure other wards were also safely staffed. Staff on both wards were positive about the responsiveness of the response team. During the inspection we saw that the response team responded quickly when alarms were activated.

In both teams there were plans for emergencies. Managers ensured that there were clear cover arrangements for sickness, leave, and vacant posts to ensure the safety of the patients.

Sickness[7]

The sickness rate for this core service was 6% between 1 April 2017 and 31 Mach 2018. The most recent month's data (31 March 2018) showed a sickness rate of 5%.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
The Orchards PICU – Maples	8%	6%
The Orchards Acute – Hawthorn Ward	3%	6%
Core service total	5%	6%
Trust Total	4%	5%

Staff Fill Rates[8] ***(Remove before publication)***

The below table covers staff fill rates for registered nurses and care staff during April, May and June 2018.

Hawthorn Ward was over filled for registered nurses for all day and night shifts for all months reported.

In addition, Hawthorn Ward had also over filled for care staff for night shifts for all months reported.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	Jun 18				May 18				Apr 18			
Maples	103.2	131.2	108.1	110.8	103.2	131.2	108.1	110.8	94.2	140.0	111.7	110.0
Hawthorn Ward	141.9	115.7	212.9	161.3	141.9	115.7	212.9	161.3	145.0	120.4	223.3	170.0

[7] 20180802 R1C Sickness analysis

[8] 20180801 R1C Safer staffing analysis

Medical staff

There was adequate medical cover day and night on both wards. On both wards, there were good cover arrangements in place for leave and absence of doctors. A doctor could attend quickly in the event of a medical emergency.

Mandatory training

Of the training courses listed, 10 failed to achieve the trust target of 85% and of those, eight failed to score above 75%. However, at inspection we saw mandatory training completion rates were higher than those reported below with an 85% completion rate. All competencies were reported month by month, excluding Information Governance. The trust informed us that Information Governance (IG) is reset to zero at the start of April and carries a separate target of 95%, which is not due to be met until the end of the year.

The electronic rota system automatically told the team managers when a staff member's training was due for renewal. Team managers completed performance reports for the trust and forwarded this information onto team leaders to discuss with staff.

Key:

Below CQC 75%	Met trust target	Not met trust target	Higher	No change	Lower	Error
	✓	✗	↑	→	↓	N/A

YTD (Current Period)	Target	Number of staff eligible	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Non-Clinical Resuscitation	85%	61	59	97%	✓	↑
Duty of Candour	85%	61	58	95%	✓	↑
Dementia Awareness (inc Privacy & Dignity standards)	85%	61	55	90%	✓	↓
Safeguarding Adults (Level 1)	85%	61	55	90%	✓	↑
Infection Prevention (Level 1)	85%	61	54	89%	✓	↑
Mental Health Act	85%	59	48	81%	✗	↓
Safeguarding Children (Level 1)	85%	61	49	80%	✗	↓
Safeguarding Children (Level 2)	85%	115	90	78%	✗	↑
Hand Hygiene	85%	59	43	73%	✗	↑
Mental Capacity Act Level 1	85%	59	43	73%	✗	↓
Infection Prevention (Level 2)	85%	59	42	71%	✗	↑
Information Governance	85%	61	43	70%	✗	↓
Medicine management training	85%	29	20	69%	✗	↑
Deteriorating and Resuscitation Training - Adults	85%	59	36	61%	✗	↑
Safeguarding Adults (Level 3)	85%	5	3	60%	✗	↑

Preventing Falls in Hospitals – Online	85%	58	33	57%	✗	↓
Core service total		**929**	**731**	**79%**	✗	↓

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff undertook a risk assessment of every patient on admission. Staff members had received training in the assessment and management of risk which they told us they found useful especially with the new plan of care.

Risk assessments were evident in all eight case notes we reviewed. Staff completed a risk assessment at admission and then updated these when the risk changed. Staff completed a monthly risk assessment audit. The team were 100% compliant with the completion of risk assessments.

Management of patient risk

Staff members discussed high risk patients in clinical meetings, ward rounds, reflective practice sessions and multidisciplinary meetings. The staff recorded these discussions in the individual clinical records. Patients' risk assessments were updated regularly and, apart from the risk to patients through poor medicine management, risks were known to all staff spoken with.

The staff teams ensured that collaborative crisis plans could be accessed by patients, families, and teams. The trust monitored the completion on crisis plans and staff teams were aware of the need to ensure crisis plans.

Staff members had developed good personal safety protocols, including lone working practices, and carried personal alarms.

Use of restrictive interventions

This core service had 241 incidents of restraint (on 97 different service users) and 70 incidents of seclusion between 1 April 2017 and 31 March 2018.

Over the 12 months, there was an increase in the incidence of both restraint and seclusion in January 2018.

The below table focuses on the last 12 months' worth of data: 1 April 2017 to 31 March 2018.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Maples	70	197	73	42 (21%)	67 (34%)
Hawthorn Ward	0	44	24	12 (27%)	0 (0%) **
Core service total	**70**	**241**	**97**	**54 (22%)**	**67 (28%)**

** Data is combined with Maples ward

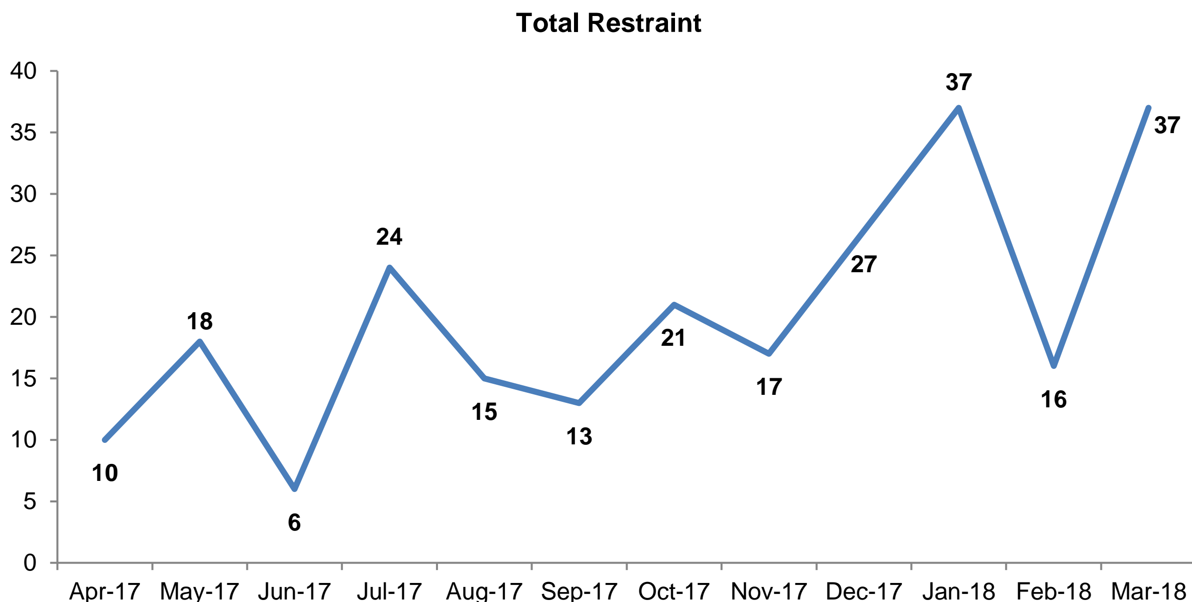
Restraint*[9]*:

[9] 20180806 R1C Restrictive intervention analysis

There were 54 incidents of prone restraint, which accounted for 22% of the restraint incidents.

There were 67 incidents of rapid tranquilisation between 1 April 2017 and 31 March 2018, the highest numbers of incidents were reported in March 2018 with 28.

There have been no instances of mechanical restraint over the reporting period.



The service manager monitored all restraints and rapid tranquillisation that took place either on the ward or in the seclusion room as each was well documented in line with trust policy and procedures. They stated that in June 2018 they identified particularly high number of restraints, so this was reviewed by the physical intervention lead who provided a report for the governance meeting. This initiated a quality improvement project for reducing violence and aggression which started two months ago. The team are introducing a pilot of the Dynamic Appraisal of Situational Aggression (DASA) tool on Maples as an outcome from the Quality Improvement project.

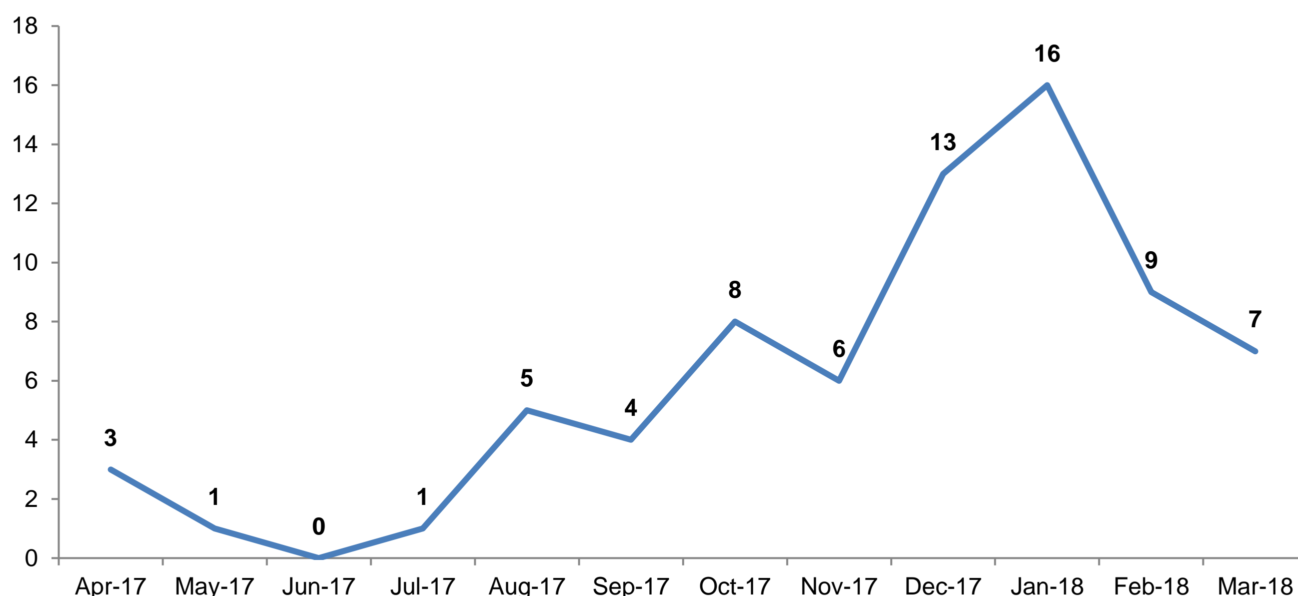
The service manager informed us that prone restraints were reviewed as part of the governance arrangements and those incidents would be escalated if they were deemed to be excessive or inappropriate, with a plan to reduce the number.

The service manager stated that in January 2018 (where the number of restraints was at its highest) the increase was due to the acuity of two patients on the wards at that time. The staff team completed risk assessments, updated new care plans and completed a report to governance group about the higher use of restraints in that period and the care plans in place in order to reduce them.

Seclusion[10]:

Over the 12 months, there was no discernible trend in the data.

[10] 20180806 R1C Restrictive intervention analysis



Segregation[11]:

There had been one instance of long-term segregation over the 12-month reporting period. The instance occurred in August 2017.

The service manager was aware of this segregation and there were regularly updated risk assessments, care plans and completed a report to governance group to ensure the patients' safety.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

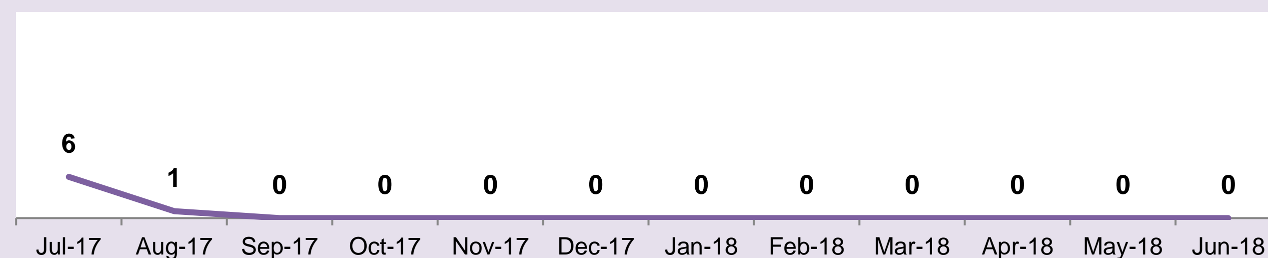
This core service made seven safeguarding referrals between 1 July 2017 and 1 June 2018, all of which concerned adults.

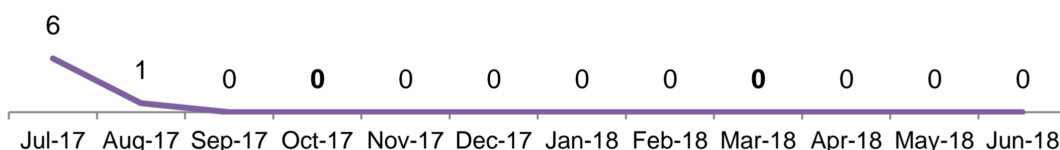
Staff members understood how to protect patients from abuse and the service worked well with other agencies to do so. All staff spoken with knew about the trust's safeguarding policy and could tell us how to make a safeguarding alert and when it was appropriate to do so. Records confirmed that 85% check of staff had completed adult safeguarding training and level 3 child protection training. There was a plan in place to ensure the other staff received the training quickly. This was checked by the managers of each individual team who then reported compliance to the service managers. The team had good links with the local safeguarding board.

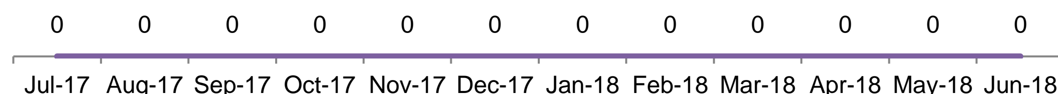
Managers monitored the number of safeguarding referrals they made. Staff completed an incident form when each safeguarding referral was made. These were monitored by the service manager.

[11] 20180806 R1C Restrictive intervention analysis

Total referrals (*July 2017 to June 2018)*







Serious case reviews[12]

Solent NHS Trust has submitted details of five serious case reviews commenced or published in the last 12 months (1 April 2017 to 31 March 2018), however, none of these relate to this core service.

Staff access to essential information

Staff members kept records of patients care and treatment. The information had recently been reviewed and all staff followed the new plans of care to ensure information was consistently kept in the same place in the electronic recording system. All appropriate trust staff could access the electronic patient records.

Medicines management

The service did not have systems in place to ensure patients' medicine management was safe.

The service regularly reviewed the effects of medication on patients' physical health in line with guidance from the National Institute for Health and Care Excellence (NICE). There was a pharmacy review of patients' medication charts daily by two pharmacists and a technician. However, when we reviewed the medical records we found a patient polypharmacy issue was not picked up by pharmacy, nursing staff or medical staff for seven days. This meant a patient was prescribed two anti-depressants, two antipsychotics medicines and two anxiolytic agents which could have a detrimental effect to their health and wellbeing. This was particularly concerning as the patient already had high blood pressure, diabetes and was assessed as a falls risk. The patient was not present at the inspection as they had absconded so we could not speak with them. However, on the day the patient absconded the patient's medication charts confirmed they had been administered all the prescribed medications.

[12] 20180703 Universal RPIR - Serious Case Reviews

A staff member showed us that medication records were not in dated order (they stated they were often like this). Staff members stated that for this particular patient their three medication charts were not in date order so information was missed on the ward round so the polypharmacy issue was not known. However, we saw all patients' medications were documented on the electronic recording system but this had not been used on the ward round when reviewing the patient's medication.

The daily pharmacy review had not picked up the issue as, we were told, both were absent at the same time and there was no contingency plan for any cover.

Another patient was prescribed an anti-psychotic at 15mg was prescribed but also PRN (as required) antipsychotic as IM (up to 10mg daily) or oral PRN as 10mg daily. The way this was written was not clear and could potentially lead to administration of 35mg a day which was above the dosage recommended in BNF (British National Formulary) Our review of all medication charts confirmed that four other patients were on high levels of antipsychotic medication above BNF.

There was no incident form completed so the service manager was unaware of the issue. However, they told us they had identified 19 other medicine errors in the last three months.

We asked members of the multidisciplinary team who attended the ward round for their account of medicines management concerns. We were told the way the paper medication forms were stored needed review and there were at times poor communication and some tensions within the team.

Medicines were stored securely in locked cabinets and fridges within locked clinical treatment rooms. They were only accessible by clinical staff.

Controlled Drugs balance checks are completed in accordance with the Trust policy by two nurses. Random balance check completed and physical stock matches register.

Medicines storage room temperature was monitored and within the correct temperature range.

Staff monitored patients taking clozapine and titration forms were completed along with appropriate blood monitoring.

Medicine incidents and errors are recorded on Datix. We were given an example how changes had been made to their practice following a recent incident.

For those patients being administered depot injections the site of injection was recorded along with reminders of when the next administration is due.

Antibiotics were reviewed periodically in line with Trust's Antibiotic Stewardship policy.

Physical health monitoring in place for those patients being initiated on Clozapine.

Track record on safety

Serious incidents requiring investigation[13]
Providers must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of an incident being identified.

Between 1 April 2017 and 31 March 2018 there were five STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was *'failure to obtain appropriate bed for child who needed it* of which there were two. One of the unexpected deaths were classified as 'Other' for type of incident.

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[13] 20180802 STEIS & SIRI analysis

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.

	Number of incidents reported	
Type of incident reported on STEIS	Hawthorn Ward	Total
Failure to obtain appropriate bed for child who needed it	2	2
Sub-optimal care of the deteriorating patient meeting SI criteria	1	1
Slips/trips/falls meeting SI criteria	1	1
Other	1	1
Total	5	5

Reporting incidents and learning from when things go wrong

'Prevention of future death' reports[14]

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been two 'prevention of future death' reports sent to Solent NHS Trust. None of these related to this particular core service.

Staff managed incidents well, they recognised incidents and reported them appropriately.

Staff had received training on how they could report incidents on the trust's electronic reporting system. Staff could explain what to report and how they would do this.

Staff members investigated incidents well and showed shared learning. We saw that there had been changes to practice after a serious incident in 2016 about the resuscitation of a patient. The learning included the introduction of staff training, new policy and procedures.

Is the service effective?

Staff members had access to up to date, accurate and comprehensive information on patients' care and treatment. In 2018 the team reviewed their care plans and developed a new plan of care which included the carer and patient voice was recovery and goal focused. In one file we saw the patient had written their own care plan.

In the 12 care records we reviewed, all had detailed and comprehensive care plans in the care planning section on the electronic recording system. The teams monitored their compliance with care plans monthly.

[14] POFD Extract

Staff members ensured crisis plans were consistently completed. The trust monitored completion and monthly data showed that compliance was good across the team.

Best practice in treatment and care

Staff members provided care and treatment based on national guidance and evidence of its effectiveness. There were care pathways in place that showed current National Institute for Health and Care Excellence (NICE) guidance for staff to follow. Evidence viewed in the care files confirmed that the team followed NICE guidance when prescribing medication and in relation to psychosis, schizophrenia and depression.

Staff members monitored patient's physical health care. In the crisis teams, 11 out of 12 care plans reviewed showed evidence of physical health monitoring and reviews. In one file a patient had refused an initial health check and the staff had not gone back to the patient to try and encourage them to have a check for 28 days.

The staff teams monitored the effectiveness of care and treatment and used findings to improve them. The service ensured analysis of outcome measures to inform service development. Staff used a bespoke outcome measure called dialogue where patients answered a series of questions about their health and wellbeing. Staff spoken with felt it was a useful measure of how the patient felt they benefitted from the care and treatment they received whilst on the wards.

Clinical staff in both teams participated in a variety of clinical audits. For example, they completed audits on care plans, medication errors and self-harm.

National and local audits[15]
This core service participated in five clinical audits as part of their clinical audit programme 2017 – 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Re-audit: Short term risk assessment of a self-harm episode on or during admission (NICE CG 16)	AMH Residential	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	Nov-17	Raise awareness of the importance of maintaining compliance with standards by presenting the audit at Solent's 2017 Research & Improvement Conference, attended by MDTs around the trust including Adult MH service.
Risk assessment for Self-harm (longer term management) (NICE CG 133)	AMH Residential	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	Nov-17	Raise awareness of the importance of maintaining compliance with standards by presenting the audit at Solent's 2017 Research & Improvement Conference; set up inclusion of psycho-education in coping strategies for self-harm patients on Orchards.
Re-audit: Discharge	AMH	MH - Acute wards for adults of working age	Clinical	Jul-17	

[15] 20180703 Universal RPIR - Audits

Summaries (AMH Inpatients 2017-18 Qtr 1)		and psychiatric intensive care units			
Care Plans for Self-harm (longer term management) (NICE CG 133)	AMH Residential	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	Nov-17	Raise awareness of the importance of maintaining compliance with standards by presenting the audit at Solent's 2017 Research & Improvement Conference; set up inclusion of psycho-education in coping strategies for self-harm patients on Orchards.
PLACE	Patient-led assessments of the care environment. 4 patient assessors and 3 staff assessors.	Maples Ward	Non-clinical, patient environment	May-18	Preliminary reports have been shared with the Services who are currently developing action plans.

Skilled staff to deliver care

Multi-disciplinary teams across this core service comprised of skilled and qualified consultants, junior doctors, nurses, nursing assistants, occupational therapists, psychologists, healthcare assistants and pharmacists.

All trust employed staff were required to undertake the trust's induction for new starters as well as a local ward-based induction process.

Ward managers told us that all staff, including bank staff and volunteers, received an induction and training when joining the trust.

DART training was provided for the ward teams during an away day initially and has since been supplemented by very regular simulations within the ward environment focusing on likely scenarios, such as ligatures. They had skill set meetings held daily between Monday to Friday, on the ward. This covered a range of areas like risk assessments, care planning or any area staff wanted to have more information.

Appraisals for permanent non-medical staff[16]

The trust's target rate for appraisal compliance is 95%. As at 30 June 2018, the overall appraisal rates for non-medical staff within this core service was 68%.

We found at the time of inspection appraisal rates were 85%.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals

[16] 20180803 R1C Appraisal analysis

The Orchards PICU – Maples	29	23	79%
The Orchards Acute – Hawthorn Ward	31	18	58%
Core service total	**60**	**41**	**68%**
Trust wide	**3416**	**1221**	**36%**

Appraisals for permanent medical staff[17]

The trust's target rate for appraisal compliance is 95%. At the time of the inspection there were no medics assigned to the Hawthorns cost centre.

Clinical supervision[18]

Between 1 April 2017 and 31 March 2018 the average rate across all three teams in this core service was 136%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Caveat from the trust: '*Clinical Supervision should be provided for all clinicians as per trust policy at least every 8 weeks as of February 2018. Therefore, we have calculated the number of sessions required each month based upon this as a minimum standard. Some teams have clinical supervision more often than this - supplemented by reflective practice, skill slots and debriefs (when required), hence rates of over 100%. Where we have identified that teams which have not been achieving this standard, plans have been implemented to ensure compliance in 2018/19'.*

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Maple Ward	216	235	109%
Hawthorn Ward	156	224	144%
Inpatient Therapies	72	146	203%
Core service total	**444**	**605**	**136%**
Trust Total	**2,057**	**2,323**	**113%**

Managerial Supervision[19]

Between 1 April 2017 and 31 March 2018 the average rate across all three teams in this core service was 106%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand data they provide.

Caveat from the trust: *Managerial supervision is every 2 months following the changes in the clinical supervision policy in February 2018. We have therefore calculated the required number of sessions based on this figure. As well as formal supervision sessions, staff have opportunity for informal managerial support as well as attendance at skill slots and reflective practice sessions. We are aware that some teams have not consistently achieved the required standard during 2017/2018 but staff and frontline managers are aware of the requirement to meet the standards within trust policy during 2018/2019 and we expect all mental health service areas to be compliant by September 2018.*

[17] 20180803 R1C Appraisal analysis

[18] 20180801 R1C Clinical and Managerial Supervision analysis

[19] 20180801 R1C Clinical and Managerial Supervision analysis

The managers provided staff with regular appraisals and managerial supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development). Within the teams, clinical and managerial supervision was combined. At the time of the inspection the rate of supervision and appraisal for the wards was 100%. This was higher than the rate provided by the trust before the inspection.

The junior doctor was supervised monthly by the consultant, they told us they found this useful. The consultant attended weekly joint case reviews with other consultants.

The managers across all teams ensured that staff had access to regular team meetings, morning briefing meetings, skill sets and handovers to share information and develop learning.

Ward name	Managerial supervision sessions required	Managerial supervision sessions delivered	Managerial supervision rate (%)
Maple Ward	156	128	82%
Hawthorn Ward	116	80	263%
Inpatient Therapies	52	137	69%
Core service total	**324**	**345**	**106%**
Trust Total	**1762**	**1645**	**93%**

Multi-disciplinary and inter-agency team work

There were a variety of multidisciplinary meetings. There were weekly multidisciplinary meeting which nurses, consultant psychiatrists, psychologist, occupational therapists and social workers attended. There was also the ward round with consultant psychiatrist and/or junior or middle grade doctor, trainee advance nurse practitioner, discharge liaison staff, benefits and asylum worker, pharmacists, discharge liaison social worker. In addition, there was a daily board review which was a very short meeting with nurses, doctors, discharge liaison nurse and an asylum worker to discuss any current risks.

However, staff were mixed about the way staff communicated in these meetings. A variety of staff expressed concerns. These were known to the trust and some actions had been taken but at the time of inspection staff still felt they had unresolved concerns.

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

Mental Health Act training figures[20]

As of 30 June 2018, 81% of the workforce in this core service had received training in the Mental Health Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

Staff members understood their roles and responsibilities under the Mental Health Act 1983 (MHA) Code of practice 2015. We reviewed MHA paperwork for patients on all wards and found most of them to be in order and stored so they were accessible to all staff who required them. We saw evidence of audits taking place of the MHA paperwork on all wards, and these were effective in most cases. For example, patients were regularly informed of their rights and any leave was

[20] 20180803 R1C Training analysis

actioned and recorded appropriately. However, in the medication charts of five patients we noted they received high dosages of anti-psychotic medication which was higher than BNF (British National Formulary) recommendations. There was no evidence of any action to address this.

Good practice in applying the Mental Capacity Act

Mental Capacity Act training figures[21]

As of 30 June 2018, 73% of the workforce in this core service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

Deprivation of liberty safeguards[22]

The trust told us that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this core service between 1 April 2017 and 31 March 2018.

Staff members understood their roles and responsibilities under the Mental Capacity Act 2005. In the files we reviewed, there was evidence of consideration of capacity and consent where this was appropriate.

