Good

Oxford Health NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RNU09	Buckinghamshire Health and Wellbeing Campus	Amber ward	HP20 1EG
RNU04	Fulbrook Centre	Cherwell ward	OX3 7JU
RNU04	Fulbrook Centre	Sandford ward	OX3 7JU

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

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

Where applicable, we have reported on each core service provided by Oxford Health NHS Foundation Trust and these are brought together to inform our overall judgement of Oxford Health NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

We rated wards for older people with mental health problems as **good** because:

Patients had a multidisciplinary assessment completed on admission and care plans were developed from this. All patients had a risk assessment. Staff were trained to deal with challenging behaviour and could access extra support when necessary. Patients had their physical healthcare needs responded to. Outcome measures were used to measure patients' progress. Medication was handled and administered correctly.

Patients received care from a range of staff that included doctors, nurses, occupational therapists and physiotherapists. There was limited psychology input. Staffing levels were satisfactory and managers actively managed their recruitment and use of bank and agency staff. Staff received supervision and appraisal. Staff were positive about the teams they worked in.

Patients and carers were positive about the staff on the wards and the care they received. The interactions and care we observed was friendly and respectful and demonstrated that staff understood patients' individual needs and concerns. Staff prompted patients to eat and drink, and tried to engage with patients even when they were confused. Patients and carers could access the complaints process, and had access to an advocacy service. There was limited evidence of patients being involved in the development of their care plans.

There was pressure on beds, but staff responded to this through daily meetings to determine who needed to be cared for on the ward and who could be supported in the community. Some patients were moved at short notice, which could be disruptive.

There were groups and activities seven days a week, and facilities on the wards such as a gym, garden, quiet room, OT kitchen, and general occupational therapy and craft room.

There were environmental risks including ligatures but there were plans to remove these where possible, or manage them safely. The wards were clean and there were infection control policies implemented. The bedrooms on Amber ward were single with ensuite bathrooms. Most of the rooms were single on Cherwell and Sandford, with shared bathrooms, but there was a programme of refurbishment underway.

There were systems for monitoring and taking action in response to incidents and gaps in the service. This included information collected by ward managers and submitted to the board centrally.

- However, Amber ward was not compliant with gender separation guidelines. There were separate corridors for male and female bedrooms, but women were placed in bedrooms on the men's corridor.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as **requires improvement** because:

- Amber ward was not compliant with gender separation guidelines. There were separate corridors for male and female bedrooms, but women were placed in bedrooms on the men's corridor.

However,

- Both Cherwell and Sandford wards were single sex.
- There were environmental risks including ligatures but there were plans to remove these where possible, or manage them safely.
- The wards were clean and there were infection control policies implemented.
- Staffing levels were satisfactory, and managers actively managed their recruitment and use of bank and agency staff.
- All patients had a risk assessment. Staff were trained to deal with challenging behaviour, and could access extra support when necessary.
- Medication was handled and administered correctly, but as necessary medication was not routinely reviewed.

Are services effective?

Good

We rated effective as **good** because:

- Patients had a multidisciplinary assessment completed on admission, and care plans were developed from this.
- Patients received care from a range of staff which included doctors, nurses, occupational therapists and physiotherapists. There was limited psychology input.
- Patients had their physical healthcare needs responded to.
- Outcome measures were used to measure patients' progress.
- Staff received supervision and appraisal.

Are services caring?

Good

We rated caring as **good** because:

- Patients and carers were positive about the staff on the wards and the care they received.
- The interactions and care we observed was friendly and respectful, and demonstrated that staff understood patients' individual needs and concerns.

Summary of findings

- Staff prompted patients to eat and drink, and tried to engage with patients even when they were confused.
- Patients had access to an advocacy service.

However:

- There was limited evidence of patients being involved in the development of their care plans.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- Although there was pressure on beds, staff responded to this with daily meetings to determine who needed to be on the ward and who could be supported in the community.
- There were groups and activities seven days a week, and facilities on the wards such as a gym, garden, quiet room, OT kitchen, and general occupational therapy