Mental Capacity Act training took place at induction and was ongoing throughout the year. The figures for staff attending the training was 80%.There was a Mental Capacity Act policy and staff knew who to approach in the trust if they need support or advice. Staff discussed patients' mental capacity at the multidisciplinary meetings.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Patient-Led Assessments of the Care Environment (PLACE) - data in relation to privacy, dignity and wellbeing[23] (Remove before publication)

The 2017 Patient-Led Assessments of the Care Environment (PLACE) score for privacy, dignity and wellbeing at one core service location(s) scored higher than similar organisations.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
St James Hospital	CHS – Adult community CHS – Children, young people and families Acute wards for adults of working age and psychiatric intensive care units Community based mental health services for older people Long stay/rehabilitation mental health wards for working age adults Wards for older people with mental health problems Community based mental health services for learning disability and autism	93.3%

[21] 20180803 R1C Training analysis
[22] 20180703 Universal RPIR - DoLS
[23] PLACE 2017 data report

Trust overall	**90.9%**
England average (mental health and learning disabilities)	**83.7%**

Kindness, privacy, dignity, respect, compassion and support

Staff members cared for patients with compassion. All the interactions we saw between patients and the staff members were kind, respectful and showed an understanding of the patients' needs.

All patients or carers we spoke with said staff listened to them and were supportive and caring. The majority of patients gave us positive feedback regarding the staff teams.

The teams respected patient confidentiality; they had soundproofing in interview rooms and used lockable bags to carry any information outside the office.

Involvement in care

Staff member's involved patients and those close to them in decisions about their care and treatment. The staff team ensured patients were involved in their care planning, risk assessments and decisions about their care.

All patients we spoke with told us staff members described treatment options and gave them choices. For example, patients told us they were given a choice of treatments.

Staff encouraged patients to attend their review meetings and staff met with some patients to design a care plan together. The majority of patients spoken with said they attended reviews. However, not all patients had copies of their care plan. However, those that did not have a copy stated that they had discussed their care plan with staff members. Both patients and staff were positive about their collaborative approach.

Involvement of patients

Staff encouraged patients to give feedback on the service. Patients completed a survey and the friends and family tests were used in the daily planning meeting and at the weekly community meeting. The patient's survey was very accessible as it was in pictorial form with happy faces and sad faces. The results of the survey was written up into a report and that informs the 'you said we did board'. Patients had fed back concern about the food and the service changed parts of the menu to include more yogurts and fruit.

Patients had access to advocacy services. There was evidence in all care files that staff regularly discussed and arranged an advocate for patients. Staff members often acted as advocates for patients at housing appointments.

Both wards had weekly community meetings with patients. Weekly community meetings sought feedback on patient's experiences during their stay, including the opportunity for actions to be implemented. In addition there were daily planning meetings for patients, where plans and arrangements for the day were discussed. Patients could also discuss any ad-hoc activities they would like staff to facilitate.

Patients were involved with the recruitment of staff in all teams. They formed part of the recruitment process for new clinical staff in 2017.

Involvement of families and carers
Staff members involved families in the care of the patient as appropriate. For example, family members we spoke with said staff involved them in the care and treatment of their relative. Patients told us they felt included in the decision-making process. Two carers told us they stayed in the ward the majority of the day to make their relative feel more comfortable and staff involved them in all decisions. There was also a weekly carers group that carers said they found useful.

Is the service responsive?

Ward moves[24] (Remove before publication)
Between 2017 and 2018, 15 patients for the core service moved wards.

Caveat from the trust: St James' Hospital, Adult Mental Health: Of the 5 patients that were transferred twice, 4 of these were when a patient was given an initial trial to Oakdene to ensure suitability before permanent transfer and were then transferred permanently or whereby the patient had a sleep over to free up a bed in an emergency and then returned to their ward the following day. The fifth patient however, was transferred to free up beds for Portsmouth system pressures. Overall, there are no concerns with transfer processes on the adult mental health wards. The 24 ward transfers over a two-year period for non-clinical or step down reasons out of a total of 163 inter-ward transfers, constituted a 14% proportion in a pressured system.

		During the last 12 months – (2017-2018)			During the previous 12 months – (2016-2017)		
Ward name	**Number of ward moves**	**Number of patients**	**How many were at 'end of life'***	**%-share of all patients**	**Number of patients**	**How many were at 'end of life'***	**%-share of all patients**
Hawthorn Ward	0	0	0	0%	0	0	0%
	1	10	0	67%	4	0	100%
	2	5	0	33%	0	0	0%
	3	0	0	0%	0	0	0%
	4+	0	0	0%	0	0	0%
	Total	**15**	**0**	**100%**	**4**	**0**	**100%**

Moves at night[25] (Remove before publication)
The trust provided information regarding the number of patients moving wards at night in this core service between 1 April 2017 and 31 March 2018.

Of the two wards reported within this core service, 13 patients were moved ward after 22:00hrs and between 08:00hrs.

Ward name	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Total
Hawthorn Ward	0	0	2	1	0	1	1	1	0	0	0	1	**7**

[24] 20180703 Universal RPIR - Ward moves
[25] 20180703 Universal RPIR - Moves at night

Maples	0	0	1	1	1	0	0	0	3	0	0	0	**6**
Core service total	**0**	**0**	**3**	**2**	**1**	**1**	**1**	**1**	**3**	**0**	**0**	**1**	**13**

Access and discharge

Bed management

Bed occupancy[26] (Remove before publication)

The trust provided information regarding average bed occupancies for one ward in this core service between 1 April 2017 and 31 March 2018.

Both of the wards within this core service reported average bed occupancies ranging above the national recommended threshold of 85% over this period.

We are unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the period that was covered.

Ward managers told us that wherever possible they ensured beds were available for patients living in the catchment area. They regularly reviewed patients to establish if they were ready for move on or discharge to make beds available. If patients were admitted out of area due to lack of beds (this had only happened during the partial closure of Maples between May – September 2018), wards worked to ensure they were admitted to their local ward as soon as a bed was available for them. Out of area bed usage was only for specialist provision for which the trust was not commissioned to provide. The trust did not move any patients due to lack of bed availability.

Beds were always available when patients returned from leave.

Staff we spoke with told us that patients were not moved between wards during an admission episode unless it was for a clinical reason, for example requiring more or less intensive nursing care.

Ward managers we spoke with told us that patient discharge times were agreed on the morning of their day of discharge. Patients were preferably discharged in the morning or during the day once their discharge was approved and their medicines were ready for collection.

The service manager told us the average length of stay was seven to 11 days on Hawthorn and eight weeks on Maple ward. The bed occupancy varied throughout the year as Maple ward partially closed six beds in May 2018 and reopened in September 2018. During this time four beds remained open and utilised while necessary building work was undertaken This was due to a serious incident which made the environment unsafe. During this time the service used out of area PICU beds but not out of area acute beds.

Ward name	Average bed occupancy range (**1 April 2017 – 31 March 2018**) (current inspection)
Maples Ward	70% - 96%
Hawthorn Ward	77% - 100%

[26] 20180703 MH RPIR - Bed Occupancy

Average Length of Stay data*[27] *(Remove before publication)

The trust provided information for average length of stay for the period 1 April 2017 to 31 March 2018.

We are unable to compare the average length of stay data to the previous inspection due to differences in the way we asked for the data and the period that was covered.

Ward name	Average length of stay range (**1 April 2017 – 31 March 2018**) (current inspection)
Maples Ward	5-40
Hawthorn Ward	6-13

Out of Area Placements*[28] *(Remove before publication)

This core service reported 18 out area placements between 1 July 2017 and 30 June 2018. As of 16 July 2018 this core service had three ongoing out of area placements.

There were no placements that lasted less than one day, and the placement that lasted the longest amounted to 3,464 days.

Thirteen out of 18 out of area placements were due to the patient being received from another provider, while five placements were because of the patient being placed with another provider due to this better suiting their care or personal needs.

Number of out of area placements	Number due to specialist needs	Number due to being received from another provider	Range of lengths (completed placements)	Number of ongoing placements
18	5	13	3-3464	3

Readmissions*[29] *(Remove before publication)

This core service reported 89 readmissions within 28 days between 1 April 2017 and 31 March 2018.

All of the readmissions were readmissions to the same ward as discharge.

The average of days between discharge and readmission was nine days. There were three instances whereby patients were readmitted on the same day as being discharged but there were 11 instances where patients were readmitted the day after being discharged.

Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
89	89	100%	0 – 30	9

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[27] 20180703 MH RPIR - Length of stay

[28] 20180703 MH RPIR - Out of area placements

[29] 20180703 MH RPIR - Readmissions

Discharge and transfers of care

Delayed discharges[30] (Remove before publication)
Between 1 April 2017 and 31 March 2018, there were 689 discharges within this core service. This amounts to 33% of the total discharges from the trust overall (2079).

Of the 689 discharges, 13 (2%) were delayed.

Within this core service, four of the 12 months (April, May, and November & December 2017) reported no delayed discharges.

The service had a monthly meeting with operations manager and service managers, inpatient units, crisis teams and recovery to manage the effective discharge of patients in a safe and timely manner. This meeting was particularly focused around barriers to discharge and what actions could be taken to reduce these. This assisted staff identify and remove barriers to discharge during patients' admission to prevent or minimise delays to their discharge such as lack of accommodation. The service had no delayed discharges.

Staff planned together with patient's for their discharge following their admission to the wards.

Staff supported patients during referrals and transfers between services – for example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit. Staff told us that accessing the psychiatric intensive care unit was generally not difficult as the wards managed acutely unwell patients without transfer to the psychiatric intensive care unit.

Lost to follow up[31] (Remove before publication)
There is no information pertaining to this core service.

Referral to assessment and treatment times[32] (Remove before publication)
The trust has identified services as measured on 'referral to initial assessment' and 'assessment to treatment'. However, there was no information pertaining to this core service.

Facilities that promote comfort, dignity and privacy needs more

Patient-Led Assessments of the Care Environment (PLACE) Assessments [33] (Remove before publication)
The 2017 Patient-Led Assessments of the Care Environment (PLACE) score for ward food at the locations scored higher than similar trusts.

The wards had suitable facilities to meet patients' needs. All of the therapy rooms in the crisis service were sound proofed so conversations could not be overheard.

The wards had good occupational therapist input and offered daily schedules of activities for patients including art, cookery, exercise games and mindfulness. On most wards patients only had

[30] 20180703 Universal RPIR - DTOC
[31] 20180703 Universal RPIR - Follow Ups
[32] 20180703 MH RPIR - Referral
[33] PLACE 2017 data report

activities scheduled from Monday to Friday and decided their own activities for each weekend with the support of weekend staff.

Staff and patients had access to a range of rooms and facilities to support the treatment and care being provide across the wards, for example clinic rooms, meeting rooms, low-stimulus calm rooms, and activity rooms, communal areas and gardens. All wards had designated treatment rooms, lounges and chill-out rooms with equipment designed to support patients to relax.

All wards had access to quiet family and visiting rooms to ensure that patients maintained relationships with family, children and friends.

Patients had access to their mobile phones in accordance with their risk assessments which were reviewed daily. Wards provided private space where patients could make private telephone calls if required.

Patients generally told us that the food was good and they could make hot drinks and have snacks day and night

Site name	Core service(s) provided	Ward food
St James Hospital	CHS – Adult community CHS – Children, young people and families Acute wards for adults of working age and psychiatric intensive care units Community based mental health services for older people Long stay/rehabilitation mental health wards for working age adults Wards for older people with mental health problems Community based mental health services for learning disability and autism	97.9%
Trust overall		**97.3%**
England average (mental health and learning disabilities)		**93.4%**

Patients' engagement with the wider community

The team helped patients to access employment and training opportunities. Patients we spoke with were very positive about the way the team enabled them to access courses and look for housing.

Meeting the needs of all people who use the service

Both wards were on ground floor for wheelchair access and had adapted toilets and bathroom.

The waiting areas and corridors in the wards contained information leaflets about local services and medication. Information leaflets about the service were provided by the trust in a range of formats. Information included how to access counselling and substance misuse services, contact advocacy and how to make a complaint.

Listening to and learning from concerns and complaints

Formal complaints[34]
This core service received 14 complaints between 1 April 2017 and 31 March 2018. Six of these were upheld, six were partially upheld and two were not upheld. None were referred to the Ombudsman.

Subject	Hawthorn Ward	Hawthorn Ward - Acute AMH	Maples Ward	Grand Total
Patient Care		4	1	**5**
Communications		2		**2**
Privacy, dignity & well being		2		**2**
Admin/policies/procedures (Inc. patient record)			1	**1**
Integrated care (Inc. delayed discharge due to absence of care package)		1		**1**
Other (specify in comments)		1		**1**
Restraint	1			**1**
Values & behaviours (staff)		1		**1**
Core service total	**1**	**11**	**2**	**14**

All staff treated concerns and complaints seriously, investigated them and learnt lessons from the results. The theme of the majority of complaints were from carers around communication break down between staff and carers. The manager phoned carers to discuss their concerns. These were addressed with the staff involved. Patients reported they were happy with the outcomes.

In addition, a weekly carer drop in group was set up so carers could raise any concerns directly with the staff. As a result of this feedback they changed the format of the care plans to include the carers view point.

Any formal complaints about the service management were dealt and investigated by an external team who are not part of the Orchard team.

Staff told us they spoke about how to make a complaint at their first meeting with a patient. Information on how to make a complaint was displayed in all the waiting rooms. This included information about the role of independent advocacy service in complaints.
Patients and carers told us they knew how to complain and were confident that the staff would act upon them.

Learning from complaints was shared at monthly governance meetings and at weekly reflective learning forums, team meetings and handovers.

[34] 20180806 R1C Complaints analysis

The service received 19 compliments during the last 12 months from 1 April 2017 to 31 March 2018, which accounted for 2% of all compliments received by the trust as a whole. The compliments were mostly about staff kindness during patients stay in the wards.

Is the service well led?

Leadership
All managers had relevant experience to carry out their role.

The team managers and the service managers had ensured the team met the requirements of the 2016 inspection report.

The teams knew who the senior managers in the trust were and told us that they visited the teams. All staff spoke positively about the increased presence of senior managers and welcomed their visits.

There were leadership training opportunities for the staff members to develop their skills as managers.

Vision and strategy
The managers promoted a positive culture that supported and valued staff. All staff knew and understood the trusts visions and values and applied them to their work. The trust's service level vision statements had been created with staff and had taken into account the trust business objectives and STP agenda.

Staff spoke positively about senior management in the trust. Staff from both wards gave feedback about services at team business meetings.

Staff could explain how they were working to deliver high quality care within the budgets available. All teams completed a benchmarking document (a document that compares their performance with other teams about waiting times, outcomes, discharge). Staff were positive about the new care plans and outcome measures.

Culture
Most of the staff we spoke with felt positive about working for the trust. They could approach mangers without concern. Staff morale was good in the teams although they stated they often felt understaffed. Staff said they mostly worked well together, however within the multidisciplinary team there were some tensions and poor communication between staff. Staff also spoke of tensions in the morning briefing meeting. Staff had raised concerns with senior managers and although they felt they were addressed at the time, they felt the manner in which some staff communicated still need improvement as some staff spoke of feeling undermined.
Staff spoke very positively about the supportive and innovative teamwork within their teams. They were positive about the culture and were positive about the impact of the service manager and managers who worked hard with the teams to meet all the requirements and recommendations of the last inspection. Staff members in the focus group stated they valued the newly introduced skill set meetings before handover and the reflective practise.

Staff were proud about the work they did. Staff felt that the trust listened to and acted upon ideas like the introduction of the new care plans.

During the reporting period there was one case where staff were either suspended, placed under supervision or were moved to a different team. The service manager stated they received good support from the trust human resources team.

All staff told us that although there were at times some tensions in the teams, there was not overall a bullying or harassment culture in any of the teams. They knew how to raise concerns without fear of victimisation and knew how to use the whistle-blowing process if they had concerns. Staff gave us examples when they had used the whistleblowing process.

The managers ensured staff were competent for their roles. Staff members received sufficient regular one to one managerial supervision to assist them care and treat patients safely.

During the reporting period, there was one case where staff have been either suspended, placed under supervision or were moved to a different ward. The member of staff concerned was placed under supervision.

Caveat: Investigations into suspensions may be ongoing, or staff may be suspended, these should be noted.

Ward name	Suspended	Under supervision	Ward move	Total
Orchards	0	**1**	**0**	1
Core service total	0	**1**	**0**	1

Governance

The governance systems were not sufficient to ensure patient safety.

Both wards had introduced systems to check the team's performance and make changes when necessary at a local and trust level. Staff had implemented recommendations from reviews of deaths, complaints, and safeguarding alerts. They undertook or participated in clinical audits and acted on the results when needed. They understood arrangements for working with other teams, both within the provider and externally, to meet the needs of patients. In 2017 Solent NHS trust took part in the National Clinical Audit of Psychosis (NCAP). The results of this audit were received in July 2018. In comparison with outcomes from the National Audit of Schizophrenia 2014, overall the trust had an average improvement rate of 30%. Of the 32 standards measured within the NCAP audit, Solent NHS Trust were in the top 3 trusts for 7 standards and top quarter for 18 of the 32 standards. The trust were above average for 23 and below the national average for 9 of the 32 standards.

Governance meetings were held on the ward each month with staff including discussing with staff what governance is and the leadership role within this. There were also monthly operational management meetings with staff

The ward held a daily training and engagement schedule, Monday to Friday. All staff coming onto the late shift went straight to this forum prior to handover to ensure staff attendance. This formed part of the services governance. Agenda items in this schedule included a reflective learning

forum,monthly governance, leadership team and staff open forum, meeting the orchards vision, security meeting, ward meetings, survey feedback and reflective practice and skills slots.

The service were fully aware of some relationship and communication issues within the MDT and were taking steps to address the situation through a number of actions, which were carefully considered, sensitive and respectful to all parties. Effective oversight was in place to see the issues through to resolution. The response and oversight was significantly good with effective management by the senior local team, and with full awareness of Directors.

Board assurance framework[35]

The trust provided its Board assurance framework. This detailed any risk scoring 15 or higher and gaps in the risk controls that affect strategic ambitions. The trust outlined three business priorities with nine sub priorities:

1. Great Care:
    a. Improve quality in line with CQC inspection requirements
    b. Provide safe staffing
    c. Use technology to work differently
2. Great place to work:
    a. Plan for long term sustainable staffing
    b. Enhance our leadership throughout the organisation
    c. Provide training that enables us to deliver great care
3. Great value for money:
    a. Further pathway integration with other providers
    b. Benchmark out services to improve productivity
    c. Change front line and corporate services to live within our income

Corporate risk register[36]

The trust has provided a document detailing 108 of their current risks of which 12 have a risk rating of high (Red), none related to this core service.

Management of risk, issues and performance

The service had an inconsistent system for identifying risks. The trust kept a risk register on the electronic reporting system. The team managers could escalate risks to the trust wide risk register, they also had their own divisional risk register and a local register.

However, not all risks were actioned immediately. For example, risks like the prescribing risks identified at this inspection had not been addressed by the staff team. But the same team had identified 19 medicine errors in the last three months and introduced a quality review.

All staff were trained in clinical risk and use of the electronic reporting system. The service had plans for emergencies like adverse weather which was known to all the team.

Overall, staff were very positive about the culture shift in the trust and in relation to their ownership of the risk register. They had confidence in the senior team to address risks. The wards undertook a monthly staff survey. This was anonymous and staff were able to raise issues or concerns through this forum. This was then discussed at a feedback session and actions agreed and monitored.

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[35] 20180801 R1C BAF & RR analysis

[36] 20180801 R1C BAF & RR analysis

Information management
The service had a systematic approach to continually improving the overall quality of its service. Both the team managers and the service managers could access a business performance report on the electronic system. These were shown to us at the inspection and discussed in staff meetings.

Engagement
The teams engaged well with patients and their families. They listened to feedback from patients, supported them and made changes because of the feedback. For example, following feedback from the patient's community meeting they recently ordered a new larger television which was wall mounted at patients request. There was also a formal Matron walk around fortnightly with infection control, domestic lead and the ward coordinator. During these walk rounds staff actively encourage feedback from patients.

The service used surveys, patient meetings, one to one meetings and the complaints procedure as formats to pick up the patient experience of the service. For example, staff ensured patients cultural food needs were met by ensuring the patient met with the catering managers and cook to devise the menu.

Learning, continuous improvement and innovation
The trust was committed to quality improvement. There had been two recent quality improvement projects on the PICU; a project on reducing violence and aggression and national project on reducing restrictive practices.

Accreditation of services[37] (Exception reporting only)
NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The trust provided information on core services, which have been awarded an accreditation together with the relevant dates of accreditation, however, none pertained this core service.

The trust were working on innovative practices relating to a combined mental health unit and a new acute bed model.

The wards had made innovative changes to the way care planning was achieved. There was an emphasis on the voice of both the patient and carers. Staff had been engaged throughout this process.

Wards for older people with mental health problems

Facts and data about this service

[37] 20180703 Universal RPIR - Accreditation

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
St James Hospital	Brooker Ward	22	Mixed

Is the service safe?

Safe and clean care environments

Staff did regular risk assessments of the care environment. Staff checked the ward environment three times every day, this raised staff's awareness of risk issues such as potential ligature points and blind spots. Any concerns about environmental risk were raised with the ward manager or senior person on duty.

Safety of the ward layout

Same sex accommodation breaches[38] (Remove before publication)
Over the 12 month period from 1 April 2017 to 31 March 2018 there were no mixed sex accommodation breaches within this core service.

This reflects the data provided to us by the trust prior to the inspection. However, during our inspection staff reported that there had been 17 mixed gender breaches since January of this year, this did not match with the data provided from the trust. Occasionally, female patients slept in a bedroom on the male corridor. When this was necessary female patients slept in the bedroom closest to the female corridor, this meant they did not need to walk past the male bedrooms to get to a communal area. The bedroom the female patient slept in had its own en-suite shower room so female patients did not need to walk down the corridor to get to a bathroom. Staff risk assessed all mixed gender breaches and raised a safeguarding referral with the local authority.

Staff mitigated blind spots on the ward. Staff were aware of the blind spots and mitigated the risks by individually risk assessing each patient. Staff were present in communal areas which allowed for good levels of observation.

Ligature risks[39] (Remove before publication)
There were ligature risks on one ward within this core service. The trust had undertaken recent (From 1 May 2018 onwards) ligature risk assessments at one location.

Brooker Ward presented a high level of ligature risk and the trust noted that the 'Audit identified immediate remedial works for bedroom doors and fixtures in the gardens. Immediate action was taken and all ligature risks have either solutions or mitigations in place for identified risks, though further work is required for some en-suite fixtures'.

The trust had taken actions in order to mitigate ligature risks 'by making sure staff were aware of ligatures within ward environment and known mitigations were in place until such time that full remedial actions could be taken'.

There was a full risk assessment of all the ligature risks on the ward. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. There was an ongoing estates programme to manage outstanding ligature risks and there was mitigation identified in the risk assessment. Staff completed daily environmental checks which included monitoring any ligature risks.

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[38] 20180703 Universal RPIR - Mixed sex breaches
[39] 20180703 MH RPIR - Ligature Risks

Maintenance, cleanliness and infection control

Patient-Led Assessments of the Care Environment (PLACE)[40] (Remove before publication)
For the most recent Patient-Led Assessments of the Care Environment (PLACE) assessment (2017) the location scored higher than the similar trusts for all four aspects overall.

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
St James Hospital	CHS – Adult community CHS – Children, young people and families Acute wards for adults of working age and psychiatric intensive care units Community based mental health services for older people Long stay/rehabilitation mental health wards for working age adults Wards for older people with mental health problems Community based mental health services for learning disability and autism	99.1%	97.9%	95.7%	96.5%
Trust overall		**99.3%**	**96.8%**	**91.9%**	**92.9%**
England average (Mental health and learning disabilities)		**98.6%**	**92.7%**	**80.6%**	**86.1%**

The ward was clean and tidy throughout. Ward furnishings were in good condition and had been well-maintained. There was a cleaning schedule in place. Sub-contractors completed a bi-monthly swab of surfaces to check for bacteria.

Staff complied with infection control principles. There were signs to remind staff to wash their hands and hand sanitisers at ward exits. Staff complied with the bare below the elbows policy and wore uniforms which all appeared clean. Staff audited hand hygiene and fed back the results on notice boards in communal areas.

Clinic room and equipment

The clinic room was clean and tidy. All the necessary equipment and emergency medicines were available to staff. The clinic room temperatures and the fridge temperatures were checked and recorded daily. The medicines in the fridge had been temporarily relocated to another ward because staff had noted the fridge temperatures were not within the correct range.
Staff checked the emergency bag once a week and the pharmacist visited daily to assist with auditing the medicines in the clinic room.

Staff did not manage sterile equipment safely, we found several products that had dates expired. The ward manager told us she recognised the storage was not fit for purpose and delegated a member of staff to date check all the remaining sterile equipment.

[40] PLACE 2017 data report

Safe staffing

Nursing staff

Staffing overview at a glance[41]
Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	31 March 2018	50.4	N/A
Total number of substantive staff leavers	1 April 2017–31 March 2018	5	N/A
Average WTE* leavers over 12 months (%)	1 April 2017–31 March 2018	8%	12%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	31 May 2018	3.6	N/A
Total vacancies overall (%)	31 May 2018	7%	5.4%
Total permanent staff sickness overall (%)	Most recent month (31 March 2018)	5%	4%
	1 April 2017 – 31 March 2018	9%	4%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	31 May 2018	18.6	N/A
Establishment levels nursing assistants (WTE*)	31 May 2018	30.8	N/A
Number of vacancies, qualified nurses (WTE*)	31 May 2018	4.0	N/A
Number of vacancies nursing assistants (WTE*)	31 May 2018	1.6	N/A
Qualified nurse vacancy rate	31 May 2018	22%	5.4%
Nursing assistant vacancy rate	31 May 2018	5%	5.4%
Bank and agency Use			
Bank staff hours filled to cover sickness, absence or vacancies (qualified nurses)	1 April 2017–31 March 2018	2,598 (6%)	N/A
Agency staff hours filled to cover sickness, absence or vacancies (Qualified Nurses)	1 April 2017–31 March 2018	90 (<1%)	N/A
Hours NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 April 2017–31 March 2018	35 (<1%)	N/A
Bank staff hours filled to cover sickness, absence or vacancies (Nursing Assistants)	1 April 2017–31 March 2018	8,130 (14%)	N/A
Agency staff hours filled to cover sickness, absence or vacancies (Nursing Assistants)	1 April 2017–31 March 2018	3,034 (5%)	N/A
Hours NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 April 2017–31 March 2018	978 (2%)	N/A

[41] 20180801 R1C Vacancy analysis ; 20180802 R1C Sickness analysis ; 20180802 R1C Turnover analysis ;20180802 R1C Bank and agency analysis

*Whole-time Equivalent

There were always enough staff on duty. Whilst there were three registered nurse vacancies and one health care support worker vacancy, agency staff were rarely used to cover shifts. Substantive staff and staff from the hospital bank covered any outstanding shifts. Bank staff were always regular staff who knew the ward well. A health care support worker would occasionally cover registered nurse shifts, to make up the numbers. However, there was always a registered nurse on duty. Activities were not cancelled due to staffing shortages and there were enough staff to manage physical interventions. For example, during our inspection we observed staff de-escalating a patient that was in distress, other patients were supported during this time.

Patients had regular one-to-one time with their named nurse. Patients' care records showed staff had spent time with patients discussing their feelings and their physical and mental health.

Establishment, Vacancy, Levels of Bank & Agency Usage[42]

This core service reported an overall vacancy rate of 22% for registered nurses at 31 May 2018.

This core service reported an overall vacancy rate of 5% for nursing assistants.

This core service has reported a vacancy rate for all staff of 7% as of 31 May 2018.

	Registered nurses			Health care assistants			Overall staff figures		
Ward/Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
The Limes	4	18.6	22%	1.6	30.8	5%	3.6	53.0	7%
Core service total	4	18.6	22%	1.6	30.8	5%	3.6	53.0	7%
Trust total	**68.1**	**846.4**	**8%**	**53.9**	**747.4**	**7%**	**166.3**	**3,083.4**	**5%**

NB: All figures displayed are whole-time equivalents

Between 1 April 2017 and 31 March 2018, bank staff filled 2,598 (6%) hours to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 90 (<1%) of hours for qualified nurses. Thirty-five hours (<1%) were unable to be filled by either bank or agency staff.

Ward/Team	Available hours	Hours filled by bank staff	Hours filled by agency staff	Hours NOT filled by bank or agency staff
Kitwood Ward	40,443	2,598 (6%)*	90 (<1%)*	35 (<1%)*
Core service total	**40,443**	**2,598 (6%)***	**90 (<1%)***	**35 (<1%)***
Trust Total	**1,123,704**	**39,989 (4%)***	**60,916 (5%)***	**8,701 (1%)***

*Percentage of total shifts

Between 1 April 2017 and 31 March 2018, 8,130 (14%) of hours were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same period, agency staff covered 3,034 (5%) of hours. Two percent (90) of hours were unable to be filled by either bank or agency staff.

[42] 20180801 R1C Vacancy analysis

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Kitwood Ward	59,514	8,130 (14%)*	3,034 (5%)*	978 (2%)*
Core service total	**59,514**	**8,130 (14%)***	**3,034 (5%)***	**978 (2%)***
Trust Total	**750,079**	**64,940 (9%)***	**35,565 (5%)***	**5,016 (1%)***

* Percentage of total shifts

Turnover[43]

This core service had five (10%) staff leavers between 1 April 2017 and 31 March 2018.

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
The Limes	50.4	5	10%
Core service total	**50.4**	**5**	**10%**
Trust Total	**2,908.4**	**422.3**	**13%**

The trust provided refreshed turnover data following the inspection for the period 1 April 2018 and 30 September 2018:

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
The Limes	9	3	33%
Core service total	**9**	**3**	**33%**

Sickness[44]

The sickness rate for this core service was 9% between 1 April 2017 and 31 March 2018. The most recent month's data (31 March 2018) showed a sickness rate of 5%.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
The Limes	5%	9%
Core service total	**5%**	**9%**
Trust Total	**4%**	**5%**

Two staff were on long term sick leave at the time of our inspection. There was some ad-hoc staff sickness but this was being managed.

Staff Fill Rates[45] ***(Remove before publication)***

The below table covers staff fill rates for registered nurses and care staff during April, May and June 2018.

[43] 20180802 R1C Turnover analysis
[44] 20180802 R1C Sickness analysis
[45] 20180801 R1C Safer staffing analysis

The Limes had under filled registered nurses day shifts across the three months reported.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	Jun 18				May 18				Apr 18			
The Limes	89.2	105.6	92.5	112.9	89.2	105.6	92.5	112.9	83.9	117.2	86.7	140.8

Medical staff

Medical locums[46]

There was adequate medical cover day and night. There were no difficulties accessing a doctor in an emergency. There was an effective out-of-hours on call doctors' roster.

Mandatory training

Training data summary[47]

The compliance for mandatory and statutory training courses at 30 June 2018 was 90%. The trust target had been revised to 90% for the period April 2018 – September 2018. Prior to this the trust target was 85%. Of the training courses listed, six failed to achieve the trust target and of those, none failed to score below 75%.

All competencies are reported month by month, excluding Information Governance, which is report as a final figure at year-end.

Key:

Below CQC 75%	Met trust target	Not met trust target	Higher	No change	Lower	Error
	✓	✗	↑	→	↓	N/A

YTD (Current Period)	Target	Number of staff eligible	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Dementia Awareness (inc Privacy & Dignity standards)	85%	54	54	100%	✓	↑
Duty of Candour	85%	54	54	100%	✓	↑
Non Clinical Resuscitation	85%	54	54	100%	✓	↑
Medicine management training	85%	15	15	100%	✓	↑
Safeguarding Adults (Level 3)	85%	1	1	100%	✓	↑
Safeguarding Adults (Level 1)	85%	54	53	98%	✓	↑

46 20180803 R1C MH Med Locum analysis

47 20180803 R1C Training analysis

Safeguarding Children (Level 2)	85%	47	45	96%	✓	↑
Safeguarding Children (Level 1)	85%	54	51	94%	✓	↑
Infection Prevention (Level 1)	85%	54	50	93%	✓	↑
Preventing Falls in Hospitals - Online	85%	47	41	87%	✓	↑
Hand Hygiene	85%	47	39	83%	✗	↑
Mental Capacity Act Level 1	85%	47	39	83%	✗	↓
Deteriorating and Resuscitation Training - Adults	85%	47	39	83%	✗	↑
Mental Health Act	85%	47	39	83%	✗	↓
Information Governance	85%	54	43	80%	✗	↓
Infection Prevention (Level 2)	85%	47	36	77%	✗	↑
Core service total		**723**	**653**	**90%**	✓	↑

Staff training compliance was high. The ward training statistics had improved since the trust submitted their data. The trust had revised their target compliance rate to 90% for the period April 2018 – September 2018. Dementia awareness, Duty of candour, non clinical resuscitation, safeguarding adults (level 3), safeguarding adults (level 1), safeguarding children (level 1), infection prevention (level 1) and information governance training were all above the trust target of 90%. Medicine management training (88%), safeguarding children (level 2) (82%), preventing falls in hospitals (87%), hand hygiene (89%), Mental Capacity Act level 1 (79%), Mental Health Act (85%) and infection prevention level 2 (77%) were below the trust target for compliance. Any staff that had not completed their training were booked onto the next available courses.

Assessing and managing risk to patients and staff

Assessment of patient risk

Of the five care records we reviewed, all five showed that risk assessments were up-to-date and regularly reviewed. Staff assessed patients' risks on admission, when there was a change in risk or as a minimum, every six months. Risk assessments had a summary which included historical risk, dynamic risk, protective factors, and a risk management plan. Descriptions of significant events entered in patient progress notes were linked to the risk assessment.

Management of patient risk

Staff were committed to reducing falls on the ward. A quality improvement programme into reducing the falls rate on the ward had been completed. As a result of the programme, staff had increased awareness of falls and the number of falls on the ward had reduced. The staff team discussed and reviewed falls at weekly multidisciplinary meetings.

Staff responded appropriately to changes in patients' risks. For example, staff described careful monitoring of patients who had an increased risk of malnutrition. Staff monitored patients through food and fluid charts and updated care plans to reflect the change in need.

Staff observed patients on a frequent basis. Patients were individually assessed to decide how frequently staff should observe them. Observation paperwork was completed accurately by an allocated staff member. Patients on the organic side of the ward were observed a minimum of four times per hour. Patients on the functional side of the ward, were observed a minimum of hourly. Staff completed observation charts to record patients' whereabouts.

There was a restrictive intervention policy in place on the ward. The restrictions in place on the ward were considered to be necessary to protect the patient group and staff and were not excessive. There was a ward 'safety thermometer' which was completed by the deputy manager. This captured information about restrictive practice and raised awareness of restrictions on the ward with staff.

The trust had successfully implemented a smoke free policy across the site. Patients were supported to have nicotine replacement therapy including lozenges, patches and E-cigarettes.

Use of restrictive interventions

Restrictive Interventions[48]:
This core service had 28 incidents of restraint (on 18 different service users) and no incidents of seclusion between 1 April 2017 and 31 March 2018.
Over the 12 months, there was an increase in the incidence of restraint in May 2017 with eight.
The below table focuses on the last 12 months' worth of data: 1 April 2017 and 31 March 2018.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Brooker	0	28	18	5 (18%)	15 (54%)
Core service total	**0**	**28**	**18**	**5 (18%)**	**15 (54%)**

Restraint[49]:
There were five incidents of prone restraint, which accounted for 18% of the restraint incidents.

There was peak in the number of restraints in May 2017.

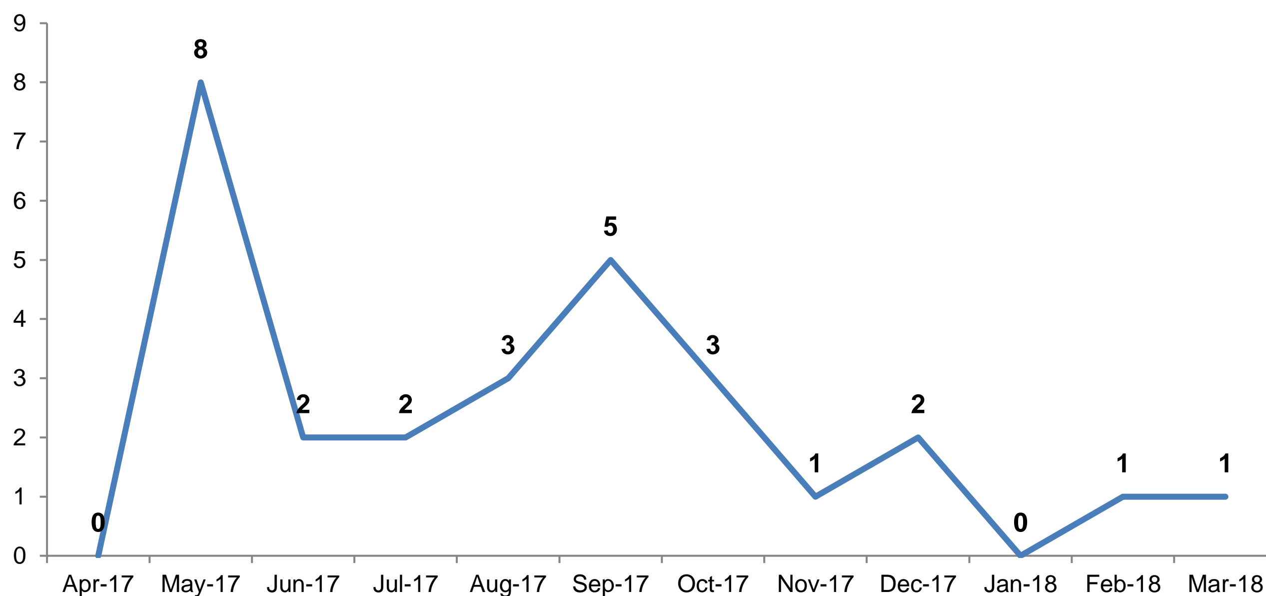
There have been no instances of mechanical restraint over the reporting period.

Staff avoided the use of prone restraint. In some instances, patients had put themselves on the floor and staff had then laid hands onto the patient, staff had documented this as a prone restraint but informed us they moved the patient into a supine position as soon as they could. Staff understood and acknowledged the risks associated with prone restraints.

The ward 'safety thermometer' included information about restraints and lower level "therapeutic holds". Staff told us that occasional therapeutic holds were used during personal care but generally the staff tried to identify the best time of day to attempt personal care which suited the patient.

Staff followed National Institute for Health and Care Excellence guidelines on the administration of rapid tranquilisation. Rapid tranquilisation is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them.

[48] 20180806 R1C Restrictive intervention analysis
[49] 20180806 R1C Restrictive intervention analysis



Seclusion[50]:
Over the 12 months, there were no reported incidents of seclusion.

Segregation[51]:
There have been no instances of long-term segregation over the 12-month reporting period.

Safeguarding

Safeguarding referrals[52]
A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

All staff understood their responsibilities in relation to safeguarding. Band 6 and band 7 staff were trained at level three in safeguarding adults at risk and child protection, all other staff were trained at level two. At our previous inspection in 2016, we found that no patient on patient assaults were being considered or reported as safeguarding events. During this inspection we found that patient on patient assaults were now being reported. Incident reports were being audited to ensure that staff continue to report safeguarding concerns. Staff told us they would make a referral if there was any suspicion of abuse or if there was a mixed gender breach.

The trust provided a family room to ensure the safety of children and young people. The family room had a children's' table and chairs and toys to keep the children entertained.

[50] 20180806 R1C Restrictive intervention analysis
[51] 20180806 R1C Restrictive intervention analysis
[52] 20180911 Safeguarding Referrals

This core service made two safeguarding referrals between 1 July 2017 and 1 June 2018, both of which concerned adults.

This reflects the data provided to us by the trust prior to the inspection. However, during the inspection we found this data provided by the trust did not match. Staff had made 23 safeguarding referrals since January 2018.

Serious case reviews[53]
Solent NHS Trust has submitted details of five serious case reviews commenced or published in the last 12 months (1 April 2017 and 31 March 2018). However, none that relate to this core service.

Staff access to essential information
There were enough computers but they were old and slow. Staff told us that computers often required maintenance because of their age.

All staff had access to the trust electronic record keeping system. Staff were supported to use the system through face-to-face training with the system coach. Staff did not raise any concerns about the system which appeared to be working well to allow them to carry out their roles. Some records were kept on paper as well as held electronically; this had not caused any problems for staff in entering or accessing information.

Medicines management
Medicines were stored securely in locked cabinets and fridges within the locked clinic room. Medicines were only accessible by clinical staff.

Controlled drugs balance checks were completed in accordance with the trust policy by two nurses.
Random balance checks were completed and physical stock matched the register.
Medicines storage room temperature was monitored and within correct temperature range.
Staff monitored patients taking clozapine and ensured appropriate blood monitoring.
Monitoring was in place for people taking high dose anti-psychotics. However, one patient had a sedative prescribed at one dose which was then crossed out to a different dose. The date of the change was not recorded which meant that it was not possible to identify what dose should have been administered on each occasion. This was raised at the time of the inspection as it had not been previously identified.

Medicine incidents and errors were recorded on the trust electronic incident recording system. Staff showed us an example of changes to practice following a recent incident.

Staff monitored patients' physical health when they were started on clozapine and high-dose antipsychotics.

Track record on safety

Serious incidents requiring investigation[54]
Providers must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of an incident being identified.

Between 1 April 2017 and 31 March 2018 there were two STEIS incidents reported by this core service. The two serious incidents were both unexpected deaths, and were classified by type of incident as 'Other'.

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[53] 20180703 Universal RPIR - Serious Case Reviews
[54] 20180802 STEIS & SIRI analysis

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.

Reporting incidents and learning from when things go wrong

'Prevention of future death' reports[55]

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been two 'prevention of future death' reports sent to Solent NHS Trust. None of these related to this particular core service.

All staff knew what incidents to report and how to report them. Staff used an electronic recording system to document incidents. Incidents were audited on a frequent basis to ensure the correct steps had taken place and the appropriate referrals had been made.

The nursing team were keen to learn from incidents internally and externally. Staff had the opportunity to attend a weekly de-brief session where they could reflect on their own practice and incidents which had occurred on the ward. Staff received feedback through reflective practice, supervision and team meetings. Staff told us there was a culture of reporting incidents and learning from them which had lifted staff morale. Staff understood their duty of candour.

Staff demonstrated that changes had been made as a result of learning from incidents. For example, a patient that had been deemed as 'not for resuscitation' had not had their paperwork for this completed in time. The patient then suffered a cardiac arrest. Staff now ensure that do not attempt cardiopulmonary resuscitation documentation is reviewed at every multidisciplinary meeting and documentation completed without delay.

Is the service effective?

Assessment of needs and planning of care

Staff completed a full assessment of patients' mental health needs. Of the five records we reviewed, all five had a thorough assessment of the patients' needs and holistic and personalised care plans in place. Care plans were up-to-date and reviewed when necessary. Care plans included aims and goals identified by staff and by the patient. Care plans included interventions staff could use to support the patient.

Staff completed thorough assessments of patients' physical health needs. Patients' physical health needs were appropriately assessed on admission and appropriate referrals were made by competent staff. Patients' care plans and risk assessments reflected their physical healthcare needs. Patients' records included occupational and physiotherapy care plans were in place which worked towards building on skills, maintaining skills, or promoting recovery.

Staff catered for individual patient needs. For example, with adapted cutlery and thickened fluids for those that needed it.

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[55] POFD Extract

Best practice in treatment and care

Patients did not receive psychological treatments to meet their needs. There was no substantive psychologist in post within the service and no psychological therapies as recommended by the National Institute for Health and Care Excellence (NICE) were being delivered. However, a psychologist had been employed to deliver psychological therapies to patients although they had not yet started. In the interim, the ward was delivering lower level treatments such as mindfulness and breathing exercises and had referred patients to improving access to psychological therapies (IAPT) services for patients with anxiety and depression.

Patients had good access to physical healthcare. Staff made appropriate referrals for specialists when needed including tissue viability nurses and speech and language therapists. The trust had successfully implemented the Lester screening tool which is a tool designed to improve the physical health of patients with a serious mental illness and is recommended by the national institute for health and care excellence (NICE). There was a physical health lead in the trust who provided staff with training and education, ran study days and 'learning slots' and supported staff with completing care plans around physical health conditions.

Staff completed food and fluid charts for patients that required monitoring. Staff updated patients' progress notes to reflect their diet and monitored patients' weight when required.
Staff supported patients to live healthier lives. There was a weekly wellbeing group which was run by the occupational therapy team, activities included in the session we observed included; chair based exercises and a memory game. Staff offered smoking cessation and nicotine replacement therapy. Information about keeping healthy could be downloaded for patients from the internet.

Staff were committed to quality improvement and frequently audited their practice. There was a comprehensive schedule of auditing, outcomes of audits were fed back through team meetings, one-to-one supervisions, study days and 'learning slots'. Posters highlighting improvements made because of auditing practice were displayed on notice boards for patients, carers and staff to see.

National and local audits[56]

This core service participated in five clinical audits as part of their clinical audit programme 2017 – 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Observing the compliance of DNACPR documentation according to DNACPR policy	OPMH	MH - Wards for older people with mental health problems	Clinical	Jul-17	1) Inform all junior doctors on the ward of inaccuracy occurring due to copy and paste of template of previous ward round entry. 2) Consultants to check the ward round entries at weekly MDT to ensure all aspects are accurate and up to date. 3) Educate nursing staff regarding DNACPR forms – white carbon copy to remain in patients notes even after discharge. 4) Inform all inpatient teams regarding documentation of specific mental capacity assessment regarding DNACPR decision – most state patient has or does not have capacity for admission, treatment and

[56] add link to source

					management but capacity specific to DNACPR not recorded often.
Re-audit: Discharge Summaries (OPMH Inpatients 2017-18 Qtr 1)	OPMH	MH - Wards for older people with mental health problems	Clinical	Jul-17	Ensure that patients have dementia screening and improve on areas of documentation where compliance is low.
Re-audit: Discharge Summaries (OPMH inpatients 2017-18 Qtr 3)	OPMH Inpatients	MH - Wards for older people with mental health problems	Clinical	Jan-18	Ensure that patients have dementia screening. Changes to OPMH discharge summary template to be discussed in Clinical governance meeting to incorporate the items not documented. Reminder to staff re the importance of documenting medication recommendations.
PLACE	Patient-led assessments of the care environment. 2 patient assessors and 1 staff assessor.	Brooker Ward - F	Non-clinical, patient environment	May-18	Preliminary reports have been shared with the Services who are currently developing action plans.
PLACE	Patient-led assessments of the care environment. 2 patient assessors and 1 staff assessor.	Brooker Ward - O	Non-clinical, patient environment	May-18	Preliminary reports have been shared with the Services who are currently developing action plans.

Skilled staff to deliver care

Patients benefitted from a range of specialists to meet patients' needs. The team included doctors, nurses, health care support workers, a physiotherapist, occupational therapists and occupational therapy technicians.

There was a holistic approach to care and treatment. Nursing staff consisted of registered mental health, general and learning disabilities nurses. There was a full induction programme for all new staff. New starters on the ward completed a supernumerary two-week period as part of their induction, although this could be extended if needed.

Appraisals for permanent non-medical staff[57]

The trust's target rate for appraisal compliance is 95%. As at 30 June 2018, the overall appraisal rates for non-medical staff within this core service was 26%. This percentage was calculated from April 2018 to June 2018 (three months only).

The rate of appraisal compliance for non-medical staff reported during this inspection was lower than the 80% reported in the previous year.

[57] 20180803 R1C Appraisal analysis

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
The Limes (Oakdene and Brooker ward combined)	54	14	26%
Trust wide	**3,416**	**1,221**	**36%**

Staff received an annual appraisal from the manger or had one booked. Since the trust submitted the data about appraisals, Brooker ward's appraisal compliance had increased to 89%. Staff appraisals reviewed the previous years' objectives and set objectives for the forthcoming year. All appraisals incorporated the trusts' vision and values and included staff views.

Appraisals for permanent medical staff[58]

The trust's target rate for appraisal compliance is 95%. As at 30 June 2018 (three months only), there were no medics assigned to the Brooker cost centre.

Clinical supervision[59]

Between 1 April 2017 and 31 March 2018 the average rate across Brooker ward in this core service was 89%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Caveat from the trust: *Clinical Supervision should be provided for all clinicians as per trust policy at least every 8 weeks as of February 2018. Therefore, we have calculated the number of sessions required each month based upon this as a minimum standard. Some teams have clinical supervision more often than this - supplemented by reflective practice, skill slots and debriefs (when required), hence rates of over 100%. Where we have identified that teams which have not been achieving this standard, plans have been implemented to ensure compliance in 2018/19.*

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Brooker Ward	288	255	89%
Core service total	**288**	**255**	**89%**
Trust Total	**2,057**	**2,323**	**113%**

Staff received frequent and effective supervision. Supervision was delivered on a one-to-one basis or in a group. Supervision records demonstrated learning through reflection and covered key areas of practice. Learning needs of staff were identified and training put in place to meet staff learning needs. For example, weekly 'skill slots' were delivered by different specialists where gaps in knowledge were identified or refreshers needed.

The trust supported staff to develop their skills and knowledge. Some staff were trained in administering subcutaneous fluids to patients when they were dehydrated. Health care support workers had received training in skin integrity and were able to administer simple dressings and registered nurses and health care support workers on the ward had been trained in phlebotomy.

[58] 20180803 R1C Appraisal analysis

[59] 20180801 R1C Clinical and Managerial Supervision analysis

Managerial Supervision[60]
Between 1 April 2017 and 31 March 2018 the average rate across all three teams in this core service was 130%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Caveat from the trust: *Managerial supervision is every 2 months following the changes in the clinical supervision policy in February 2018. We have therefore calculated the required number of sessions based on this figure. As well as formal supervision sessions, staff have opportunity for informal managerial support as well as attendance at skill slots and reflective practice sessions. We are aware that some teams have not consistently achieved the required standard during 2017/2018 but staff and frontline managers are aware of the requirement to meet the standards within trust policy during 2018/2019 and we expect all mental health service areas to be compliant by September 2018.*

Ward name	Managerial supervision sessions required	Managerial supervision sessions delivered	Managerial supervision rate (%)
Brooker Ward	208	271	130%
Core service total	**208**	**271**	**130%**
Trust Total	**1,762**	**1,645**	**93%**

Multi-disciplinary and interagency team work
Staff held weekly multidisciplinary meetings, meetings were attended by doctors, a registered nurse and an occupational therapist or physiotherapist if required. Care co-ordinators were invited to attend meetings but were not always available.

Staff held professional and effective handovers of information about patients. The ward team had developed a handover sheet which covered different aspects of the patients' physical and mental health, this included; mobility, diet, Mental Health Act status, resuscitation status, and any risk issues. This allowed staff to have a snap shot of the patients' needs without having to check care records from a computer in the office. The face-to-face handover that we attended was facilitated by the nurse in charge of the shift. Patients' presentation, care needs and risk issues were discussed in detail and handed over to the incoming shift.

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

Mental Health Act training figures[61]
As of 30 June 2018, 83% of the workforce in this core service had received training in the Mental Health Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

The training compliance reported during this inspection was the same as the 83% reported last year.

Staff had access to support an advice from the trust Mental Health Act team. The Mental Health Act team collected and audited Mental Health Act section paperwork, reminded staff about when section renewals were due and communicated with the ward about appeals and reading patients' rights. Staff had access to the Mental Health Act code of practice through the trust intranet.

Patients had access to advocacy. Patients were routinely referred to independent mental capacity advocates unless they stated they did not want support from them.

[60] 20180801 R1C Clinical and Managerial Supervision analysis
[61] 20180803 R1C Training analysis

Patients received their rights under the Mental Health Act in line with trust policy. Staff attempted to give patients their rights verbally and in writing, staff recorded their discussions in the patients' legal file. Where patients were unwilling or unable to understand their rights, staff made further attempts at a time where the patient was more settled.

Staff encouraged patients to use the leave they had been authorised. Sectioned patients were written up for section 17 leave to allow them to leave the hospital. Staff assessed patient risk prior to allowing them to leave the ward. Records of patients' section 17 leave were clear and accessible to staff.

All five informal patients we spoke with were aware they could leave the ward when they wanted to. There was a sign up on the office door on the functional side of the ward advising patients they could leave. The sign on the organic ward had been removed by patients and not replaced.

Good practice in applying the Mental Capacity Act

Mental Capacity Act training figures[62]

As of 30 June 2018, 83% of the workforce in this core service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

The training compliance reported during this inspection was lower than the 88% reported last year.

Staff had a good understanding of the Mental Capacity Act. Decisions such as capacity to consent to admission were clearly recorded in patients' records. However, the assessment was tick box and there was limited detail in the assessments about what discussions were had with the patient.

Capacity to consent to restrictive interventions such as bed sensors and sensor mats were not clearly recorded. However, staff told us they discussed the use of these devices with patients and they were risk assessed. If a patient was distressed or objected, the team would risk assess, consider alternatives, or trial without. Staff had recently made changes to the care planning system which meant there was no longer an obvious place to record patients' capacity in relation to these types of devices.

The provider had a policy on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff knew how to access the policy and understood the procedures.

Staff made Deprivation of Liberty Safeguards applications for patients that were being deprived of their liberty and lacked capacity to consent to their admission. There was significant back log for best interest assessments with the local authority, staff monitored the progress of applications and followed up applications.

Staff audited the use of the Mental Capacity Act. Audits checked that staff ensured any conditions that were included in the deprivation of liberty safeguards authorisation were being met and monitored the input of the relevant persons' representative. A relevant person's representative is usually a friend or family member who will ensures that the rights of a person being deprived of their liberty are protected.

Deprivation of liberty safeguards[63]

The trust told us that 23 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this core service between 1 April 2017 and 31 March 2018.
The greatest number of DoLS applications was made in December 2017 with five.

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[62] 20180803 R1C Training analysis

[63] 20180703 Universal RPIR - DoLS

CQC received 23 direct notifications from Solent NHS Trust between 1 April 2017 and 31 March 2018[64].

Number of DoLS applications made by month													
	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Total
Applications made	2	0	1	2	2	3	1	3	5	2	1	1	**23**
Applications approved	0	1	0	0	1	0	0	0	0	1	0	0	**3**

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Patient-led assessments of the care environment (PLACE) - data in relation to privacy, dignity and wellbeing[65] (Remove before publication)

The 2017 Patient-Led Assessments of the Care Environment (PLACE) score for privacy, dignity and wellbeing at one core service location(s) scored higher than similar organisations.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
St James Hospital	CHS – Adult community CHS – Children, young people and families Acute wards for adults of working age and psychiatric intensive care units Community based mental health services for older people Long stay/rehabilitation mental health wards for working age adults Wards for older people with mental health problems Community based mental health services for learning disability and autism	93.3%
Trust overall		**90.9%**
England average (mental health and learning disabilities)		**83.7%**

Patients were active partners and felt involved in their care. Staff were committed to working in partnership with people. All patients we spoke with told us that staff were kind and treated them with respect. Patients were very positive about the care they received on the ward. Staff were visible and easily accessible to patients. Staff were observed comforting distressed patients in a genuine way.

Staff followed a person-centred approach. Records showed evidence of discussion with patients about goals and aims for admission. There was a holistic approach with patients physical and mental health care needs being well considered. Patients emotional and social needs were highly valued by staff and were embedded in their care and treatment. For example, a staff member had

64 20180801 Notifications & DoLS
65 PLACE 2017 data report

invited a priest for a Polish speaking patient onto the ward to meet the patients spiritual needs. The staff had also provided the patient with cue cards written in Polish so they were able to express their needs clearer.

At meal times, staff were attentive to all patients. There was a protected meal times policy in place on the ward which allowed staff time to create a calm and quiet environment for patients. Patients had choice over what they ate and said the food tasted good.

Four of the five patients we spoke with knew the reason for their admission to hospital. Three of five patients knew what their medication was and what it was for, the other two knew they could ask staff if they wanted to know what it was for.

Staff maintained patients' confidentiality. Patients records were kept confidentially and staff were discreet in their interactions with patients.

Involvement in care

Involvement of patients

Patients were orientated to the ward on admission. Patients told us they were shown around the ward by staff when they arrived on the ward and given an admission pack. Posters were displayed in patients' bedrooms telling the patient who their named nurse was. All the patient bedrooms on the ward had individualised names on the doors with images relating to the individual patients' hobbies or previous employment. One example showed a patient who had previously been a seamstress and identified that care needs had been individualised to help the patient identify their room.

Staff involved patients in planning their care. Patients views or participation was included in all care plans. However, it was not clear if patients were receiving copies of the care plans from the records. Staff reported they share care plans with patients where appropriate. However, they reported those with significant cognitive impairment or who might become distressed did not receive copies of their care plans.

Staff held a weekly patient forum where patients could share their views about their care. Staff kept a feedback box in reception for patients and carers. Feedback forms were given to discharged patients, all completed forms were sent to quality leads and the outcomes were then fed back on a report which staff displayed on notice boards in communal areas.

Staff completed the 'this is me' document with patients and carers. This gave staff areas for discussion with patients, their likes and dislikes, and ways of engaging them in hobbies or interests. Staff reported they gave a copy of this document to care homes, families, or agencies when patients moved on. A laminated copy of this document was kept in patients' bedrooms.

Involvement of families and carers

The two carers we spoke with told us that they were involved in treatment decisions and staff regularly updated them. Both carers we spoke with felt that their relatives were safe on the ward and were happy with the care they were receiving. The carers were invited to multidisciplinary team meetings and updated on any changes to care.

Is the service responsive?

Ward moves[66] (Remove before publication)
The trust provided information regarding the number of patients moving wards in this core service between 1 April 2017 and 31 March 2018.
Six patients moved wards once after being admitted.

		During the last 12 months – YR 1 (2017-2018)			During the previous 12 months – YR2 (2016-2017)		
Ward name	Number of ward moves	Number of patients	How many were at 'end of life'*	%-share of all patients	Number of patients	How many were at 'end of life'*	%-share of all patients
Brooker	0	0	0	0%	0	0	0%
	1	6	0	100%	0	0	0%
	2	0	0	0%	0	0	0%
	3	0	0	0%	0	0	0%
	4+	0	0	0%	0	0	0%
	Total	**6**	**0**	**100%**	**0**	**0**	**0%**

Moves at night[67] (Remove before publication)
The trust provided information regarding the number of patients moving wards at night in this core service. Between 1 April 2017 and 31 March 2018, no patient moved wards after 22:00.

Access and discharge

Bed management

Bed occupancy[68] (Remove before publication)
The trust provided information regarding average bed occupancies for the Brooker Ward in this core service between 1 April 2017 and 31 March 2018.
Brooker ward reported average bed occupancies ranging above the national recommended minimum threshold of 85% over this period.
We are unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the period that was covered.
There were no out-of-area placements at the time of our inspection. Staff told us out-of-area placements rarely occurred.

Ward name	**Average bed occupancy range (**1 April 2017 – 31 March 2018**) (current inspection)**
Brooker Ward	83% - 113%

Average Length of Stay data[69] (Remove before publication)
The trust provided information for average length of stay for the period 1 April 2017 to 31 March 2018.
We are unable to compare the average length of stay data to the previous inspection due to differences in the way we asked for the data and the period that was covered.

Ward name	**Average length of stay range (**1 April 2017 – 31 March 2018**) (current inspection)**
Brooker Ward	26-65

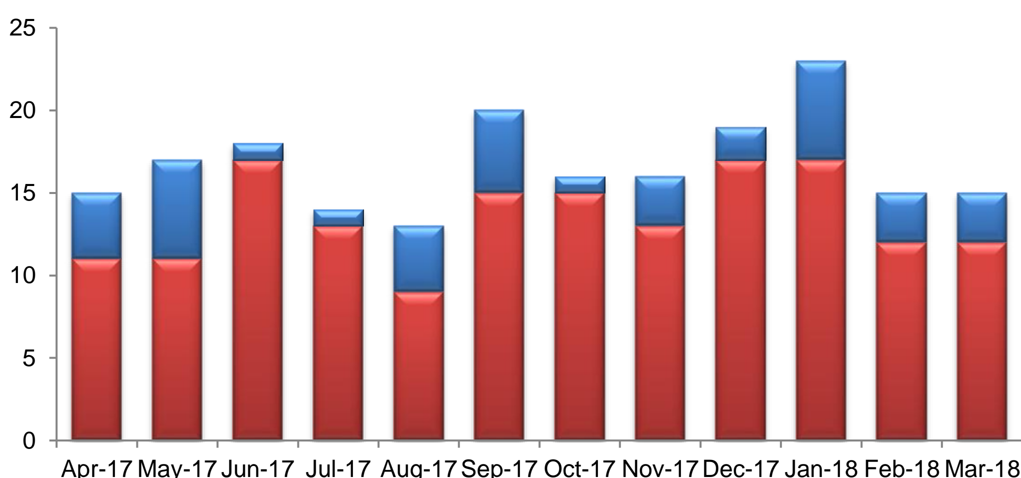
66 20180703 Universal RPIR - Ward moves
67 20180703 Universal RPIR - Moves at night
68 20180703 MH RPIR - Bed Occupancy
69 20180703 MH RPIR - Length of stay

Out of Area Placements*[70] *(Remove before publication)
This core service reported no out area placements between 1 July 2017 and 30 June 2018.

Readmissions*[71] *(Remove before publication)
This core service reported no readmissions within 28 days between 1 April 2017 and 31 March 2018.

Discharge and transfers of care

Delayed discharges*[72] *(Remove before publication)
Between 1 April 2017 and 31 March 2018, there were 162 discharges within this core service. This amounts to 8% of the total discharges from the trust overall (,2079).
The graph below shows the delayed discharges across the 12-month period.



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Number of delayed discharges	4	6	1	1	4	5	1	3	2	6	3	3
Number of discharges	11	11	17	13	9	15	15	13	17	17	12	12

Beds were available for patients living in the catchment area. At the time of our inspection there were five delayed transfers of care. Delayed transfers of care were usually the result of issues in securing a placement or funding for a patient. Staff told us this process had improved since there was an allocated nurse within the trust responsible for liaising with the local authority. This person supported ward staff to complete the paperwork in their absence.
Staff held weekly capacity and flow meetings. When patients went on overnight leave either home or on another ward there was always a bed available for them when they returned. Patient transfers always happened at an appropriate time of day. Staff had access to a psychiatric intensive care bed within the trust if a patients' mental health deteriorated and staff could no longer support them on the ward safely.

Lost to follow up*[73] *(Remove before publication)
The trust provided information for lost to follow up for the period 1 April 2017 to 31 March 2018. However, none of the information related to this core service.

[70] 20180703 MH RPIR - Out of area placements
[71] 20180703 MH RPIR - Readmissions
[72] 20180703 Universal RPIR - DTOC
[73] 20180703 Universal RPIR - Follow Ups

Referral to assessment and treatment times[74] ***(Remove before publication)***
The trust identified services as measured on 'referral to initial assessment' and 'assessment to treatment'. However, none pertained to this core service.

Facilities that promote comfort, dignity and privacy

Patient-led assessments of the care environment (PLACE) assessments [75] ***(Remove before publication)***
The 2017 Patient-Led Assessments of the Care Environment (PLACE) score for ward food at the locations scored higher than similar trusts.

Site name	Core service(s) provided	Ward food
St James Hospital	CHS – Adult community CHS – Children, young people and families Acute wards for adults of working age and psychiatric intensive care units Community based mental health services for older people Long stay/rehabilitation mental health wards for working age adults Wards for older people with mental health problems Community based mental health services for learning disability and autism	97.9%
Trust overall		**97.3%**
England average (mental health and learning disabilities)		**93.4%**

All patients had their own bedrooms with en-suite shower rooms. Patients had a lockable drawer in their bedrooms to keep their personal possessions and the bedrooms on the functional side of the ward had lockable safes. Patients bedrooms have their names on, patients are encouraged to personalise the door name sign with words or pictures that described them.

There were a range of rooms available for patients to use. Rooms included; a clinic room suitable to examine patients in, an occupational therapy kitchen, an arts and crafts room and a multi-faith room. There were male and female day rooms and a dining room on both the functional and organic parts of the ward. Patients could meet their visitors including young children in a family room in the reception area.

Staff on the ward had made the environment dementia friendly. Skirting boards and doorways to patients' bedrooms were painted contrasting colours and non-patient doorways were blended in. Artwork on the walls provided reminiscence prompts and large windows provided patients with a good view of the outside and natural light. The garden was not yet entirely suitable for the client group, and the Trust were taking action to address this. This included a re-plant of the entire garden area towards the end of the summer, and this was undertaken by local sixth form students in conjunction with the National Citizen's Community Service.

Meanwhile, the gardens were in use on a daily basis and patients were supported to access these accompanied by staff.

Patients said they enjoyed using the gardens which provided a therapeutic space for patients to engage in activities such as planting and low level gardening.

[74] 20180703 MH RPIR - Referral
[75] PLACE 2017 data report

Patients could only make a private telephone on their own mobile telephone. There were no restrictions on patients keeping their own telephones. If patients did not have their own mobile telephone they could use the ward phone but because it was not cordless, the patient had to make the call in the staff office with a member of staff present.

Patients could ask staff for hot drinks throughout the day and night but they were unable to make their own. Patients on the functional ward could make their own cold drinks but patients on the organic side of the ward had to ask staff to do this for them. There were no snacks available for patients to freely access, however, patients could keep snacks in their rooms and could ask staff to make them something if they were hungry.

Patients' engagement with the wider community
Staff supported patients to maintain relationships with their friends and family. There were some restrictions on visiting times, however, staff were flexible with visitors that could not make those times.

Meeting the needs of all people who use the service
The main site entrance and Brooker ward were fully accessible to people with physical disabilities. There was a disabled access toilet in reception, wide doorways and corridors and disabled access bathroom and shower rooms on the ward.

Most signage on the ward was in easy read format. There were words and pictures on signage around the ward to support patients to find their way around. Staff had created a patient orientation board which included the weather, the season and the time of day, patients completed this with staff support. There was a staff photo board on the ward on both the functional and organic sides so that patients and carers could familiarise themselves with the regular staff on the ward.

Patients were offered information about a range of conditions and services. Leaflets were available regarding dementia, smoking, advocacy, carers and safeguarding.

Staff learnt short statements in other languages for patients whose first language was not English. Some staff had learnt short statements in the patient's first language and developed cards to communicate with the patient. Staff had also downloaded a translator application on their phones. Staff had arranged for a priest to visit a patient who spoke the same language as them.

Patients had a choice of food to meet their dietary needs. Hot meals were served every day with a vegetarian option. The ward could provide for special diets including kosher, halal or vegan.

Listening to and learning from concerns and complaints

Formal complaints[76]
This core service received five complaints between 1 April 2017 and 31 March 2018. One of these were upheld, three were partially upheld and one was not upheld. None were referred to the Ombudsman.

Subject	Brooker Ward (The Limes) - OPM	Grand Total
Communications	1	**1**
Patient Care	3	**3**
Values & behaviours (staff)	1	**1**
Grand Total	**5**	**5**

Complaints were investigated by the trust and action was taken. We reviewed complaints that had been made about the ward. There were examples of actions the trust had taken to respond to complaints. For example, the ward had improved and extended its activities programme and

[76] 20180806 R1C Complaints analysis

involved patients in choosing the artwork for the walls. One carer told us that staff had explained the complaints procedure to them when they visited the ward. There were leaflets in reception advising patients and carers how they could make a complaint. However, none of the five patients we spoke with knew how to make a complaint and the leaflets in reception were only available to patients when they left the ward.

Compliments[77]
This core service received 18 compliments during the last 12-months from 1 April 2017 to 31 March 2018, which accounted for 2% of all compliments received by the trust as a whole.

Is the service well led?

Leadership
There was strong leadership demonstrated on the ward. Leaders were experienced in an older person's inpatient setting and were knowledgeable about the needs of staff and patients on the ward.

Senior leaders had a good understanding of the services they managed. Senior leaders had identified previous concerns within the service and taken steps to address these. Senior leaders had identified areas that still required development and highlighted these to staff and patients on communal notice boards.

Senior leaders were visible on the ward. Staff knew who they were and found them to be approachable and supportive. The ward manager had relocated their office to the ward so that they were more accessible to staff and patients. Staff told us senior leaders listen to staff about what is going well and what needs to improve.

Leadership courses were available to staff internally and externally. Staff were given opportunities to develop their skills and knowledge.

Vision and strategy
There was a clear statement of the trust's vision and values. Posters highlighting the trust's vision and values were displayed around the hospital. Staff understood the trust's vision and values and had developed their own vision and values at ward level as a team. The vision and values of the trust were discussed with staff as part of their appraisal.

Culture
Medical and non-medical staff felt respected, valued and supported. Staff felt motivated by the open and reflective culture on the ward. Staff felt they could raise concerns and would be listened to and were aware of the whistleblowing procedure.

There was access to freedom to speak up guardians. Staff could access support from freedom to speak up guardians either online or by telephone.

Staff appraisals included discussions about career development and opportunities for staff to develop their experience and skills.

All staff were referred to occupational health following long term sickness. Staff had access to an anonymous helpline if they were experiencing stress at work or at home and required support.

The trust held monthly staff awards in recognition of staff success. Staff voted monthly and the trust circulated details of who had won the award.

[77] 20180703 Universal RPIR - Compliments

Suspension and supervised practice[78]

During the reporting period, there was one case where a Band 6 staff nurse was placed under supervision.

Caveat: Investigations into suspensions may be ongoing, or staff may be suspended, these should be noted.

Ward name	Suspended	Under supervision	Ward move	Total
The Limes	0	1	0	1
Core service total	0	**1**	**0**	1

Governance

Board assurance framework[79]

The trust provided its Board assurance framework. This detailed any risk scoring 15 or higher and gaps in the risk controls that affect strategic ambitions. The trust outlined three business priorities with nine sub priorities:

1. Great Care:
    a. Improve quality in line with CQC inspection requirements
    b. Provide safe staffing
    c. Use technology to work differently
2. Great place to work:
    a. Plan for long term sustainable staffing
    b. Enhance our leadership throughout the organisation
    c. Provide training that enables us to deliver great care
3. Great value for money:
    a. Further pathway integration with other providers
    b. Benchmark our services to improve productivity
    c. Change front line and corporate services to live within our income

Staff had developed thorough governance processes on the ward. There were audits in place around ligature assessment, infection control, environmental, Mental Capacity Act, patient and carer involvement and physical healthcare. Staff showed us action plans where steps had been taken to improve the service.

The matron worked closely with the ward manager to implement good governance structures, such as implementing learning from incidents, complaints and raising safeguarding concerns with the local authority. Staff contributed to monthly business meetings and separate governance meetings. The ward manager also held a weekly reflective session with staff where they could de-brief on any incidents that had occurred.

Staff had made significant changes as a result of a complaint from patients and carers. For example, there was a new and improved activities programme, consideration to artwork around the ward and a bid had recently been granted to renovate the three gardens to make them dementia friendly.

Corporate risk register[80]

The trust has provided a document detailing 108 of their current risks of which 12 have a risk rating of high (Red). However, none related to this core service.

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[78] 20180703 Universal RPIR - Suspension & Supervised

[79] 20180801 R1C BAF & RR analysis

[80] 20180801 R1C BAF & RR analysis

Management of risk, issues and performance
The ward manager had access to the risk register and authorisation to add further risks to it. Staff were aware of what was on the risk register.

There was an in-depth ligature audit and action plan. There was a clear plan of estate works and when these would take place to reduce ligature risks. However, managers had not updated the local ligature audit to remove risks once the estates team had completed the work.

Staff had access to emergency continuity plans on the staff intranet. Staff were aware of how to find these and what action to take in different situations. For example, if there was a diarrhoea and vomiting outbreak.

Information management
Staff used electronic systems and additional paper records, these were accessible to all staff. There were enough computers and staff had access to equipment to help them provide care to patients. However, staff told us the computers were slow and often required repairing.

Staff kept patients' records safe. Electronic records were accessed by staff using an individual staff log on, paper records were kept securely.

The ward manager had access to all the information required to be able to carry out the management role. The ward manager had access to information relating to incidents, safeguarding referrals, sickness and complaints. Staff updated information relating to patient care frequently and all staff including the ward manager had access to this information on their handover sheets.

Staff made safeguarding referrals to the local authority when required. The ward manager had oversight of all notifiable incidents that had occurred on the ward and the action taken following these events.

Engagement
Staff could access up-to-date information about developments within the trust on the trust intranet. Staff felt involved in developments on the ward and understood what developments were happening within the trust.

The trust collected feedback through the family and friends survey. Managers fed back this information to staff through the trust governance meetings and the ward manager displayed outcomes on notice boards in communal areas of the ward.

Learning, continuous improvement and innovation
The trust was committed to quality improvement. There had been two recent quality improvement projects on the ward; a successful project to reduce the risk of patient falls and a project to make the ward more 'dementia friendly'.

Accreditation of services[81] (Exception reporting only)
NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The trust provided information on which services have been awarded an accreditation together with the relevant dates of accreditation. However, there was no information for this core service.

[81] 20180703 Universal RPIR - Accreditation

Mental health crisis services and health-based places of safety

Facts and data about this service

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
St James Hospital	Crisis Resolution Home Treatment Team	Appointments available 24/7 7 days a week	Mixed

Is the service safe?

Safe and clean environment

The staff of both the crisis team and health-based place of safety team ensured that the buildings were safe for patients to use. The trust carried out a regular ligature point audit at both locations and put plans in place to mitigate any risks. staff in both the crisis team and the health-based place of safety carried out daily checks. These were visual checks and staff did not make a record of the checks. However, we saw evidence that staff had identified faults and reported them appropriately for repair.

The trust had fitted both the health-based place of safety and the interview rooms used by the crisis team with an alarm system. Staff carried a personal alarm to active the alarm system and call for help. Reception staff issued the handsets to staff and tested them to ensure they worked.

The crisis team had a clinic room used to store medication and other equipment for physical health checks. It was clean and tidy and all equipment was calibrated and maintained as part of the trust central contract. All disposable equipment we checked was in date. We found two sharps boxes (storage boxes used to keep used needles and other sharp items safe until the can be disposed of) had been filled for over a year without being disposed of, we told the manager and they arranged for them to be removed.

The health-based place of safety was well maintained and had recently been renovated, to convert it from a two-bedroom unit into a one-bedroom unit with a lounge. The crisis team office was clean and tidy and mostly well maintained. The manager showed us plans to renovate the offices that would improve the environment for staff and address some maintenance issues such as damage to the carpet. The renovations were due to take place in the next few months.

Both teams followed infection control principals. We saw signs about hand washing in both environments and staff in the health-based place of safety carried hand gels to clean their hands. Staff also had badges promoting flu vaccinations.

Safe staffing

There were enough staff with the right skills and experience employed by the trust at both the crisis team and the health-based place of safety to provide safe care and treatment. At the time of our visit the crisis team employed registered nurses, social workers, psychiatrists and support workers. The team had employed an occupational therapist but they were undergoing employment checks at the time of our inspection.

The trust employed a senior registered nurse on every shift on the psychiatric intensive care unit to provide registered nurse cover and manage the care of patients in the health-based place of safety.

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	31 March 2018	25.3	N/A
Total number of substantive staff leavers	1 April 2017 – 31 March 2018	1.2	N/A
Average WTE* leavers over 12 months (%)	1 April 2017 – 31 March 2018	5%	12%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	31 May 2018	0.2	N/A
Total vacancies overall (%)	31 May 2018	1%	5.4%
Total permanent staff sickness overall (%)	Most recent month (31 March 2018)	7%	4%
	1 April 2017 – 31 March 2018	4%	4%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	31 May 2018	11.4	N/A
Establishment levels nursing assistants (WTE*)	31 May 2018	11.3	N/A
Number of vacancies, qualified nurses (WTE*)	31 May 2018	-0.3	N/A
Number of vacancies nursing assistants (WTE*)	31 May 2018	0.5	N/A
Qualified nurse vacancy rate	31 May 2018	-3%	5.4%
Nursing assistant vacancy rate	31 May 2018	5%	5.4%
Bank and agency Use			
Bank staff hours filled to cover sickness, absence or vacancies (qualified nurses)	1 April 2017 – 31 March 2018	1,440 (6%)	N/A
Agency staff hours filled to cover sickness, absence or vacancies (Qualified Nurses)	1 April 2017 – 31 March 2018	501 (2%)	N/A
Hours NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 April 2017 – 31 March 2018	0 (0%)	N/A
Bank staff hours filled to cover sickness, absence or vacancies (Nursing Assistants)	1 April 2017 – 31 March 2018	434 (2%)	N/A
Agency staff hours filled to cover sickness, absence or vacancies (Nursing Assistants)	1 April 2017 – 31 March 2018	0 (0%)	N/A
Hours NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 April 2017 – 31 March 2018	0 (0%)	N/A

*Whole-time Equivalent

The crisis team was available 24 hours a day and had adequate staff cover across the day and night. We reviewed the team rota for the past two months and saw that this matched the core numbers needed. The manager told us they would occasionally be short of staff due to last minute staff sickness. The trust had set the number of staff employed in the crisis team over 10 years ago. The manager told us they were reviewing staffing numbers and work flow to ensure they used the staffing as effectively as possible.

The team case load on the day of our visit was 24. Staff told us that the team caseload averaged 15. The team reviewed the caseload daily at handover meetings and twice a week at the multidisciplinary team meetings, which the psychiatrist also attended.

This core service reported an overall vacancy rate of -3% for registered nurses at 31 May 2018. This indicates that there may be an over-establishment of staff.

This core service reported an overall vacancy rate of 5% for registered nursing assistants.

This core service has reported a vacancy rate for all staff of 1% as of 31 May 2018.

	Registered nurses			Health care assistants			Overall staff figures		
Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Crisis Resolution	-0.3	11.4	-3%	0.5	11.3	5%	0.2	26.5	1%
Core service total	**-0.3**	**11.4**	**-3%**	**0.5**	**11.3**	**5%**	**0.2**	**26.5**	**1%**
Trust total	**68.1**	**846.4**	**8%**	**53.9**	**747.4**	**7%**	**166.3**	**3083.4**	**5%**

NB: All figures displayed are whole-time equivalents

Overall vacancy rates at the crisis team were lower than the trust average.

The trust did not give us information about vacancies in the health-based place of safety but we were told there was always an identified nurse on duty.

Between 1 April 2017 and 31 March 2018, bank staff filled 1,440 (6%) of hours to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 501 (2%) of hours for qualified nurses. No hours were unable to be filled by either bank or agency staff.

Team	Available hours	Hours filled by bank staff	Hours filled by agency staff	Hours NOT filled by bank or agency staff
Crisis Resolution	22,230	1,440 (6%)*	501 (2%)*	0 (0%)*
Core service total	**22,230**	**1,440 (6%)***	**501 (2%)***	**0 (0%)***
Trust Total	**1,123,704**	**39,989 (4%)***	**60,916 (5%)***	**8,701 (1%)***

*Percentage of total shifts

Between 1 April 2017 and 31 March 2018, 434 (25) of hours were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same period, the trust did not use any agency staff, and there were no shifts left unfilled.

Team	Available hours	Hours filled by bank staff	Hours filled by agency staff	Hours NOT filled by bank or agency staff
Crisis Resolution	22,152	434 (2%)*	0 (0%)*	0 (0%)*
Core service total	**22,152**	**434 (2%)***	**0 (0%)***	**0 (0%)***

Trust Total	750,079	64,940 (9%)*	35,565 (5%)*	5,016 (1%)*

* Percentage of total shifts

This core service had 1.2 (5%) staff leavers between 1 April 2017 and 31 March 2018.

Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Crisis Resolution	25.3	1.2	5%
Core service total	**25.3**	**1.2**	**5%**
Trust Total	**2,908.4**	**422.3**	**13%**

The trust provided refreshed turnover data following the inspection for the period 1 April 2018 and 30 September 2018:

Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Crisis Resolution	10.9	1	9%
Core service total	**10.9**	**1**	**9%**

The sickness rate for this core service was 4% between 1 April 2017 and 31 March 2018. The most recent month's data (31 March 2018) showed a sickness rate of 7%.

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Crisis Resolution	7%	4%
Core service total	**7%**	**4%**
Trust Total	**4%**	**5%**

The trust did not collect data on sickness within the health-based place of safety as it formed part of the sickness on the psychiatric intensive care unit.

Medical staff

Between 1 April 2017 and 31 March 2018, there was no data pertaining to this core service.

During the inspection we were told that there was one consultant psychiatrist and an another psychiatrist with the team Monday to Friday during 9am and 5pm and that the team could access psychiatrist support 24 hours a day via the trust on call system.

Mandatory training

The compliance for mandatory and statutory training courses at 30 June 2018 was 80%. Of the training courses listed, six failed to achieve the trust target and of those, five failed to score above 75%.

Staff training competencies were reported monthly, excluding Information Governance, which is reported as a final figure at year-end.

Key:

Below CQC 75%	Met trust target	Not met trust target	Higher	No change	Lower	Error
	✓	✗	↑	→	↓	N/A

YTD (Current Period)	Target	Number of staff eligible	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Safeguarding Adults (Level 3)	85%	1	1	100%	✓	↑
Dementia Awareness (inc Privacy & Dignity standards)	85%	29	28	97%	✓	↑
Duty of Candour	85%	29	28	97%	✓	↑
Safeguarding Children (Level 1)	85%	29	28	97%	✓	↑
Non Clinical Resuscitation	85%	29	27	93%	✓	↑
Safeguarding Adults (Level 1)	85%	29	27	93%	✓	↑
Safeguarding Children (Level 2)	85%	45	40	89%	✓	↑
Medicine management training	85%	15	13	87%	✓	↑
Infection Prevention (Level 1)	85%	29	25	86%	✓	↑
Infection Prevention (Level 2)	85%	25	20	80%	✗	↓
Mental Capacity Act Level 1	85%	29	21	72%	✗	↑
Preventing Falls in Hospitals - Online	85%	23	14	61%	✗	↑
Hand Hygiene	85%	25	15	60%	✗	↑
Deteriorating and Resuscitation Training - Adults	85%	22	12	55%	✗	↓
Information Governance	85%	29	13	45%	✗	↓
Core service total		**388**	**312**	**80%**	✗	↓

We requested training figures for September and saw that the crisis team's compliance with mandatory had gone up to 92% overall. The trust had revised their target compliance rate to 90% for the period April 2018 – September 2018. Dementia awareness, Duty of candour, non clinical resuscitation and safeguarding adults, level 1 and level 3 were all above the trust target of 90%. Medicine management training (89%), safeguarding children (level 2) (80%), preventing falls in hospitals (59%), hand hygiene (61%), Mental Capacity Act level 1 (79%), infection prevention level 1 and 2 (86% and 77%) and deteriorating and resuscitation training were below the trust target for compliance. We requested training data for Mental Health Act training and the trust told us that only registered staff completed the training three yearly. At the time of our visit 65% of staff had been trained in the Mental Health Act with the remaining staff booked to complete training in November 2018.
The trust does not collect training information about the health-based place of safety staff as it is included in the data for the psychiatric intensive support unit.

Assessing and managing risk to patients and staff

Assessment of patient risk
The crisis and health-based place of safety teams undertook a risk assessment of all patients at the initial contact and updated them regularly.

We reviewed eight records from the crisis team and saw that they all had an up to date comprehensive risk assessment in place. All records showed that risk assessments were updated following changes in the patient's risk or incidents and that risk was reviewed with patients during visits.

We reviewed eight records of patients who had been admitted to the health-based place of safety and saw that they had an up to date risk assessments from their admission.

All patients open to the crisis team should have a crisis plan in place. Four of the seven care records we reviewed that should have had a crisis plan in place did not. Staff told us that three of the four patients did have a crisis plan but were unable to find it on the day of our visit. We saw that staff discussed risk and how patients could manage their risk with patients during visits. The team monitored the completion of crisis plans and recorded it on a board so that they could see who had them and we saw evidence in patients' files that staff had recorded when a crisis plan still needed to be completed.

Management of patient risk
In the crisis team staff monitored patients risk daily at team handovers. Patients were monitored based on the level of risk they presented and staff agreed with the patient how many visits they needed weekly based on the level of risk. We saw that this occurred in the team handovers and staff had recorded the outcome in the patients' records.

Neither the health-based place of safety or the crisis team had a waiting list. The crisis team have a gatekeeping role for admissions into the acute patient ward and report that there is no waiting list for beds.

Senior trust managers showed us that the health-based place of safety was in use on average 35% of the time. However, the local police reported that they could not always take patients to the health-based place of safety when needed. The trust senior manager were aware of the polices concerns and it had been agreed that the private ambulance service would notify the trust if they had been unable to respond to a police request because the health-based place of safety was full.

Both the crisis teams and the health-based place of safety had developed good personal safety protocols, including lone working practices, and there was evidence that staff followed them. In the crisis teams staff recorded what visits they were going on and when they would return and this was checked by the shift leader who remained in the building.

Safeguarding
The trust trained all staff in the crisis team and health-based place of safety in safeguarding adults and children. Staff understood what they needed to report as a safeguarding issue and how to do this. We saw evidence in files and during meetings that staff recognised safeguarding issues and referred them to the local safeguarding team when they needed to. The staff team gave us examples of safeguarding issues that included patients being targeted because of their race or sexuality. The service had a good relationship with the local authority safeguarding team and could speak to staff for advice when needed.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority have their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made four safeguarding referrals between 1 July 2017 and 1 June 2018, of which four concerned adults and no children.

Referrals		
Adults	**Children**	**Total referrals**
4	**0**	**4**

There was one peak identified in adult referrals across the period in October 2017 with two. The other two referrals occurred in September 2017 and April 2018 where each month reported one referral.

This is the information the trust provided us with prior to our visit. However, while we were on site the team manager told us they had made more referrals than this but did not keep a record of this. The trust told us they were making changes to the electronic incident system so that they would be able to track the number and outcome of safeguarding referrals more easily.

Solent NHS Trust has submitted details of five serious case reviews commenced or published in the last 12 months. However, none of these related to this core service.

Staff access to essential information

In both the crisis teams and the health-based place of safety staff kept electronic records of patients' care and treatment. All trust staff could access the electronic patient records. However, staff from the ambulance provider who supervised patients in the health-based place of safety did not have access to these records. The trust did not have a plan in place to address this.

The ambulance service kept a paper record of the care they provided to the patient in the health-based place of safety. At the time of our visit the trust did not keep a record of this but had the hourly record kept by the registered nurse in charge of the patients care. This meant that trust could not be sure they had a complete record of the care given to the patient. We discussed this with the lead for the health-based place of safety and senior managers and they told us they would now take a photocopy of the ambulance services records and keep this in the patients record.

Staff in the crisis team told us that they could not always access a computer when lots of staff were on duty and that the computers could be slow. The team manager and senior managers within the trust told us that the planned refurbishment of the offices included work to address these issues.

Medicines management

The crisis team stored individual patient's medication in the clinic room which they supplied and administered to patients. Staff provided medication on a risk assessed basis and would monitor compliance with medication if it was needed. Staff in the crisis team mostly followed good practice in the management of medication. For example, all medication the team had reasonability for was recorded on the patients' prescription chart, but in four of the nine records reviewed staff had not signed to confirm medication had been delivered. Staff disposed of medication according to the trust policy, but we found a closed medication bin that had not been collected in the clinic room. We told the team manager and they arranged for the medication bin to be removed.

Both the crisis team and the health-based place of safety made sure that patients managed their medication well and would liaise with the patients GP's as necessary.

Staff reviewed patients' physical health and monitored for any side effects to medication. Staff told us that when patients were referred to the crisis team they would monitor and review medication with the patient.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 April 2017 and 31 March 2018 there was one STEIS incident reported by this core service. Of the total number of incidents reported, the most common type of incident was *'Apparent/actual/suspected self-inflicted harm meeting SI criteria'* with one. There were no unexpected deaths for this core service.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS (if not comparable briefly outline differences).

	Number of incidents reported	
Type of incident reported on STEIS	Crisis Home Resolution Team	Total
Apparent/actual/suspected/self-inflicted harm meeting SI criteria	1	1
Total	1	1

We confirmed this information while on site.

Reporting incidents and learning from when things go wrong
The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been two 'prevention of future death' reports sent to Solent NHS Trust. None of these related to this core service.

All staff we spoke with at both the health-based place of safety and the crisis team knew how to report incidents using the trusts electronic incident reporting system. The managers could give feedback and share learning via the electronic incident reporting system and at team meetings. Managers would also discuss learning from incidents in individual supervision sessions. Staff discussed incidents in handover meetings and at debrief sessions following an incident. All staff understood the need to be honest with patients following incidents, sometimes known as the duty of candour, and there was a policy in place to ensure patients received information about mistakes and an apology when needed.

The manager of the crisis team told us how they had changed the discharge processes following an incident and now they ensured a senior member of staff reviewed a patient care prior to discharge. Managers had introduced a system when they needed to extend detentions in the health- based place of safety with patients.

Is the service effective?

Assessment of need and planning of care
We reviewed eight care records for patients at the crisis team and saw that seven had an up to date comprehensive assessment of the patients' needs in place. The assessments included physical and mental health needs. The care records showed what the plan of care was and that it was recovery focused. Staff recorded what involvement the patient had and that they had agree with the plan of care. Staff reviewed risk with the patient at every visit and updated the care record following this. However, there were only up to date care plans and crisis plans in place in three of the eight records we reviewed. This meant that staff could not easily identify the most up to date information about the patient. One record was not complete because staff had not been able to contact the patient.

Staff had recorded how they had attempted to contact the patient and what they would continue doing.

At the health-based place of safety, we reviewed eight records of care. These included electronic and paper records that staff made. We found that all patients had an electronic risk assessment and care plan. However, the private ambulance service that provided care in the health-based place of safety did not have access to this record and there was not a comprehensive risk assessment and care plan available to them. This meant staff giving direct care did not have easy access to information needed to give care to the patient.

Best practice in treatment and care

In both the health-based place of safety and the crisis teams staff members provided care and treatment based on national guidance. The crisis team provided psychological therapies recommended by the National Institute for Health and Care Excellence (NICE). This included dialectic behaviour therapy (DBT), a type of psychological therapy that tries to identify and change negative thinking patterns and pushes for positive behavioural changes.

The Crisis team and health-based place of safety reviewed patient physical health and gave advice around healthy living. If patients gave permission to do so, staff accessed the patient's GP records and requested a summary from the GP. The crisis team referred patients on to other services when needed. Staff had access to blood results online and, with patients' agreement, made and confirmed appointments via text messaging.

Patients not admitted to hospital following a period of detention in the health-based place of safety were always referred to the crisis team.

The crisis team were auditing referrals and case records at the time of the inspection.

This core service participated in no clinical audits as part of their clinical audit programme 2017 – 2018.

Skilled staff to deliver care

The crisis team had access to a full range of professionals including psychiatrist, registered nurses, social workers, a psychologist and support workers. The services had recruited an occupational therapist but they had not started work at the time of the inspection. Staff had the required skills and experience to provide the service.

Crisis team staff received a four-week induction where they shadowed other staff and before leading on visits and completing assessments. The manager agreed learning outcomes with the member of staff during supervision and review this at the end of the four weeks and identify any outstanding learning.

The trust's target rate for appraisal compliance is 95%. As at 30 June 2018, the overall appraisal rates for non-medical staff within this core service was 21%.

The wards/teams failing to achieve the trust's appraisal target were Crisis resolution with an appraisal rate of 21% (albeit this is only for a two-month period). The compliance for last year was 79%.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Crisis Resolution	29	6	21%

Core service total	**29**	**6**	**21%**
Trust wide	**3,416**	**1,221**	**36%**

The trust’s target rate for appraisal compliance is 95%. As at 30 June 2018, there was no data for medical staff for this core service.

Since the crisis team manager was appointed they have been working to improve appraisal completion rates. At the time of our visit 64% of staff had received an appraisal.

Between 1 April 2017 and 31 March 2018 the average rate across the team in this core service was 14%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it’s important to understand the data they provide.

Caveat from the trust: *Clinical Supervision should be provided for all clinicians as per trust policy at least every 8 weeks as of February 2018. Therefore, we have calculated the number of sessions required each month based upon this as a minimum standard. Some teams have clinical supervision more often than this - supplemented by reflective practice, skill slots and debriefs (when required), hence rates of over 100%. Where we have identified that teams which have not been achieving this standard, plans have been implemented to ensure compliance in 2018/19.*

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
CRHTT	180	26	14%
Core service total	**180**	**26**	**14%**
Trust Total	**2,057**	**2,323**	**113%**

Between 1 April 2017 and 31 March 2018 the average rate across the team in this core service was 18%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it’s important to understand the data they provide.

Caveat from the trust: *Managerial supervision is every 2 months following the changes in the clinical supervision policy in February 2018. We have therefore calculated the required number of sessions based on this figure. As well as formal supervision sessions, staff have opportunity for informal managerial support as well as attendance at skill slots and reflective practice sessions. We are aware that some teams have not consistently achieved the required standard during 2017/2018 but staff and frontline managers are aware of the requirement to meet the standards within trust policy during 2018/2019 and we expect all mental health service areas to be compliant by September 2018.*

Ward name	Managerial supervision sessions required	Managerial supervision sessions delivered	Managerial supervision rate (%)
CRHTT	130	24	18%
Core service total	**130**	**24**	**18%**
Trust Total	**1,762**	**1,645**	**93%**

Contrary to the data above, staff told us they received supervision in line with the trust policy. All staff we spoke with said they felt supported by the manager. The team also had peer and group supervision sessions. We saw that supervision rates averaged at 73% between June and September. The trust told us that this was because of short term sickness and leave. There were regular team meetings, we reviewed the minutes of these and saw that staff were given the opportunity to review incidents and discuss changes to practice.

The crisis team manager would discuss training needs with staff as part of their supervision. There was an agreed development programme in place for support workers and qualified members of the crisis team which allowed them to access specialist training relevant to their role. The trust did not collect data about supervision rates of the health-based place of safety staff as they were in the psychiatric intensive care unit data.

There were no staff on performance management at the crisis team or the health-based place of safety. Managers could access the trust policy via the local intranet and knew where to get support if they needed to performance manage staff.

Multidisciplinary and interagency team work

The crisis team held multidisciplinary team meetings to discuss patients twice weekly. All team members attended these meetings and discussed high-risk cases, new referrals and alternative strategies. There was a team handover meeting three times a day. We saw a team handover meeting that was well structured and discussed individual patients in detail. Staff members were very knowledgeable about their patients' needs and risks. The team agreed the plan of work for the shift which included visits to patients.

The crisis team had good working relationships with other services including local GP's, adult community teams and the inpatient service. The crisis team had a discharge facilitator who attended discharge meetings to identify what support patients needed.

Senior managers in the trust told us that they had good working relationships with the other services that are part of the Hampshire wide crisis concordat, which included the police, a private ambulance service and a local mental health trust.

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

As of 30 June 2018, there was no information pertaining to Mental Health Act training for this core service.

At the time of the inspection the trust told us that 64% of staff had received Mental Health Act training. The remaining staff had training booked for the following month.

Staff at both the crisis team and the health-based place of safety could access the trusts policies on the Mental Health Act Code of Practice via the trusts intranet. There were Mental Health Act administrators on site that the teams knew how to access and who they were. The crisis team manager said that they could also speak with the Approved Mental Health Professionals (AMHPs) if they needed advice about the Mental Health Act.

Staff working in the crisis team and health-based place of safety understood their responsibility under the Mental Health Act. For example, we saw in patient records that staff had explained patients' rights to them when appropriate and in a way they would understand. We spoke to one patient in the health-based place of safety who confirmed that staff had explained their rights and was able to tell us what they were. All Mental Health Act paperwork we reviewed appeared to be correct.

Good practice in applying the Mental Capacity Act
As of 30 June 2018, 72% of the workforce had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

The training compliance reported during this inspection was similar to the 72% reported last year.

Staff understood the principles of the Mental Capacity Act and their responsibilities. Staff could access the trusts policy on the Mental Capacity Act via the trust intranet and were able to get advice from the Mental Health Act administrators and AMHPs when needed. We saw evidence that staff considered and addressed issues around capacity appropriately in the 16 care records we reviewed.

Training in the Mental Capacity Act was mandatory. However, the training compliance by the crisis team was below the 80% set by the trust.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Involvement in care
All the interactions we saw between patients and staff members from both the crisis team and health-based place of safety were kind and compassionate. During meetings and when we talked with staff they spoke about patients in a respectful manner and showed an understanding of their needs.

Staff directed patients to other services and supported them to access them when it was appropriate.

All patients and carers we spoke with gave us positive feedback about the staff teams.

The teams respected patient confidentiality by using soundproofed interview rooms and lockable bags to carry any information outside the office. The health-based place of safety had been reorganised to improve confidentiality. For example, they had moved the meeting area away from the door into the ward to prevent discussions being overheard.

Involvement in care

Involvement of patients
Staff from the crisis team involved patients in decisions about their care. Staff would discuss different options for treatment with patients giving them the information needed to make an informed choice. For example, staff gave patients leaflets about medication that listed side effects.

Staff communicated with patients in a way that was meaningful to them. Staff could access interpreters and information leaflets in different languages and in sign language. The team also had a folder for people with learning disabilities that included advice on how to communicate with them.

Patients could give feedback to the service and input in to the development of the service. Staff gave patient’s feedback forms to complete but they had received limited information back. Staff had then run workshops for patients and their families and carers to allow them an opportunity to express their views about the service. Managers had organised a patients’ forum and the trust used members of the forum on recruitment interview panels.

Staff gave patients information about local advocacy services.

Involvement of families and carers
Staff encouraged family and carers to be involved in the patients care. Staff would invite families to meetings when it was appropriate. Staff spoke with families as part of the assessment process and referred to family therapy and carers centre when needed. Staff encouraged families and carers to have carers assessments at the carers centre.

The service also invited families and carers to the workshops held to get feedback about the service. Families and carers could also give feedback about services at the carers centre.

Is the service responsive?

Access and waiting times

The trust has identified the below service in the table as measured on ‘referral to initial assessment’ and ‘assessment to treatment’.

Name of hospital site or location	Name of team	Service Type	Days from referral to initial assessment		Days from assessment to treatment		Comments, clarification
			Target	Actual (mean)	Target	Actual (mean)	
St James Hospital	Crisis Resolution Home Treatment	AMH Crisis Team	4 hours for urgent but negotiated with patient	0	N/A	0	Following Crisis Assessment treatment may not be indicated, it may be provided by the team via home treatment, the person may be signposted to another service or they could be admitted to the ward

Between 1 April 2017 and 31 March 2018, the average wait time for a follow up appointment for this core service was 0.4 weeks.

The crisis team was available 24 hours a day so patients could access it when needed. The crisis team met its target of contacting urgent referrals within four hours and seeing them within 24 hours. We saw in records and meetings that if patients were difficult to engage, staff would continue to encourage patients to engage and would discuss how to do this at the handover meetings. For example, the team would be flexible with appointment times. Patients and staff told us they rarely needed to cancel appointments and when they did they would arrange a new appointment at the time.

The crisis teams had accepted referrals from patients, GPs, hospital and community teams. A private ambulance provider brought patients to the health base place of safety. Although there were no reported instances where the service was not available for patients in the last year, there was no system in place to record when the police requested transport and it was not available.

The facilities promote comfort, dignity and privacy
The crisis team had access to enough suitable rooms to meet the needs of the patients. All meeting rooms were appropriately soundproofed. The manager told us that the trust was refurbishing the office to improve the working environment which was sometimes loud if several people were talking at the same time.

The health-based place of safety had a bedroom and sitting area for the patients to use and only admitted one patient at a time.

Patients' engagement with the wider community
The crisis team offered support around education and employment needs and would refer patients to local advocacy groups for additional support. Patients told us that the service offered them support with what they needed.

The crisis team supported patients to keep contact with families and carers and would refer patients to family therapy when needed.

Meeting the needs of all people who use the service
Both the crisis service and the health-based place of safety were suitable for disabled access. Both were on the ground floor, had wide doorways, had amble space for wheelchair access and accessible toilets.

There were information leaflets about patients' rights under the Mental Health Act, local services and medication at the crisis service and in the health-based place of safety. Leaflets about the service provided by the trust were in a range of formats. Information was available about substance misuse services, advocacy and making a complaint.

Both the crisis team and the health-based place of safety could access interpreters and signers when needed to communicate with patients.

The crisis team provided food to patients. They could give some food directly, provide food vouchers and had a list of local soup kitchens patients could access.

Listening to and learning from concerns and complaints

This core service received seven complaints between 1 April 2017 and 31 March 2018. Four of these were upheld, one was partially upheld one was not upheld and one complaint was withdrawn. None were referred to the Ombudsman.

Subject	Crisis AMH (Orchards)	Grand Total
Communications	3	**3**
Values & behaviours (staff)	2	**2**
Integrated care (inc delayed discharge due to absence of care package)	1	**1**
Patient Care	1	**1**
Grand Total	**7**	**7**

This core service received one compliment during the last 12 months from 1 April 2017 and 31 March 2018 which accounted for less than 1% of all compliments received by the trust as a whole.

Patients we spoke with said they knew how to complain. Staff gave them information about making complaints, staff would not always give patients information about complaints at the first visit if they were agitated or distressed. Patients felt able to complain and did not feel that staff treated them unfairly.

All staff in both the crisis team and the health-based place of safety knew how to respond to complaints. Staff referred concerns to the team manager and if needed would help the patient to make the complaint. Staff told us that they got feedback from complaints at staff meetings and during supervision sessions. The team manager would apologise to patients if a compliant was upheld and explain how the team would prevent it from happening again.

The trust had received no written complaints about the health-based place of safety.

Is the service well led?

Leadership

The team manager of the crisis team had been in post since May and had been in a similar role in a different mental health core service prior to this. The trust recruitment process ensured they had the skills and knowledge for their current post. In addition to their managerial and clinical supervision they received leadership mentoring from a senior manager within the trust.

The ward manager for the psychiatric intensive care unit was responsible for the health-based place of safety and there was a senior nurse who was the lead for the unit. There was also a senior trust manager responsible for the unit. All managers were aware of and responded to challenges relating to working with a new private ambulance provider.

The team managers of both the crisis team and the health-based place of safety understood how the services were working to provide high quality care. For example, the crisis team was working to improve on the time from referral to first face to face meeting and the health-based place of safety was working to improve assessment times for patients.

Staff reported that leaders in both services were approachable and available when needed.

There were leadership development opportunities available to staff at all levels.

Vision and strategy

All the staff we spoke to understood the trust's values and were proud to work there. The crisis team manager was using the trusts values to develop the business plan of the team. Staff told us that senior managers communicated the trust values to the staff teams and followed them in their work.

Staff could provide feedback into the development of the service and the business plan at team meetings.

Staff explained how they work to deliver high quality care. For example, looking at the number of staff needed to visit patients based on risk assessments which could increase the number of visits.

Culture

The managers of the crisis teams and the health-based place of safety worked in ways that promoted an open and supportive culture. Staff we spoke to felt supported and were proud to work in their team and the wider trust. Staff told us they would be happy to raise concerns with their manager, knew where to access the whistle blowing policy and how to contact a speak up guardian.

The managers were confident in managing staff performance issues. No staff were being performance managed during our visit but the managers told us where they could find relevant policies and how they could get support. The managers told us that the staff members got on well and staff dealt with disagreements professionally.

Supervision and appraisals included discussions about professional and staff development.
All staff had access to occupational health services and the trust had staff awards to recognise staff achievements, innovation and hard work.

Staff said that the chief executive had visited trust locations in a bus and invited staff on board to have a cup of tea, cake and to ask any questions they had.

Morale at the crisis team was good but staff and the manager told us it was changeable as staff prepared for the temporary move to another premises and changes to the teams work pattern. Morale of staff at the health-based place of safety was good.

During the reporting period, there were no cases where staff have been either suspended, placed under supervision or were moved to a different team for this core service.

Governance
The crisis teams had introduced systems to check their performance and make changes when necessary. Staff had made changes following complaints and safeguarding alerts. They undertook clinical audits and acted on the results. They had agreed key performance indicators that included readmissions within 30 days, waiting times and staff sickness.

The health-based place of safety provided reports to the board and the monthly Hampshire crisis concordat meeting. The report detailed agreed key performance indicators which included how long assessments take and any breaches to the 24-hour limit of detention in the health-based place of safety.

Senior trust managers had found that they did not have assurance that staff working for the private ambulance service, providing care in the health-based place of safety, had the necessary training and skills. To address this, they had arranged to attend the contract monitoring meeting between the CCG and the private ambulance service so that they can be assured of this.

The trust provided its Board assurance framework. This detailed any risk scoring 15 or higher and gaps in the risk controls that affect strategic ambitions. The trust outlined three business priorities with nine sub priorities:

4. Great Care:
    a. Improve quality in line with CQC inspection requirements
    b. Provide safe staffing
    c. Use technology to work differently
5. Great place to work:
    a. Plan for long term sustainable staffing
    b. Enhance our leadership throughout the organisation
    c. Provide training that enables us to deliver great care
6. Great value for money:
    a. Further pathway integration with other providers
    b. Benchmark our services to improve productivity
    c. Change front line and corporate services to live within our income

The trust has provided a document detailing 108 of their current risks of which 12 have a risk rating of high (Red). However, none related to this core service.

Management of risk, issues and performance
The managers of both the crisis team and the health-based place of safety could submit items to the trust risk register. The managers knew how to escalate concerns via the electronic incident system and senior managers when needed. All staff we spoke with knew how to use the electronic incident system to report risks.

The crisis team had emergency plans in place to address issues such as adverse weather conditions while continuing to deliver a service.

Information management
Both the crisis team and the health-based place of safety team collected information that they used to review and improve the quality of the services. Managers accessed the information relating to the performance of the service and they discussed this with staff at team meetings and during one to one supervision session. For example, senior managers were aware of the 24-hour breaches in the health-based place of safety and reviewed the incidents to identify if they could be avoided.

The trust systems provided information in a way that was easy to understand and did not breach patient confidentiality.

Engagement
Staff of both the crisis team and the health-based place of safety were told about changes to the services at team meetings and on the trust intranet. Staff told us that team and senior managers were approachable and would discuss changes with them.

The crisis team engaged with patient and their families. Patients and families we spoke with said that they were listened to and staff acted on what they said. For example, changing appointment times and using text messages to communicate with the patients.

Patients admitted to the health-based place of safety could feedback about the service via the trusts patient advice and liaison service. Staff had leaflets they could give to patients on how to provide feedback. Staff told us that they would follow their duty of candour if patients were likely to breach the 24-hours and explain why they needed to remain detained.

Learning, continuous improvement and innovation

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.
The trust provided information on which services have been awarded an accreditation together with the relevant dates of accreditation. However, there was no information for this core service.

The crisis team was committed to innovation and improvement through continuous learning. For example, they were reviewing the demand of the service and looking to change rotas to improve their referral to assessment time to exceed their commissioner expectations. They were reviewing innovative practice from around the country and looking to see if they could develop a crisis suite, a unit that patients could come to at times of crisis to receive support.

At the time of our visit the health-based place of safety was not involved in any quality improvement programmes. However, staff had reviewed delays in assessment times and now began following up assessments sooner to avoid 24-hour breaches. The service had developed an assessment for 24-hour breaches to ensure that staff balanced a patients right to live with their right to liberty and that senior managers were involved in this decision-making process.

Community-based mental health services for older people

Facts and data about this service

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
St James Hospital	Older Persons Mental Health (OPMH) Memory Clinic		Mixed
St James Hospital	Older Persons Mental Health (OPMH) Community Services (north/South/Central)		Mixed
St James Hospital	Older Persons Mental Health (OPMH) Memory Clinic	8	Mixed
St James Hospital	Older Persons Mental Health (OPMH) Community Services (north/South/Central)	Medical, Care Co-ordinator clinics/appointments available throughout the week	Mixed

Is the service safe?

Safe and clean environment

The waiting area was large and contained seats for patients while waiting for an appointment. It was clean and the furnishings were in good condition. There were a range of consulting rooms available to staff. They were clean and comfortable with adequate soundproofing. There were no call alarms in the consulting rooms.

Staff adhered to infection control principles, including handwashing. The manager completed hand hygiene audits and posters on hand hygiene were visible in bathrooms and at handwashing points. The trust had an infection control policy.

Environmental risk assessments had been completed. However, the ligature points risk assessment did not contain any actions against several highlighted ligature points. Where action points had been identified, these were not recorded in the trust’s risk register and there were no action points recorded to mitigate some of the ligature points. The work required did not feature on the risk register.

Safe staffing

Staffing overview at a glance[82]

There were no vacancies within the team. A psychologist had recently been appointed but had not yet started.

There was rapid access to a psychiatrist and medical cover. The team had two clinical leads and two consultants. Staff told us they routinely covered each other's patients when necessary. The team also had four junior doctors, two speciality doctors and a regular locum doctor.

The team manager used bank staff when necessary. There was a bank nurse in post to cover maternity leave and the manager reported she could access bank staff when she felt it was necessary.

The average caseload was approximately 42 patients per full time member of staff. Patients had historically been allocated to staff based on GP practice, however the manager had just implemented a caseload management tool. This enabled staff to assess their caseload by acuity and gave a score to indicate each staff member's capacity.

Staff monitored patients in the 'memory monitoring service' every 6 months to review their anti-dementia medication. One registered nurse and one healthcare support worker managed this caseload. The caseload between them was 634 patients. Staff were managing this caseload well. However, there was no clear discharge procedure or maximum caseload size for the memory monitoring service. The service should closely monitor this caseload as the number could potentially become risky in the future unless staffing levels are closely managed.

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	31 March 2018	47.5	N/A
Total number of substantive staff leavers	1 April 2017–31 March 2018	4	N/A
Average WTE* leavers over 12 months (%)	1 April 2017–31 March 2018	8%	12%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	31 May 2018	2.7	N/A
Total vacancies overall (%)	31 May 2018	6%	5.4%
Total permanent staff sickness overall (%)	Most recent month (31 March 2018)	3%	4%
	1 April 2017 – 31 March 2018	3%	4%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	31 May 2018	18.1	N/A
Establishment levels nursing assistants (WTE*)	31 May 2018	8.4	N/A
Number of vacancies, qualified nurses (WTE*)	31 May 2018	0.5	N/A
Number of vacancies nursing assistants (WTE*)	31 May 2018	-1.0	N/A

[82] add link to source

Qualified nurse vacancy rate	31 May 2018	3%	5.4%
Nursing assistant vacancy rate	31 May 2018	12% over establishment	5.4%
Bank and agency Use			
Bank staff hours filled to cover sickness, absence or vacancies (qualified nurses)	1 April 2017–31 March 2018	0 (0%)	N/A
Agency staff hours filled to cover sickness, absence or vacancies (Qualified Nurses)	1 April 2017–31 March 2018	0 (0%)	N/A
Hours NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 April 2017–31 March 2018	0 (0%)	N/A
Bank staff hours filled to cover sickness, absence or vacancies (Nursing Assistants)	1 April 2017–31 March 2018	0 (0%)	N/A
Agency staff hours filled to cover sickness, absence or vacancies (Nursing Assistants)	1 April 2017–31 March 2018	0 (0%)	N/A
Hours NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 April 2017–31 March 2018	0 (0%)	N/A

*WholeTime Equivalent

Establi***shme***nt, Vacancy, Levels of Bank & Agency Usage[83]

This core service reported an overall vacancy rate of 3% for registered nurses at 31 May 2018.

This core service reported an overall vacancy rate of -12%, which indicates it is over established for registered nursing assistants.

This core service has reported a vacancy rate for all staff of 6% as of 31 May 2018.

	Registered nurses			**Health care assistants**			**Overall staff figures**		
Ward/Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
OPMH Memory Clinic	1	1	100%	-0.8	2.6	-31%	1	1	100%
OPMH HQ	-0.5	2.5	-20%	-0.2	2.8	-7%	1.9	24.7	7%
OPMH CPN Team	0	9.8	0%	0	3	0%	0	13.8	0%
OPMH Intermediate Care	0	4.8	0%	0	0	0%	-0.2	8	-3%
Core service total	**0.5**	**18.1**	**3%**	**-1**	**8.4**	**-12%**	**2.7**	**47.5**	**6%**
Trust total	**68.1**	**846.4**	**8%**	**53.9**	**747.4**	**7%**	**166.3**	**3083.4**	**5%**

NB: All figures displayed are whole-time equivalents

Between 1 April 2017 and 31 March 2018, the core service reported no bank or agency usage for registered nurses or healthcare assistants.

[83] 20180801 R1C Vacancy analysis

Turnover[84]
This core service had 3.6 (8%) staff leavers between 1 April 2017 and 31 March 2018.

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
OPMH CPN Team	14.8	2.0	14%
OPMH Intermediate Care	7.4	1.0	14%
OPMH HQ	21.7	0.6	3%
Core service total	**43.9**	**3.6**	**8%**
Trust Total	**2,908.4**	**422.3**	**13%**

The trust provided refreshed turnover data following the inspection for the period 1 April 2018 and 30 September 2018:

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
OPMH CPN Team	4.1	0	0%
OPMH Intermediate Care	3.4	0	0%
OPMH HQ	17.9	1.8	10%

Sickness[85]
The manager provided recent sickness figures for the team. The current sickness rate was 6.9% which is over the trust target. However, this had reduced and the manager had a plan in place to manage sickness levels.

The sickness rate for this core service was 3% between 1 April 2017 and 31 March 2018. The most recent month's data [31 March 2018] showed a sickness rate of 3%.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
OPMH Intermediate Care	14%	10%
OPMH CPN Team	0%	3%
OPMH HQ	1%	1%
Core service total	**3%**	**3%**
Trust Total	**4%**	**5%**

[84] 20180802 R1C Turnover analysis
[85] 20180802 R1C Sickness analysis

Mandatory training

Training data summary[86]

The compliance for mandatory and statutory training courses at 30 June 2018 was 77%. Of the training courses listed, 16 failed to achieve the trust target and of those, seven failed to score below 75%.

All competencies are reported month by month, excluding Information Governance, which is report as a final figure at year-end.

Key:

Below CQC 75%	Met trust target	Not met trust target	Higher	No change	Lower	Error
	✓	×	↑	→	↓	N/A

YTD (Current Period)	Target	Number of staff eligible	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year
Mental Health Act	85%	1	1	100%	✓	-
Non Clinical Resuscitation	85%	56	54	96%	✓	↑
Safeguarding Adults (Level 1)	85%	56	53	95%	✓	↑
Duty of Candour	85%	56	52	93%	✓	-
Dementia Awareness (inc Privacy & Dignity standards)	85%	56	50	89%	✓	-
Infection Prevention (Level 1)	85%	56	45	80%	×	↑
Deteriorating and Resuscitation Training - Adults	85%	45	36	80%	×	↑
Safeguarding Children (Level 2)	85%	81	64	79%	×	↓
Safeguarding Children (Level 1)	85%	56	43	77%	×	-
Medicine management training	85%	26	20	77%	×	↑
Hand Hygiene	85%	48	35	73%	×	↑
Mental Capacity Act Level 1	85%	48	34	71%	×	↓
Information Governance	85%	56	32	57%	×	↓
Safeguarding Adults (Level 3)	85%	17	9	53%	×	-
Preventing Falls in Hospitals - Online	85%	43	23	53%	×	↑
Infection Prevention (Level 2)	85%	47	25	53%	×	↑
Resuscitation	85%	0	0	0%	×	-
Safeguarding Children (Level 3)	85%	0	0	0%	×	-
Resuscitation - Level 2 - Adult Basic Life Support	85%	0	0	0%	×	-
Core service total		**748**	**576**	**77%**	×	↑

The manager kept a training log with figures that differed to the trust reported numbers. Mental Capacity Act had been completed by 75% of eligible staff. 94% of the team had completed safeguarding adults level one and two, 95% were trained in safeguarding children level one and 83% were trained in safeguarding children level two. On site we found that more than one member of staff required Mental Health Act training. 50% of staff requiring Mental Health Act training had completed it or were up to date.

[86] 20180803 R1C Training analysis

The trust introduced deteriorating and resuscitation training (DART) following our last inspection to enable staff to identify unwell patients and deliver resuscitation.

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed eight patient care records. All records had a patient risk assessment in place. These were comprehensive and well detailed. Risk assessments, including a physical health assessment, were completed at initial referral and regularly updated. The team had undertaken a quality improvement project to ensure patient views are incorporated into risk assessments. We saw evidence of this in all risk assessments reviewed.

Staff completed crisis plans for all patients. The information contained in these depended on individual patient need. However, staff were not completing advanced decisions with patients.

Management of patient risk

Nurses triaged all initial referrals. They escalated any referrals to the crisis team that required an urgent response.

All patients were provided with the telephone number for the crisis team and could use this for support out of hours. Staff also referred patients to the crisis team if a patient's risk increased and they needed more support.

Staff reviewed risks regularly. The manager held weekly meetings for the team to review patient risks and required actions. Patient risks were also reviewed in regular multidisciplinary team meetings.

Staff had safe lone working procedures. The team used a "sky guard" alarm system on home visits, which tracked their location and had an emergency alarm. Staff completed a board on the staff office to monitor their whereabouts and called the office when they had safely left an appointment. Staff told us they felt safe working within the lone working policy.

The trust had introduced a bag containing drugs and equipment for a medical emergency. Staff completed weekly checks of this bag online to their manager. Staff had received training to use the bag.

Safeguarding

Safeguarding referrals[87]

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made no safeguarding referrals between 1 July 2017 and 1 June 2018.

[87] 20180911 Safeguarding Referrals

The team had robust safeguarding procedures. Staff made 13 safeguarding referrals between January 2018 and October 2018. The manager kept a safeguarding log of all referrals made, required actions and outcomes. Safeguarding concerns were discussed in meetings and documented in patient notes. Staff were confident and competent in identifying safeguarding concerns and the reporting procedures. There was a safeguarding poster on the wall in the service with the process to follow and contact details of the safeguarding link nurse. Safeguarding referrals were discussed during the monthly governance meetings.

Serious case reviews[88]

Solent NHS Trust has submitted details of five serious case reviews commenced or published in the last 12 months (1 April 2017 and 31 March 2018). However, none of these reviews were related to this core service.

Staff access to essential information

Staff used an electronic care record system to record patient information and clinical records. The team was making changes to become a "paper light" service. However, some paper records were still used. Where paper records were used, these were stored in line with trust policy. Staff had individual access to the electronic care record system. Staff used the same care record system as the local GP surgeries. This allowed vital information to be easily shared. The trust had introduced an internal intranet system where managers and staff could access policies and procedures necessary to deliver patient care.

Medicines management

Nurses followed good practice in medicines management. Nurses stored medication in locked medicines cupboards. The keys were kept in a coded key safe, to which only the registered nurses had the code. Nurses monitored the storage temperature of medicines and transported medication in lockable bags to patient's homes in line with trust policy. Medication and its containers were appropriately disposed of. The lead nurse undertook quarterly audits of the depot cards and two nurses would check and sign each depot card prior to administration.

Staff reviewed the effects of medication on patient's physical health. Doctors undertook physical health screening for patients before starting and whilst receiving antipsychotic medication, including screening blood tests. The results of which were shared with the GP. Staff also completed necessary physical health checks for patients prescribed anti-dementia drugs. Nurses checked patient's physical observations before administering depot medication. The team regularly audited patient notes to ensure all physical health checks were being completed.

Track record on safety

Serious incidents requiring investigation[89]

Providers must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of an incident being identified.

Between 1 April 2017 and 31 March 2018 there were three STEIS incidents reported by this core service. Of the total number of incidents reported, two were pending review at the date of reporting. The remaining incident was a VTE meeting SI criteria.

[88] 20180703 Universal RPIR - Serious Case Reviews

[89] 20180802 STEIS & SIRI analysis

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.

Type of incident reported on STEIS	Total incidents
Pending review (a category must be selected before incident is closed)	2
VTE meeting SI criteria	1
Total	**3**

Reporting incidents and learning from when things go wrong

'Prevention of future death' reports[90]

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been two 'prevention of future death' reports sent to Solent NHS Trust. None of these related to this particular core service.

Staff reported incidents using the electronic system, including non-safeguarding incidents, safeguarding incidents and deaths. The team manager reviewed all incident forms and emailed the raising staff member when the incident was closed including the outcome of the investigation into the incident. Incidents were discussed in monthly governance meetings and in individual supervision sessions.

Since January 2018 there had been 14 incidents reported (excluding deaths). 10 related to medication errors, two for self-harm, one information governance incident and one overdose of a patient. There were 86 deaths reported, which were expected. If an unexpected occurred, the manager reported there would be a review. There had been two serious incidents requiring investigation and one HIRI reported since January 2018. When a death was reported, a clinical judgement tool was completed that fed into the mortality review. In some cases, an immediate management report was requested. Deaths were discussed in the trust learning from deaths panel and learning shared was shared with the team.

We saw an example of learning from incidents when a patient's depot card had been incorrectly completed. The service now required two nurses to check the card before signing it off.

Staff followed their duty of candour following incidents. We saw an example of this when a patient received a letter about somebody else. The service sent a letter to apologise for the incident and stated the incident would be investigated and learned from.

Is the service effective?

[90] POFD Extract

Assessment of needs and planning of care

All patient records contained comprehensive mental health assessments. Staff completed and documented physical health assessments where required and communicated well with district nursing teams. These assessments fed into holistic, recovery orientated care plans that were completed collaboratively with patients.

Best practice in treatment and care

The service offered a range of treatment options suitable for the patient group. The treatments were those recommended by, and were delivered in line with, National Institute for Health and Social Care Excellence (NICE) guidance. These included medication and psychological therapies. The team also referred patients to a third sector organisation for post dementia diagnosis support, such as groups for patients and carers. There was regular monitoring of physical health depending on need, including annual physical health checks for those prescribed an antipsychotic medication.

We saw very good evidence of staff using rating scales for cognitive impairment, such as Mini-Mental State Examination (MMSE) and Montreal Cognitive Assessment Test (MOCA). However, outside of the memory monitoring service, the team was not routinely collecting information on patient outcomes.

Patients did not have access to neuropsychology. This would be of benefit to patients when routine cognitive testing does not clearly indicate whether a patient has a cognitive impairment or if it is not clear what the correct dementia subtype diagnosis is.

***National and local audits*[91]**

This core service participated in two clinical audits as part of their clinical audit programme 2017 – 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Cardiometabolic monitoring in patients with psychosis on antipsychotics in OPMH	OPMH	MH - Community-based mental health services for older people	Clinical	Dec-17	1. Refresher training for community & inpatient staff. 2. Staff to be reminded of our service's consistent lack of measuring waist circumference in the last two audits.
Re-audit: Quality of referral letter to Solent OPMH Memory Service	OPMH	MH - Community-based mental health services for older people	Clinical	Jan-18	The audit will be shared with services who refer patients to OPMH; education will be provided regarding the expected standard; refer patients for screening investigations as opposed to routine blood tests and the senior nurse doing triage is to contact the referrer to request essential missing information.

The clinical manager undertook a quality improvement project on service user and carer involvement in their care. This has led to changes in care plan templates and recording of patient notes. The team manager had also completed a hand hygiene audit and an audit around the quality of care planning within the service.

[91] RPIR universal - audits

Skilled staff to deliver care

The team had access to a full range of specialist staff. This included consultant psychiatrists, registered nurses, a social worker and occupational therapists. There were no speech and language therapists or dieticians within the team but these were easily accessible if required. The psychologist had recently left the team but the trust had appointed to this post. In the interim, staff could refer patients to the psychologist within the adult mental health services. Staff were also trained in psychological therapies such as cognitive behavioural therapy and motivational interviewing.

Appraisals for permanent non-medical staff[92]

The trust's target rate for appraisal compliance is 95%. As at 30 June 2018 (two months only), the overall appraisal rates for non-medical staff within this core service was 34%.

The rate of appraisal compliance for non-medical staff reported during this inspection was lower than the 83% reported in the previous year.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
OPMH HQ	24	11	46%
OPMH Intermediate Care	9	3	33%
OPMH CPN Team	14	2	14%
Core service total	**47**	**16**	**34%**
Trust wide	**3,416**	**1,221**	**36%**

At the time of our inspection, 88% of staff had received their appraisal or it had been scheduled. Appraisals were of high quality and focused on staff's personal and professional development.

Appraisals for permanent medical staff[93]

The trust's target rate for appraisal compliance is 95%. As at 30 June 2018 (two months only), the overall appraisal rates for medical staff within this core service was 80%.

The rate of appraisal compliance for medical staff reported during this inspection was higher than the 60% reported in the previous year.

Team name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals
OPMH HQ	5	4	80%
Core service total	**5**	**4**	**80%**
Trust wide	**84**	**66**	**79%**

[92] 20180803 R1C Appraisal analysis

[93] 20180803 R1C Appraisal analysis

Clinical supervision[94]
Between 1 April 2017 and 31 March 2018, the average rate across OPMH Community in this core service was 86%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Caveat from the trust: *Clinical Supervision should be provided for all clinicians as per trust policy at least every eight weeks as of February 2018. Therefore, we have calculated the number of sessions required each month based upon this as a minimum standard. Some teams have clinical supervision more often than this - supplemented by reflective practice, skill slots and debriefs (when required), hence rates of over 100%. Where we have identified that teams which have not been achieving this standard, plans have been implemented to ensure compliance in 2018/19.*

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
OPMH Community	90	77	86%
Core service total	**90**	**77**	**86%**
Trust Total	**2,057**	**2,323**	**113%**

The team manager kept a supervision record. Staff told us that their supervision was useful and meaningful. The registered nurses were regularly receiving their clinical supervision. However, the healthcare support workers were receiving it less often than trust policy of every eight weeks.

Multidisciplinary and interagency team work
Staff held comprehensive multidisciplinary team meetings on a weekly basis for each geographical area. Staff reviewed each patient and discussed concerns and safeguarding. Staff kept meeting minutes and documented discussions in patient notes.

There was good evidence of communication within the team and with the crisis team and the inpatient wards. Staff attended the bed state meetings for the wards to ensure the community team was involved in patient's discharge from hospital and attended care plan approach meetings on the wards if their patients were inpatients.

The team worked in partnership with local third sector organisations who also provided support for the patient group. We saw evidence of referrals to these organisations and their information was available for patients in reception.

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

Mental Health Act training figures[95]
As of 30 June 2018, 100% (one staff member) of the workforce in this core service had received training in the Mental Health Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

Staff had access to administrative support and legal advice on the implementation of the Mental Health Act and its Code of Practice.

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94 20180801 R1C Clinical and Managerial Supervision analysis
95 20180803 R1C Training analysis

The service employed a specialist nurse to undertake section 117 reviews with patients.

Staff were not clear how to access independent mental health act advocates and did not routinely offer this to patients.

Good practice in applying the Mental Capacity Act

Staff were competent and confident in the key principles of the Mental Capacity Act. Staff clearly documented issues around capacity. Capacity assessments were regularly undertaken and were decision specific and of good quality.

Staff were not clear how to access independent mental capacity act advocates and did not routinely offer this to patients.

Mental Capacity Act training figures[96]

As of 30 June 2018, 71% of the workforce in this core service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

The training compliance reported during this inspection was slightly lower than the 72% reported last year.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with dignity and respect. We saw that staff showed a caring and compassionate attitude towards patients.

Patients and carers told us they felt satisfied with the care they received. Patients and carers reported staff could easily be contacted, and staff were quick to respond to a crisis. Staff were described as kind, caring, and supportive. One carer told us that a nurse went "above and beyond" to form a therapeutic relationship with her husband, showing persistence, patience and kindness.

Staff understood and were respectful of patient's needs, including personal, cultural, social and religious needs. Staff used interpreters to support patient appointments and to translate written correspondence when required. Staff supported patients to access community based social, cultural, and religious groups.

Patients were given timely support and information to cope emotionally with their care, treatment or condition. Staff referred patients and carers to other agencies for ongoing post diagnostic support, such as Remind and the Alzheimer's Society.

Staff understood the need to uphold patient confidentiality. Staff used lockable briefcases when in the community to store paperwork. Staff sought consent before sharing information.

Involvement in care

[96] 20180803 R1C Training analysis

Involvement of patients
Managers sought feedback from patients and carers about the service they had received. At the time of this inspection, the team manager was developing a new patient and carer survey to support service improvements.

Staff routinely involved patients and carers in decision making. During our observations of appointments, staff communicated with people so that they understood their care, treatment and condition. Staff offered patients opportunities to ask questions. Staff involved patients in decisions about their medication and treatment. Patients and carers told us they felt involved in decisions about their care.

During our last inspection, we found staff did not routinely share copies of care plans with patients. However, at this inspection we reviewed eight patient records, staff now regularly shared copies of care plans with patients and where possible. Staff identified and included patient's views, aims and goals in documentation. Patient's care plans were person centred.

We did not see evidence of staff routinely providing information to patients about advocacy services. Staff told us they did not routinely use independent mental capacity advocates (IMCA), or independent mental health advocates (IMHA). While staff gave patients an information pack about the service this did not contain information about advocacy services. However, staff could explain how they would access IMCA or IMHA if required, and a patient advice and liaison service poster could be seen in the patient waiting area.

Involvement of families and carers
Staff identified patient's family, friends and carers and involved them in the delivery of care. Staff were flexible when planning clinical appointments with patients and their carers. Two carers told us they felt involved and well supported by the team.

At the last inspection, there was no formal patient or carer involvement within the team. During this inspection, we found those with personal experience of using services had recently supported management in recruiting new staff.

Is the service responsive?

Access and waiting times

Referral to assessment and treatment times[97] (Remove before publication)
The trust identified services as measured on 'referral to initial assessment' and 'assessment to treatment'. However, none pertained to this core service.

The manager reported there was no waiting list. Nurses triaged the referrals and patients would be seen in order of priority. Nurses were able to refer to the crisis team if necessary. The manager monitored the amount of time from referral to initial assessment and reported on those waiting over six weeks. The manager also reported against a national target of 18 weeks. There had been one breach of the 18 week target in the past 12 months.

Staff tried not to cancel appointments where possible. When staff were off sick unexpectedly, a member of the administration team contacted patients to rebook appointments if there was no cover available.

[97] 20180703 MH RPIR - Referral

All staff tried to be flexible with appointment times and locations. Staff were proactive in attempt to re-engage patients who did not attend their appointments and would involve carers in this process.

The facilities promote comfort, dignity and privacy
Staff had access to consulting rooms which were clean and furniture/examination couches were in a good state of repair. All rooms were sufficiently soundproof. Staff also saw patient's in their own homes.

Patients' engagement with the wider community
Staff provided good support to patient's families and carers and engaged them in the assessment and treatment process. The occupational therapists supported patients in their own homes and within the community. Staff referred patients and carers to third sector organisations within the community, including support groups.

Meeting the needs of all people who use the service
There were examples of reasonable adjustments for disabled access. There service had an automatic door and a ramp into the building for wheelchair access. At our last inspection we noted some areas were too small for certain wheelchair access. The trust had reviewed this and put mitigation in place for wheelchair users to be seen in an adjacent building as the cost involved to widen doors was not signed off by estates due to the services upcoming relocation.

Staff had access to interpreting services. A member of staff gave a recent example of using an interpreter not only in appointments but also to translate clinic letters for the patient.

There was a range of information available to patients, including leaflets about dementia, local services and how to complain. There were many notice boards with information about the service and also outcomes of recent audits and outcomes.

Listening to and learning from concerns and complaints

Formal complaints[98]
This core service received no complaints between 1 April 2017 and 31 March 2018.
On site we found that there had been two complaints made since January 2018. One was ongoing, the other was partially upheld. The partially upheld complaint concerned a relative who was not happy with how their relative had been assessed. The patient advice and liaison service had been involved in this complaint.

Information on the patient advice and liaison service was displayed in the waiting area. Information on how to make a complaint was not included in the patient information packs provided at assessment.

The team used the 'friends and family' feedback forms to gain feedback from patients and carers however the manager reported that little feedback was received in this way. The manager has sourced an alternative patient-friendly feedback form and has booked a training session for the staff, although it has not yet been implemented.

[98] 20180806 R1C Complaints analysis

Compliments[99]
This core service received four compliments during the last 12-months from 1 April 2017 to 31 March 2018, which accounted for less than 1% of all compliments received by the trust as a whole.
The service did not keep a log of compliments received. There were cards from patients and relatives on display on some notice boards. The manager said these cards were later sent to the trust to log.

Is the service well led?

Leadership
The team manager demonstrated the skills, knowledge and experience to carry out the role effectively. Staff spoke highly of the team manager and told us the manager was supportive and easily accessible.

The manager implemented monthly staff surveys within the team to monitor staff morale and positive and negative comments staff had about the previous month.

Staff told us that senior management were accessible and visible, including the board.

The team manager had a good understanding of the service and could discuss the aims and priorities of the service.

The team manager had made links with other community team managers within the trust and now attended their meetings to share learning and quality and improvement ideas.

Staff had leadership and professional development opportunities. However, staff reported that they found work pressures often prevented access.

Vision and strategy
The manager and staff were aware of the trust vision and strategy and how it applied to their service. The team had developed their own team mission statement and team objectives.

The staff we spoke with were working hard to provide high quality care within the budget restraints. Staff told us there was a 12 month ‘higher cost placement project’ within the trust where value for money was assessed in the more expensive placements. The trust had successfully trialled 24-hour home care twice as part of this project.

Culture
The culture amongst the team was supportive, motivated and enthusiastic. Staff told us morale had been low but was improving. Staff attributed this to new staff members joining the team and positive, meaningful audits with comprehensive follow up to improve the quality of work produced by the team. Staff spoke with care and passion when talking about the care they deliver.

There had been no reports of bulling or harassment within the team. Staff worked well together and felt supported by their manager.

Staff knew the whistleblowing policy and told us they felt confident raising concerns. Staff felt that concerns raised would be taken seriously by the team manager.

Staff were recognised by senior management for their achievements. For example, the cleaner had been awarded a lifetime achievement award by the trust.

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[99] 20180703 Universal RPIR - Compliments

Suspension and supervised practice[100]
During the reporting period, there were no suspensions or cases of supervised practice for this core service.

Caveat: Investigations into suspensions may be ongoing, or staff may be suspended, these should be noted. We saw evidence that the manager was addressing issues around staff performance appropriately.

Governance
The team manager held monthly governance meetings for the whole team. Feedback from incidents, deaths and risks were discussed and minutes were shared with the team. The manager escalated issues from the team governance meeting to the senior management governance meeting if required. The manager attended the senior management governance meetings monthly.

The matron worked closely with the team manager to implement good governance structures, such as implementing learning from incidents, complaints and safeguarding alerts.

The team manager had good governance systems within the service. The manager kept oversight of safeguarding alerts with the safeguarding log and managed incidents via an online system. The manager and staff completed audits and implemented learning effectively within the team.

Board assurance framework[101]
The trust provided its Board assurance framework. This detailed any risk scoring 15 or higher and gaps in the risk controls that affect strategic ambitions. The trust outlined three business priorities with nine sub priorities:

7. Great Care:
    a. Improve quality in line with CQC inspection requirements
    b. Provide safe staffing
    c. Use technology to work differently
8. Great place to work:
    a. Plan for long term sustainable staffing
    b. Enhance our leadership throughout the organisation
    c. Provide training that enables us to deliver great care
9. Great value for money:
    a. Further pathway integration with other providers
    b. Benchmark out services to improve productivity
    c. Change front line and corporate services to live within our income

Corporate risk register[102]
The trust has provided a document detailing 108 of their current risks of which 12 have a risk rating of high (Red). However, none related to this core service.

[100] 20180703 Universal RPIR - Suspension & Supervised
[101] 20180801 R1C BAF & RR analysis
[102] 20180801 R1C BAF & RR analysis

Management of risk, issues and performance
Staff discussed risk in their monthly governance meetings. The team manager would take any risk items to the senior management governance meeting for escalation to the trust risk register. The team currently had no risks on the trust risk register.

The trust maintained a risk register but this did not include any entries for the team. The team manager did not hold a local risk register. The ligature points risk assessment did not feature on the trust risk register. The manager told us that risks and whether to add them to the risk register was discussed in monthly governance meetings. We saw evidence that risks and the risk register were discussed at governance meetings. However, no risks were considered to need escalation to the risk register.

Information management
Staff used electronic systems, including laptops and mobile phones for remote working. The team used the same electronic record keeping system as their GP practices which enabled efficient information sharing.

The trust had introduced an intranet which allowed all staff access to policies and procedures necessary for patient care.

Engagement
Patients and carers had the opportunity to feedback about the service through the friends and family survey. The team manager shared results from this within the team governance meeting, as well as compliments cards and letters.

Staff had access to the trust intranet to be kept up to date with developments, news and changes. Staff discussed service developments within the team monthly governance meetings.

Learning, continuous improvement and innovation
The team used quality improvement methods to develop service delivery. A quality improvement board was on display in the office with examples of quality improvement work that had taken place. Quality improvement projects that had taken place included a project about patient and carer involvement in their care and improvement to care plan and risk assessment documentation.

The team manager had implemented weekly risk meetings and the caseload management tool to ensure safe staffing and improve quality of patient risk management.

Accreditation of services[103] (Exception reporting only)
NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The trust provided information on which services have been awarded an accreditation together with the relevant dates of accreditation. However, there was no information for this core service.

[103] 20180703 Universal RPIR - Accreditation

Long stay/rehabilitation mental health wards for working age adults

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
St James Hospital	Oakdene AMH Rehabilitation Service	14	Mixed

Is the service safe?

Safe and clean care environments

Safety of the ward layout
Oakdene ward was a fourteen bedded, single storey, ward for men and women, on the St James hospital site. Staff had a good view of the whole environment because staff were allocated different areas of the ward.

Observation of ward areas was possible because of the layout of the building and it had open plan communal areas and wide corridors. Additional staff could be brought in for patient observation.

Staff carried out risk assessments of the care environment. The team risk register included a comprehensive record of environmental risks and how they were mitigated. While the ward layout allowed staff to observe many parts of the ward, staff mitigating the risk through increased observation.

Staff carried personal alarms which were regularly tested to alert others in emergencies when necessary. Patients had access to nursing call alarms in their bedrooms.

Same sex accommodation breaches[104] (Remove before publication)
Over the 12 month period from 1 April 2017 to 31 March 2018 there were no mixed sex accommodation breaches within this core service.

The ward was compliant with guidance on eliminating mixed sex accommodation, although patients on the ward were both male and female, bed spaces of each gender were based in separate corridors. There were separate male and female lounges for patients, however female patients had to walk by the male lounge to access the female lounge.

Ligature risks[105] (Remove before publication)
All known ligature risks were identified, assessed, risk rated and mitigated by staff observation. The ward had many ligature points. These ligature points included wiring of patients` personal appliances.

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[104] 20180703 Universal RPIR - Mixed sex breaches
[105] 20180703 MH RPIR - Ligature Risks

To help manage ligature risks, the ward manager completed audits of points that patients could fix a cord or rope to for the purpose of strangulation (known as a ligature point). These audits identified risks and included methods of managing them. Staff managed the ligature risks in the bedrooms with observation levels based on a risk assessment of the patients.

We saw work which had been carried out since our last inspection in June 2016 where non-collapsible curtain rails had been replaced. There was a ligature point in the form of a tree in one of the two gardens available for patients on the ward. However, to mitigate that risk the garden was locked and patients could only access the garden under supervision. Staff had access to ligature cutters in the nursing office and in the emergency equipment bag.

There were ligature risks on one ward within this core service. The trust had undertaken recent (from 1 May 2018 onwards) ligature risk assessments at one location. None of the wards had not had a ligature risk assessment in the last 12 months.

Oakdene ward presented a high level of ligature risk due to ‘ligature risks being either mitigated or solutions being proposed – mostly they are low with the exception of some en-suite fixtures and fittings’.

The trust had taken actions in order to mitigate ligature risks – ‘staff aware of ligatures within ward environment and known mitigations in place’.

Maintenance, cleanliness and infection control

The ward was clean, tidy and in a good state of repair. We saw a detailed and comprehensive cleaning schedule on the cupboard in the house keeper`s room.

Patient-Led Assessments of the Care Environment (PLACE)[106] (Remove before publication)

For the most recent Patient-Led Assessments of the Care Environment (PLACE) assessment (2017) the location scored higher than the similar trusts for all four aspects overall.

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
St James Hospital	CHS – Adult community CHS – Children, young people and families Acute wards for adults of working age and psychiatric intensive care units Community based mental health services for older people Long stay/rehabilitation mental health wards for working age adults Wards for older people with mental health problems Community based mental health services for learning disability and autism	99.1%	97.9%	95.7%	96.5%
Trust overall		**99.3%**	**96.8%**	**91.9%**	**92.9%**
England average (Mental health and learning disabilities)		**98.6%**	**92.7%**	**80.6%**	**86.1%**

[106] PLACE 2017 data report

Cleaners visited the ward regularly. We reviewed the infection control policy for the organisation and the local infection control procedures which were robustly applied and audited such as hand washing and mattress cleaning.

The ward manager carried out regular environmental checks. We saw staff completing environmental checks to ensure any required maintenance was reported. For example, broken door handles, damaged furniture or locks.

Seclusion room (if present)
Oakdene ward did not use seclusion and did not have facilities for seclusion. If a patient required this level of intensive treatment then they would be transferred to a different ward.

Clinic room and equipment
The clinic room was clean, and well stocked with equipment and emergency medicines. The clinic room temperatures and the fridge temperatures were checked and recorded daily.

However, not all equipment had been maintained and safety checked. We saw evidence that physical health examination equipment was not checked regularly. For example blood glucose monitoring equipment was not calibrated regularly although staff told us this was done daily.

Sterile equipment was not managed safely as we found a number of products that had passed their expiry date. Staff told us that they recognised that the storage was not fit for purpose and delegated a member of staff to date check all the remaining sterile equipment and discard the out of dates ones.

Staff checked the emergency response kit once a week and the pharmacist visited daily to assist with auditing the clinic room and disposing of medicine appropriately.

Safe staffing

Nursing staff
The ward had appropriate levels of staffing to meet the needs of patients. There were two qualified nurses and two support workers during the day shifts and one qualified nurse and two support workers at night. In addition to this the ward manager worked Monday to Friday 9am to 5pm.

The ward manager could increase the number of staff on the ward if needed. The manager had to report any increases in staff to a senior management panel, who reviewed the reasons for extra staffing. The deputy ward manager told us that the panel would not prevent the ward from increasing staffing levels. There was always an experienced member of staff present on the ward. There were enough staff to give patients one to one time. Staff told us that they rarely cancelled escorted leave due to staff shortages, but if so, they would rearrange for the same day or as soon as possible.

Staffing overview at a glance[107]
The table below presents information that was made available by the trust in advance of this inspection. This inspection took place on the 18 October 2018, over six months since this data was submitted as accurate.

Definition

[107] 20180801 R1C Vacancy analysis ; 20180802 R1C Sickness analysis ; 20180802 R1C Turnover analysis ;20180802 R1C Bank and agency analysis

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	31 March 2018	18.6	N/A
Total number of substantive staff leavers	1 April 2017–31 March 2018	5.4	N/A
Average WTE* leavers over 12 months (%)	1 April 2017–31 March 2018	26%	12%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	31 March 2018	10	N/A
Total vacancies overall (%)	31 March 2018	39%	5.4%
Total permanent staff sickness overall (%)	Most recent month (At 31 March 2018)	0%	4%
	1 April 2017–31 March 2018	3%	4%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	31 March 2018	12.8	N/A
Establishment levels nursing assistants (WTE*)	31 March 2018	9.0	N/A
Number of vacancies, qualified nurses (WTE*)	31 March 2018	7.4	N/A
Number of vacancies nursing assistants (WTE*)	31 March 2018	0	N/A
Qualified nurse vacancy rate	31 March 2018	58%	5.4%
Nursing assistant vacancy rate	31 March 2018	0%	5.4%
Bank and agency Use			
Bank staff hours filled to cover sickness, absence or vacancies (qualified nurses)	1 April 2017–31 March 2018	1830 (7%)	N/A
Agency staff hours filled to cover sickness, absence or vacancies (Qualified Nurses)	1 April 2017–31 March 2018	2625 (11%)	N/A
Hours NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 April 2017–31 March 2018	323 (1%)	N/A
Bank staff hours filled to cover sickness, absence or vacancies (Nursing Assistants)	1 April 2017–31 March 2018	3649 (20%)	N/A
Agency staff hours filled to cover sickness, absence or vacancies (Nursing Assistants)	1 April 2017–31 March 2018	782 (4%)	N/A
Hours NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 April 2017–31 March 2018	187 (1%)	N/A

*Whole-time Equivalent

Establi***shme***nt, Vacancy, Levels of Bank & Agency Usage[108]

This core service reported an overall vacancy rate of 58%% for registered nurses at 31 March 2018.

This core service reported an overall vacancy rate of 0% for nursing assistants.

This core service has reported a vacancy rate for all staff of 39% as of 31 March 2018.

[108] 20180801 R1C Vacancy analysis

At the time of inspection, Oakdene ward had successfully recruited two qualified nurse posts and had an outstanding two qualified nurse vacancies. The ward manager addressed these vacancies by use of bank staff and agency staff who were block booked in advance. There was regular rotation of staff between night and day shifts. The ward manager who was originally supernumerary assisted and supported with the running of the ward to cover the vacancies.

	Registered nurses			Health care assistants			Overall staff figures		
Ward/Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Oakdene	7.4	12.8	58%	0	9	0%	10	25.8	39%
Core service total	**7.4**	**12.8**	**58%**	**0**	**9**	**0%**	**10**	**25.8**	**39%**
Trust total	**68.1**	**846.4**	**8%**	**53.9**	**747.4**	**7%**	**166.3**	**3,083.4**	**5%**

NB: All figures displayed are whole-time equivalents

Between 1 April 2017 and 31 March 2018, bank staff filled 7% of hours to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 11% of hours for qualified nurses. One percent of hours were unable to be filled by either bank or agency staff.

Ward/Team	Available Hours	Hours filled by bank staff	Hours filled by agency staff	Hours NOT filled by bank or agency staff
Oakdene	24,980	1,830 (7%)*	2,625 (11%)*	323 (1%)*
Core service total	**24,980**	**1,830 (7%)***	**2,625 (11%)***	**323 (1%)***
Trust Total	**1,123,704**	**39,989 (4%)***	**60,916 (5%)***	**8,701 (1%)***

*Percentage of total shifts

Between 1 April 2017 and 31 March 2018, bank staff to cover sickness, absence or vacancy for nursing assistants filled 20% of hours.

In the same period, agency staff covered 4% of hours. One percent of hours were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Oakdene	18,077	3,649 (20%)*	782 (4%)*	187 (1%)*
Core service total	**18,077**	**3,649 (20%)***	**782 (4%)***	**187 (1%)***
Trust Total	**75,0079**	**64,940 (9%)***	**35,565 (5%)***	**5,016 (1%)***

* Percentage of total shifts

Turnover[109]

This core service had 5.4 (26%) staff leavers between 1 April 2017 and 31 March 2018.

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Oakdene	18.6	5.4	26%
Core service total	**18.6**	**5.4**	**26%**
Trust Total	**2,908.4**	**422.3**	**13%**

The trust provided refreshed turnover data following the inspection for the period 1 April 2018 and 30 September 2018:

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Oakdene	7.8	0	0%
Core service total	**7.8**	**0**	**0%**

At the time of this inspection the modern matron told us the staff turnover rate for the month of August for Oakdene ward was 16%. However, the modern matron was not able to explain why staff why leaving.

Sickness[110]

The sickness rate for this core service was 3% between 1 April 2017 to 31 March 2018. The most recent month's data (31 March 2018) showed a sickness rate of 0%.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Oakdene	0%	3%
Core service total	**0%**	**3%**
Trust Total	**4%**	**5%**

At the time of this inspection the modern matron told us the staff sickness rate for the month of August for Oakdene ward was 5%.

Staff Fill Rates[111] ***(Remove before publication)***

Oakdene ward used regular bank staff and agency in order to meet the clinical needs of patients on the ward and to manage risks when there were staff shortages. These staff were block booked in advance to promote continuity of care and familiarity for patients. Where there were gaps in staffing numbers, these were covered by staff who were originally supernumerary. For example, the manager would assist.

The below table covers staff fill rates for registered nurses and care staff during April, May and

[109] 20180802 R1C Turnover analysis

[110] 20180802 R1C Sickness analysis

[111] 20180801 R1C Safer staffing analysis

June 2018.

Oakdene ward had under filled for registered nurses for all day shifts across all months reported.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	Jun 18				May 18				Apr 18			
Oakdene	76.8	104.8	109.7	100.0	76.8	104.8	109.7	100.0	74.0	107.5	123.3	98.3

Medical staff

Medical locums[112]
Staff had access to a consultant psychiatrist with experience in rehabilitative care and two staff grade doctors. They could also access the trust`s on call psychiatry service after hours.

Between 1 April 2017 and 31 March 2018, agency staff to cover sickness, absence or vacancy for medical locums filled 100% of hours.

Please be advised that the total number of hours 'not filled' was not provided and the number of hours filled by bank staff was null.

Mandatory training

Training data summary[113]
The compliance for mandatory and statutory training courses at 30 June 2018 was 82%. Of the training courses listed, 15 failed to achieve the trust target of 90%, and of those, nine failed to score above 75%.

All competencies are reported month by month, excluding Information Governance, which is report as a final figure at year-end.

On the day of our inspection, the deputy ward manager told us that staff had booked onto or completed mandatory training for Mental Health Act, Information Governance, Hand Hygiene, Infection Prevent and Preventing Falls in Hospitals to ensure they were up to date.

Key:

Below CQC 75%	Met trust target	Not met trust target	Higher	No change	Lower	Error
	✓	✗	↑	→	↓	N/A

YTD (Current Period)	Target	Number of staff eligible	Number of staff trained	YTD Compliance	Trust Target Met	Compliance change when compared to previous year

[112] 20180803 R1C MH Med Locum analysis

[113] 20180803 R1C Training analysis

Duty of Candour	85%	19	19	100%	✓	↑
Non-Clinical Resuscitation	85%	19	19	100%	✓	↑
Medicine management training	85%	9	9	100%	✓	↑
Dementia Awareness (inc Privacy & Dignity standards)	85%	19	18	95%	✓	↓
Safeguarding Adults (Level 1)	85%	19	18	95%	✓	↓
Safeguarding Children (Level 1)	85%	19	18	95%	✓	↓
Safeguarding Children (Level 2)	85%	32	29	91%	✓	↑
Infection Prevention (Level 1)	85%	19	16	84%	✗	↑
Mental Capacity Act Level 1	85%	18	15	83%	✗	↑
Deteriorating and Resuscitation Training - Adults	85%	15	12	80%	✗	↑
Mental Health Act	85%	19	14	74%	✗	↓
Information Governance	85%	19	12	63%	✗	↓
Hand Hygiene	85%	18	11	61%	✗	↑
Infection Prevention (Level 2)	85%	18	11	61%	✗	↓
Preventing Falls in Hospitals - Online	85%	16	9	56%	✗	↑
Safeguarding Adults (Level 3)	85%	1	0	0%	✗	↑
Core service total		**279**	**230**	**82%**	✗	↑

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed seven care records. Staff had completed a comprehensive risk assessment for all patients on admission and updated them regularly in fortnightly multi-disciplinary meetings. They used a standardised form in the electronic care records system to do this. Risk assessment for patients were categorised and recorded as low, medium or high depending on the level of risks. Staff were very aware and able to describe patients` risks and risk management plans in depth.

However, specialised risk assessment such as Historical, Clinical, Risk Management-20 (HCR-20) were not always completed for patients who required these specific risk assessments. The Historical, Clinical, Risk Management-20 (HCR-20) is an assessment tool that helps mental health professionals estimate a person's probability of violence. Staff told use that HCR-20 risk assessment were not always done due to the limited availability of the psychologist. Staff told us that lead to the Home Office delaying the grant of leave for patients who were restricted by the Home Office.

Management of patient risk

Staff followed the risk assessment template on the electronic records system. There were no blanket restrictions that were in place for the benefit of patients.

Staff followed the trust’s search policy. They conducted searches when risks were identified or situations warranted it under the policy.

All voluntary patients were able to leave the ward on request as the ward entrance door was not locked. Information about how to leave the ward was also visible on noticeboards around the ward. The observation policy required staff to have seen each patient on the ward, minimally, every hour and to document this check.

Patients could freely access the communal garden for fresh air. The trust implemented a smoke free policy in 2018. Staff offered patients nicotine replacement on admission. The trust had organised smoking awareness and cessation sessions for patients and staff.

Use of restrictive interventions

Restrictive Interventions[114]:
Oakdene ward did not have access to a seclusion room for staff to use restrictive interventions. Staff relied upon de-escalation in the management of aggression.

This core service had two incidents of restraint (on two different service users) and no incidents of seclusion between 1 April 2017 and 31 March 2018.

The below table focuses on the last 12 months' worth of data: 1 April 2017 to 31 March 2018.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Oakdene	**0**	2	2	1 (50%)	0 (0%)
Core service total	**0**	**2**	**2**	**1 (50%)**	**0 (0%)**

Restraint[115]:
There was one incident of prone restraint, which accounted for 50% of the restraint incidents.

There were no incidents in the use of rapid tranquilisation.

There have been no instances of mechanical restraint over the reporting period.

Seclusion[116]:
Over the 12 months, there was no use of seclusion.

Segregation[117]:
There have been no instances of long-term segregation over the 12-month reporting period.

Safeguarding

Safeguarding referrals[118]
A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

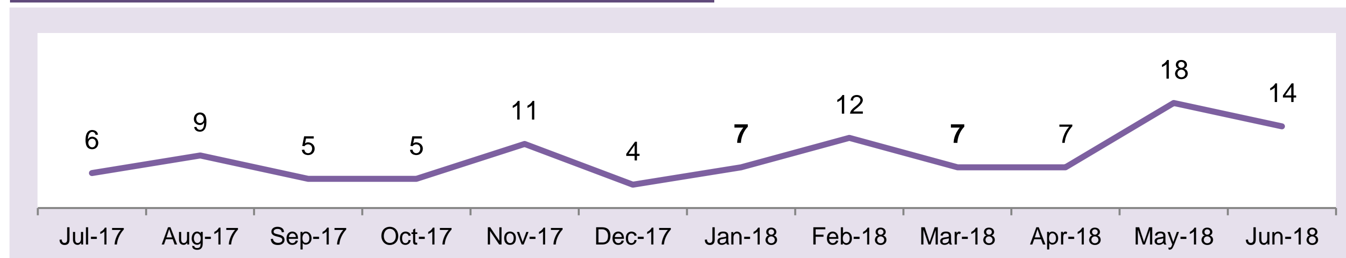
This core service made 105 safeguarding referrals between 1 July 2017 and 1 June 2018, all of which concerned adults.

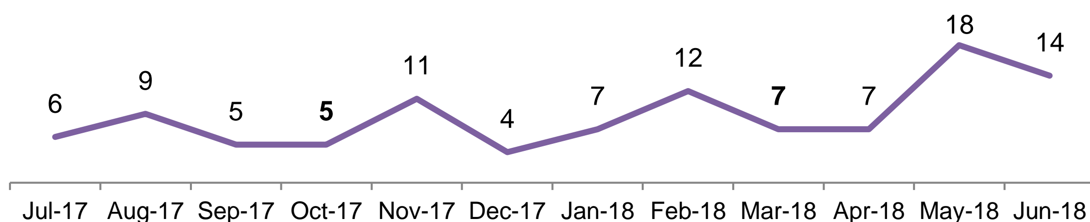
Number of referrals		
Adults	**Children**	**Total referrals**
105	0	**105**

114 20180806 R1C Restrictive intervention analysis
115 20180806 R1C Restrictive intervention analysis
116 20180806 R1C Restrictive intervention analysis
117 20180806 R1C Restrictive intervention analysis
118 20180911 Safeguarding Referrals

There was one peak in May 2018 in adult referrals across the time period.

Total referrals (*July 2017 to June 2018)*





Staff made safeguarding referrals and sought advice from their team and the trust`s safeguarding team. During this inspection staff told us they knew what needed reporting as safeguarding and how to make an alert. There were posters in communal areas of the ward that contained information on how to make a safeguarding referral.

Staff reported they developed good and effective working relationships with the local authority and felt confident to contact the safeguarding team.

Visitors, including children were welcomed. A private meeting room was available at the reception for use when children visited. The communal lounge was also used as a visiting room when patients had visitors.

Serious case reviews[119]
Solent NHS Trust has submitted details of five serious case reviews that commenced or were published in the last 12 months (1 April 2018 to 31 March 2018). However, none of them relate to this core service.

Staff access to essential information
Staff had timely and secure access to information through the electronic records system. All staff had access to records when they needed them. There were enough computers to allow staff to access the electronic notes each shift.

[119] 20180703 Universal RPIR - Serious Case Reviews

Paper records were also used for medication charts, consent to treatment documents and section 17 leave paperwork. Staff did not report any issues co-ordinating between paper and electronic records and we did not find any problems.

Medicines management

There were organisational policies and procedures in place around ordering and storing medication.

Staff securely stored medicines in the clinic room and recorded that they remained within their recommended temperature ranges.

The ward pharmacist visited daily conducting an audit to ensure correct medicine management. Medical staff followed prescribing guidance from the National Institute for Health and Care Excellence.

All medicine charts were inspected and all medication doses were within the parameters set by the British National Formulary. Medicines were administered in accordance with consent to treatment forms T2, T3 and section 62 of the Mental Health Act for urgent administration of medication except for medicine administration for one patient. We saw that one patient was being administered doses of medicines more than the authorised limit on their T3 form. No section 62 had been written for this person. The excess dose had been highlighted by the Trust pharmacy team but no action was recorded. When we spoke with the nurse on duty, they told us that they had not noticed that it was above the limits. We discussed this with the Trust pharmacy team who told us that this would be raised through the MDT meeting but that it would not be flagged as needing urgent action. There was a weekly audit undertaken on the ward of T2 and T3s. This was then discussed at a local MHA monitoring group each month. A report was then submitted to the MHA scrutiny committee quarterly. T2, T3 and Section 62 forms apply to medication used to alleviate the symptoms of mental disorder and their side effects as detailed in the Mental Health Act 1983. Practitioners must not prescribe or administer medicines to service users detained under The Act after the three months period without first ensuring that a valid T2, T3 or Section 62 form has indicated that the treatment can be given. It is essential to check these prior to each administration.

All consent to treatment forms were up to date.

As part of the re-enablement process, staff encouraged patients to self-administer their medicines. All bedrooms had medication safes in them so that patients could manage their own medication.

Track record on safety

Serious incidents requiring investigation[120]

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 April 2017 and 31 March 2018 there were no STEIS incidents reported by this core service.

A ‘never event’ is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

During our inspection, we did not identify any incidents that should have been reported to the Strategic Information Executive System that staff had not.

[120] 20180802 STEIS & SIRI analysis

Reporting incidents and learning from when things go wrong

'Prevention of future death' reports[121]

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been two 'prevention of future death' reports sent to Solent NHS Trust. None of these were related to this particular core service.

Staff reported incidents and learning from them was shared. All staff knew what to report as an incident using electronic records system. All staff had access to the electronic incident reporting system. All staff were trained to use the SBAR (situation, background, assessment, recommendation) reporting tool, we saw evidence of this when looking at patients` care records and incident reports.

We checked three incidents that we found in records, all had been reported in line with the trust's policy.

Learning from feedback was shared with staff. The deputy ward manger told us the manager gave staff feedback on incidents after review. Staff shared learning from incidents in handovers, team meetings and reflective practice sessions. The deputy ward manager told us that they received information about learning elsewhere in organisation at team business meetings which they share with ward staff. The deputy ward manager and the ward manager ensured staff and patients had a debrief following an incident. This was usually part of patient`s meetings, handovers, supervisions, team meetings and reflective practice sessions.

The deputy ward manager told us staff understood their duty of candour and would always explain to patients and families if something had gone wrong in their care. However, staff had not had to do so.

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[121] POFD Extract

Is the service effective?

Assessment of needs and planning of care

We examined seven care records on Oakdene ward, all of which showed good practice in a range of areas. The records showed staff completing a comprehensive mental health assessment of the patient either before, at or soon after admission. Staff assessed patients' physical health needs in a timely manner after admission and on an ongoing basis.

Care plans were personalised, holistic, and recovery-orientated. The computer records system had been updated to include a section of overarching goals from the patient's view, including a timeframe for these to be achieved. Care plans were updated to reflect changes. Patients were offered copies of their care plans.

Care plans included reference to advance care planning, prompting staff to ask if people had made advance decisions or statements. If so their wishes were included within the care plan.

The admission assessments were timely and comprehensive. Staff assessed and managed physical health through weekly monitoring. Staff used the National Early Warning Score (NEWS) physical health assessment tool for general monitoring of physical health. This benefitted patients by alerting staff to changes in physical health conditions. Staff also used a malnutrition universal screening tool (MUST) to establish and enable monitoring of nutritional risks.

DIALOG outcome scales were used to monitor patient outcomes. DIALOG is an outcomes measure to support structured conversation between patients and clinician whilst focusing on the patients' views of quality of life, needs for care and treatment satisfaction.

Clinical staff were actively involved in clinical audit on Oakdene ward, for example hand hygiene monitoring and mattress and pillow assessment audits. Infection control audit results were available for patients and staff to see in communal areas of the ward.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions delivered were in line with best practice guidance. These included medication and occupational therapies and activities, training and work opportunities intended to help patients acquire and develop independent living skills.

However, ongoing psychological therapy on the ward was limited and was delivered to patients on referral. A psychologist worked with patients on the ward to deliver therapies and intervention once an assessment took place. This was limited as the psychologist was based at the Orchard unit (acute inpatient service) and was responsible for providing psychology to Oakdene as well as the Orchard Unit. This was identified in our last inspection in June 2016. In order to address this the modern matron told us that the trust trained two staff in psychological therapies and interventions such as cognitive behaviour therapy (CBT), Dialectical behaviour therapy (DBT) and mindfulness, however, these staff had since left. The modern matron also told us that senior management were aware of this and were going to recruit a psychologist to address this.

Staff ensured that patients had good access to physical healthcare. The nursing team completed a physical health review on a weekly basis and prior to the patients' multidisciplinary team meeting. All patients had a minimum of an annual physical health check.

Staff assessed and met patients' needs for food and drink, including dietary needs as part of the core assessment process. Staff supported patients to live healthier lives, including providing smoking cessation.

The occupational therapist ran lifestyle groups. This was to support patients with exercise, nutrition and a healthy lifestyle. The occupational therapist also facilitated access to community resources such as local gym.

The ward valued the input of family and carers. The triangle of care leads on the ward supported family liaison across the staff team, including signposting for carer's assessments and family therapy as appropriate.

Staff were committed to quality improvement and frequently audited their practice. There was a comprehensive schedule of auditing, outcomes of audits were fed back through team meetings, one-to-one supervisions, study days and skills slots. Posters highlighting improvements made as a result of auditing practice were displayed on notice boards for patients, carers and staff to see.

National and local audits[122]

This core service participated in two clinical audits as part of their clinical audit programme 2017 – 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
National Clinical Audit of Psychosis (NCAP) (NICE CG 178)	Mental Health	MH - Long stay/rehabilitation mental health wards for working age adults	Clinical	Nov-17	1. Development of a pathway to improve interventions for abnormal lipids (we improved from 29% to 50% against a national average of 52%); 2. development of systems to identify high dose prescribing (we improved incidence from 12% to 10% against a national average of 7.5%) and poly-pharmacy with antipsychotics (we improved from 19% to 16% against a national average of 10%); 3. Improved processes for documenting patient involvement in prescribing decisions (we improved 38% to 54% against a national average of 65%) alongside further provision of patient information on anti-psychotics (we improved from 28% to 33% against a national average of 30%)..
PLACE	Patient-led assessments of the care environment. 2 patient assessors and 1 staff assessor.	Oakdene Ward	Non-clinical, patient environment	May-18	Preliminary reports have been shared with the Services who are currently developing action plans.

Skilled staff to deliver care

There was the right skill mix of staff to deliver patients` care on Oakdene ward. At the time of the inspection, the multidisciplinary team included the modern matron, ward manager, nurses, support

[122] 20180703 Universal RPIR - Audits

workers, psychologist, occupational therapist, social worker, a pharmacist and psychiatrist. A pharmacist visited daily to audit medicine administration and conduct audit around medicine management. The occupational therapist was based on the ward and assess patients' needs and develop individual activity plans for patients. The staff were experienced in rehabilitation care, and were knowledgeable about the needs of patients on the ward. Staff told us that they had received specialist training in mental health rehabilitation or group facilitation from the occupational therapist. There were appropriate induction procedures in place for new staff.

The modern matron told us that staff had supervision every month. This was held with more senior nurses on the ward and staff said they were receiving regular supervision. However, staff supervisions were not recorded every month in line with the trust`s policy. The deputy ward manager reported that staff were receiving regular supervision but sometimes this was done in an informal way.

Staff were able to request specialist training and staff said access to this was good.

The ward manager was able to explain how they managed poor performance effectively and promptly.

***Appraisals for permanent non-medical staff*[123]**

Staff had appraisal every year. This was held with more senior nurses on the ward and staff said they were receiving yearly appraisal. However, when we reviewed staff records and saw that no staff appraisals were not recorded yearly in line with the trust`s policy.

The trust's target rate for appraisal compliance is 95%. As at 30 June 2018, the overall appraisal rates for non-medical staff within this core service was 11%. Appraisal rates are reset to zero at the beginning of the financial year.

The wards/teams failing to achieve the trust's appraisal target were Oakdene with an appraisal rate of 11% (albeit this is only for a two-month period).

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Oakdene	18	2	11%
Core service total	**18**	**2**	**11%**
Trust wide	**3,416**	**1,221**	**36%**

***Appraisals for permanent medical staff*[124]**

The trust's target rate for appraisal compliance is 95%. As at 30 June 2018, the overall appraisal rates for medical staff within this core service was 0%.

However, Oakdene, had an appraisal rate of 100% at the time of the inspection.

[123] 20180803 R1C Appraisal analysis

[124] 20180803 R1C Appraisal analysis

Ward name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals
Oakdene	1	1	100%
Core service total	**1**	**1**	**100%**
Trust wide	**84**	**66**	**79%**

Clinical supervision[125]
Between 1 April 2017 and 31 March 2018 the average rate across Oakdene ward in this core service was 76%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Caveat from the trust: '*Clinical Supervision should be provided for all clinicians as per trust policy at least every 8 weeks as of February 2018. Therefore, we have calculated the number of sessions required each month based upon this as a minimum standard. Some teams have clinical supervision more often than this - supplemented by reflective practice, skill slots and debriefs (when required), hence rates of over 100%. Where we have identified that teams which have not been achieving this standard, plans have been implemented to ensure compliance in 2018/19'.*

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Oakdene Ward	**120**	**91**	**76%**
Core service total	**120**	**91**	**76%**
Trust Total	**2,057**	**2,323**	**113%**

Managerial Supervision[126]
Between 1 April 2017 and 31 March 2018 the average rate across all three teams in this core service was 32%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Caveat from the trust: '*Managerial supervision is every 2 months following the changes in the clinical supervision policy in February 2018. We have therefore calculated the required number of sessions based on this figure. As well as formal supervision sessions, staff have opportunity for informal managerial support as well as attendance at skill slots and reflective practice sessions. We are aware that some teams have not consistently achieved the required standard during 2017/2018 but staff and frontline managers are aware of the requirement to meet the standards within trust policy during 2018/2019 and we expect all mental health service areas to be compliant by September 2018'.*

Ward name	Managerial supervision sessions required	Managerial supervision sessions delivered	Managerial supervision rate (%)

[125] 20180801 R1C Clinical and Managerial Supervision analysis
[126] 20180801 R1C Clinical and Managerial Supervision analysis

Oakdene Ward	120	38	32%
Core service total	**120**	**38**	**32%**
Trust Total	**1762**	**1645**	**93%**

Multi-disciplinary and interagency team work

There was a multi-disciplinary team meeting every week with individual patients reviewed every two weeks. The nursing and medical team and occupational therapist attended the meeting. Ward staff always invited the patients care co-ordinator, psychologist and social worker but they were not always able to attend. Patient records showed good joint working between the medical and nursing teams.

Staff received a handover at the beginning of each shift. The handover on Oakdene ward was comprehensive and informative. The handover included information about patients' current mental state, changes to their legal status, care plans and risk assessments.

Staff reported good working relationships with other teams such as the community recovery team and could get input from patients' care co-ordinators when they needed it. Care co-ordinators from community teams attended the multidisciplinary team meetings as and when required.

Staff also reported good working relationships with drug and alcohol services, local colleges and other local voluntary agencies.

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

Mental Health Act training figures[127]

As of 30 June 2018, 74% of the workforce in this core service had received training in the Mental Health Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

The training compliance reported during this inspection was lower than the 81% reported last year.

Staff we spoke with had a good understanding of the Mental Health Act and understood the restriction on patients detained under the Mental Health Act. Staff knew how to get advice and support about the Mental Health Act and the Mental Health Act Code of Practice from a Mental Health Act administrator.

The service reported a Mental Health Act training compliance of 74% compared to a trust average of 85% as at June 2018. However, when during our inspection the ward manager told us that 78% of staff had completed the Mental Health Act training as of August 2018. This remained lower than the trust targeted percentage.

The trust had policies and procedures relating to the Mental Health Act and staff could access these via the trust`s intranet. Patients were able to access an independent mental health advocate. Contact information was available for patients and staff knew how to refer patients to the advocate. The deputy ward manager told us that the advocate visited regularly and attended care review meetings if the patient requested them to.

Staff explained patients their rights under s132 of the Mental Health Act regularly and recorded they had done so in the patient electronic record. Whilst reviewing patient records we saw patients had applied for Mental Health Act tribunals and Mental Health Act, managers meetings which indicated patients were aware of their rights to appeal.

Staff could access paper work associated with patients' detention electronically.

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[127] 20180803 R1C Training analysis

Staff could also access section 17 leave paper work on the electronic patient record. During this inspection we saw staff referring to the section 17 documents before allowing and signing patients out for leave. We saw a clear display of information about voluntary patient's rights to leave the ward freely.

The Mental Health Act office audited the legal paperwork to ensure the ward complied with the Act.

Good practice in applying the Mental Capacity Act

Mental Capacity Act training figures[128]

As of 30 June 2018, 83% of the workforce in this core service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all core services for inpatients and all community staff and renewed every three years.

The training compliance reported during this inspection was higher than the 71% reported last year.

On the day of our inspection, 80% of staff on Oakdene had completed the Mental Capacity Act training. The deputy ward manager told us staff had booked onto this training to ensure they were up to date.

Staff had a good level of understanding of the Mental Capacity Act and the guiding principles. We saw evidence where staff had used the act to assess capacity for patients to manage finances after giving them every possible assistance to make specific decisions for themselves.

Staff had access to Mental Capacity Act policy from the intranet and told us that they could get advice on the Mental Capacity Act, including deprivation of liberty safeguards from the Mental Health Act administrator.

Deprivation of liberty safeguards[129]

The trust told us that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this core service between 1 April 2017 and 31 March 2018.
At the time of our inspection, no patients were subject to deprivation of liberties safeguards (DoLS).

[128] 20180803 R1C Training analysis
[129] 20180703 Universal RPIR - DoLS

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support
We observed staff interacting with patients in a respectful, caring and appropriate manner, both individually and in groups. Staff were approachable and provided patients with help, emotional support and advice any time they needed it. The staff team knew the patient group well and amended their approach to meet the perceived needs of individuals. Staff understood the patients' needs including their different social and cultural needs.

Staff supported patients in their care. For example, staff explained patients' conditions and treatment and referred patients to external services such as advocacy, housing and the vocational team.

We observed staff being flexible in their approach toward patients, responding positively to requests and needs and also offering advice and guidance that was age and situationally appropriate.

Patients said staff treated them in a friendly, helpful and caring manner and they were happy and felt safe around staff and on the ward.

Staff stored confidential information securely. Staff kept patient records in locked cupboards and on an electronics system to protect confidentiality.

During our last inspection in June 2016 we saw that there was only one bathroom available and this required staff supervision, which infringed on patients' privacy and dignity. During this inspection we saw that curtains were fitted to maintain patients` privacy and dignity when they were supervised in the bathroom.

Patient-Led Assessments of the Care Environment (PLACE) - data in relation to privacy, dignity and wellbeing[130] (Remove before publication)
The 2017 Patient-Led Assessments of the Care Environment (PLACE) score for privacy, dignity and wellbeing at one core service location(s) scored higher than similar organisations.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
St James Hospital	CHS – Adult community CHS – Children, young people and families Acute wards for adults of working age and psychiatric intensive care units Community based mental health services for older people Long stay/rehabilitation mental health wards for working age adults Wards for older people with mental health problems Community based mental health services for learning disability and autism	93.3%
Trust overall		**90.9%**
England average (mental health and learning disabilities)		**83.7%**

Involvement in care

Involvement of patients

Staff showed newly admitted patients around the ward. Staff provided patients with a welcome pack which included information relating to the ward, house rules, recovery treatments, activities and other agencies that work with the ward.

130 PLACE 2017 data report

Staff told us that they involved patients in planning care. Staff sat with patients and discussed their care plans and what the patient would like recorded in them. There was a care planning meeting, attended by the patient and their multidisciplinary team to discuss current treatment and review care plans. Staff recorded the meeting in the electronic care records.

Patients could access advocacy which was advertised on the ward. Staff could refer patients upon their request. Patients could give feedback about the service via "community meetings", and directly to the ward manager.

We saw records to show that patients were supported to make advance decisions about their views and preferences on a range of things, such as what treatment they would prefer, who they would like to be contacted in a crisis, their spiritual views and their food preferences. This was usually done upon admission to the ward.

Involvement of families and carers

Staff said that they involved family and carers appropriately in patient`s care. They said that carers involvement varied depending on the patients that were on the ward and the patient`s choice. The deputy ward manager told us that staff and patients had invited their families to care programme approach meetings. The trust also ran carers assessment and support which were delivered by the psychologist in the Community Mental Health Team based at the St Mary's site. Staff told us they tried to include families and carers and they collected feedback through surveys.

We spoke with a carer of one of the patient on Oakdene ward. The carer complimented staff for being kind, caring, approachable and helpful.

Is the service responsive?

Ward moves[131] (Remove before publication)

Between 2017 and 2018, no patients for the core service moved wards.

Moves at night[132] (Remove before publication)

The trust provided information regarding the number of patients moving wards at night in this core service between 1 April 2017 and 31 March 2018.
Of the one ward reported within this core service, one patient had moved wards after 22:00hrs and between 08:00hrs.

Ward name	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Total
Oakdene	0	1	0	0	0	0	0	0	0	0	0	0	**1**
Core service total	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**

Access and discharge

131 20180703 Universal RPIR - Ward moves

132 20180703 Universal RPIR - Moves at night

Bed management

Bed occupancy[133] (Remove before publication)

The trust provided information regarding average bed occupancies for one ward in this core service between 1 April 2017 and 31 March 2018.

Oakdene Ward within this core service reported some average bed occupancies ranging above the national recommended minimum threshold of 85% over this period.
We are unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the period that was covered.

Staff completed initial assessments before admission to determine the patient's suitability for the service. Staff and senior managers attended weekly "capacity inflow meetings" to discuss referrals and suitability of patients for each ward. At the time of our visit there were fourteen patients admitted on Oakdene ward.

The ward never admitted patients into the beds of patients on leave, which meant they could return from leave at any time. Staff only asked patients to move bedrooms for clinical reasons. Staff told us when they had needed to move patients back to an acute or intensive care unit, they were able to do so.

Ward name	Average bed occupancy range (1 April 2017 – 31 March 2018) (current inspection)
Oakdene Ward	71% - 103%

Average Length of Stay data[134] (Remove before publication)

The trust provided information for average length of stay for the period 1 April 2017 to 31 March 2018. We are unable to compare the average length of stay data to the previous inspection due to differences in the way we asked for the data and the period that was covered.

Ward name	Average length of stay range (1 April 2017 – 31 March 2018) (current inspection)
Oakdene Ward	20 - 457

Out of Area Placements[135] (Remove before publication)

This core service reported no out area placements between 1 July 2017 and 30 June 2018.

The modern matron reported there were no out of area placements and beds were available for patients living in the catchment area. Oakdene ward did not a waiting list during our visit.

Readmissions[136] (Remove before publication)

This core service reported no readmissions within 28 days between 1 April 2017 and 31 March 2018.

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133 20180703 MH RPIR - Bed Occupancy
134 20180703 MH RPIR - Length of stay
135 20180703 MH RPIR - Out of area placements
136 20180703 MH RPIR - Readmissions

Discharge and transfers of care

Delayed discharges[137] (Remove before publication)

Between 1 April 2017 and 31 March 2018, there were 46 discharges within this core service. This amounts to 2% of the total discharges from the trust overall (2079).

Eleven of the 12 months reported no delayed discharges at all within this core service. March 2018 was the only month with one delayed discharge.

Patients and staff planned discharges and they happened at an agreed time.

The deputy ward manager told us that there was one patient who was ready for discharge on Oakdene ward. At the time of our inspection there was no discharge plan in place. The ward did not view this as a delayed discharge as there was no community placement and funding available and they would not be discharged until this was available.

Senior managers and staff met weekly in “capacity inflow meetings” to discuss discharges and to monitor the care pathway to ensure that patients were receiving appropriate care.

Lost to follow up[138] (Remove before publication)

There was no information pertaining to this core service.

Referral to assessment and treatment times[139] (Remove before publication)

The trust identified services as measured on ‘referral to initial assessment’ and ‘assessment to treatment’. However, none pertained to this core service.

Facilities that promote comfort, dignity and privacy

Patient-Led Assessments of the Care Environment (PLACE) assessments [140] (Remove before publication)

The 2017 Patient-Led Assessments of the Care Environment (PLACE) score for ward food at the locations scored higher than similar trusts.

Site name	Core service(s) provided	Ward food
St James Hospital	CHS – Adult community CHS – Children, young people and families Acute wards for adults of working age and psychiatric intensive care units Community based mental health services for older people Long stay/rehabilitation mental health wards for working age adults Wards for older people with mental health problems Community based mental health services for learning disability and autism	97.9%
Trust overall		**97.3%**
England average (mental health and learning disabilities)		**93.4%**

During our inspection in June 2016 we identified that patients did not have lockable space to store their valuables. However during this inspection we saw that this was addressed and patients had their own bedroom with secure storage. Patients had the opportunity to personalise their rooms with

137 20180703 Universal RPIR - DTOC

138 20180703 Universal RPIR - Follow Ups

139 20180703 MH RPIR - Referral

140 PLACE 2017 data report

posters and could use their own bed linen. Staff told us patients could also have personal belongings such as stereos and televisions in their room if they wished.

There were rooms for group activities, communal areas for patients to gather. Patients had access to a patient kitchen on the ward and access to drinks and snacks at all times.

Patients had access to a pay phone, they were also able to borrow the ward telephone for phone calls. The ward had a communal garden that was unlocked during the day. Patients could request access to the garden for fresh air and at night.

Patients gave mixed feedback on the quality of the food provided on the ward but they could cook their own food if they wanted to. Patients had access to hot and cold drinks and fruits at all hours and staff could make them snacks as needed.

Patients' engagement with the wider community

Staff encouraged patients to maintain links with the community and based these on the patients' specific goals and interests. Staff said they encouraged and supported patients to attend community based activities such as bowling, attending the local church, attending the local library and making use of public transport.

Staff helped patients to identify and meet educational and employment needs. We saw evidence of this as we saw a patient leaving the ward to attend work at the library at the local university.

Meeting the needs of all people who use the service

Oakdene ward had appropriate facilities for patients or staff requiring disabled access. There was an adapted bathroom, or toilets in the bedroom corridor for people with mobility problems.

Information on treatments, how to complain, what to do if they suspected abuse and patients' rights under the Mental Health Act was available to patients, on the ward notice boards, and in the patient welcome pack. Information provided to patients was in easy read form.

Information leaflets were printed in English only; this was in keeping with the ward and local population demographics at the time of inspection. The deputy ward manager advised that they could access information in other languages, and access interpreters and signers on request.

Patients had a choice of food to meet dietary requirement of religious and ethnic groups and to meet their preference. We saw that there was always a vegetarian option on the menu.

Patients told us that they were aware of the hospital chaplaincy service and how to access this, however they were encouraged to access spiritual facilities in the local community as required.

Listening to and learning from concerns and complaints

Patients knew how to complain and staff managed their complaints appropriately. There was one complaint in the twelve months prior to our inspection, however detail of this was not available at the time our inspection. The trust had an appropriate complaints procedure in place. There were leaflets telling patients how to make a complaint that staff gave to patients on admission. There were posters on display on the ward telling patients of how they could complain. Staff explained how they would manage complaints and feedback to patients following a complaint. The deputy ward manager told us that they received feedback relating to concerns and would share this with staff via meetings and supervision.

Staff were able to give examples of learning from concerns or complaints elsewhere in the organisation, such an implementation of night observation based on individual patient`s risks.

Formal complaints[141]
This core service received one complaint between 1 April 2017 and 31 March 2018. The subject of the complaint was 'values and behaviours (staff)', and it was partially upheld

Compliments[142]
This core service received no compliments during the last 12 months from 1 April 2017 to 31 March 2018.

Is the service well led?

Leadership
The ward had a dedicated ward manager. The ward manager had been working in the role for several years and had made improvements to the service since the last inspection in June 2016. There was strong leadership from the modern matron, the ward manager and the ward psychiatrist. They were experienced in working in a rehabilitation setting and were knowledgeable about the needs of staff and patients on the ward. They worked the majority of their week on the ward and staff found them approachable.

The ward also benefited from the leadership provided by the consultant psychiatrists. Staff felt that the doctors had been a positive addition to the ward. Staff said that the psychiatrists, the modern matron, the manager and the wider multi-disciplinary team worked together to ensure good care on the ward.

Vision and strategy
Staff spoke openly about the organisation they worked for and identified strengths and weaknesses. Staff were able to advise us of the aims of the organisation and how these translated into their own roles in providing care and treatment for patients. The team objectives were based upon the organisation's aims.

Staff reported that senior members of the organisation were approachable and supportive and had visited the ward in the past.

Culture
Staff were positive about the work they did and felt they worked well together. Staff said they felt respected, supported and valued. Staff also said they felt proud working for the trust and within their team.

Staff were aware of how to raise concerns including the whistle-blowing process and felt they could do so without fear of retribution.

The deputy ward manager told us that they dealt with poor performing staff when needed. We saw personal development plans and action plans which supported staff struggling to perform well while reviewing staff supervision and appraisal records.

Sickness rate was calculated on a monthly basis for the ward. Staff sickness levels for Oakdene ward was 5% for the month of August, the latest data provided by the modern matron. The modern

[141] 20180806 R1C Complaints analysis
[142] 20180703 Universal RPIR - Compliments

matron felt this was due to non-work related sickness. Staff were aware of the support available to them from through the occupational health service.

Suspension and supervised practice[143]

During the reporting period, there were no cases where staff had been either suspended, placed under supervision or were moved to a different ward.

Governance

The governance processes on the unit were robust. There were audits in place around ligature assessment, infection control, environmental and mattress checks. The manager showed us detailed action plans relating to these.

The ward manager identified clinical key performance indicators that were embedded in their practice. This ensured that patients were thoroughly assessed against standard health measures, these were recorded on patients' notes. This included nutritional assessments within 24 hours of admission, completion of regular modified early warning scores, and identification, management, and prevention of spread of infections. The deputy ward manager told us that these performance indicators were used to measure the team's performance.

Quality improvement work, plans relating to improving patient care and patient experience were used by the ward.

The capacity to make informed decision of patients was mainly seen in relation to consent to treatment.

Staff had been adhering to the safeguarding policy in raising safeguarding alerts when appropriate to do so, alerts were escalated to the Local Authority safeguarding team and the Care Quality Commission.

The deputy ward manager told us the ward management team had sufficient authority to perform their role effectively apart from the requirement for authorisation of additional staff and/or expenditure.

The ward manager had submitted items to the trust's risk register by escalating these at the governance and business meetings which were held fortnightly.

Board assurance framework[144]

The trust provided its Board assurance framework. This detailed any risk scoring 15 or higher and gaps in the risk controls that affect strategic ambitions. The trust outlined three business priorities with nine sub priorities:

10. Great Care:
    a. Improve quality in line with CQC inspection requirements
    b. Provide safe staffing
    c. Use technology to work differently
11. Great place to work:
    a. Plan for long term sustainable staffing
    b. Enhance our leadership throughout the organisation
    c. Provide training that enables us to deliver great care
12. Great value for money:

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[143] 20180703 Universal RPIR - Suspension & Supervised

[144] 20180801 R1C BAF & RR analysis

a. Further pathway integration with other providers
b. Benchmark our services to improve productivity
c. Change front line and corporate services to live within our income

Corporate risk register[145]
The trust has provided a document detailing 108 of their current risks, of which 12 have a risk rating of high (Red). However, none of the risks related to this core service.

Management of risk, issues and performance
The ward manager kept a local risk register that included safeguarding referrals they had made a list of ligature points and environmental issues on the ward. The deputy manager told us the manager discussed the risk register at the unit management meeting and agreed to escalate risks to senior management and board level if needed.

Information management
The electronic care records system was accessible to staff and helped to protect patients` confidentiality. There were enough computers and staff had access to equipment to help them provide care to patients.

The manager had access to information relating to incidents, safeguarding referrals, sickness and complaints. Learning from these was shared with staff in team meetings, during supervision or to individual staff in needed.

The manager received regular performance updates from the trust. This allowed the manager to monitor and manage the team's performance.

Engagement
Staff told us that feedback was collected through the friends and family tests and patient surveys. Staff displayed feedback from patients notice boards in the corridors, where patients commented on the care they received and their recovery journey. Staff used this to make improvement in the care provided to patients.

Learning, continuous improvement and innovation

Accreditation of services[146] ***(Exception reporting only)***
NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The trust provided information on which services have been awarded an accreditation together with the relevant dates of accreditation. However, there was no information for this core service.

At the time of our visit the ward team were not involved in any research but the deputy ward manager told us that staff could participate in research if they wanted and that the organisation will support staff to do so.

[145] 20180801 R1C BAF & RR analysis
[146] 20180703 Universal RPIR - Accreditation

Staff were actively involved and used quality improvement methods in their practice and delivery of care for patients such as promoting and monitoring of physical health of patients, smoking cessation. One of the ward Quality Improvement champions shared the journey of the project which included meeting, collection data and evidence around missing signature and missed doses of medication. The quality improvement champion told us how learning was shared and action plans were implemented following this project. Following this project the ward implemented a medicine handover where by drug charts were now checked at the start of each shift.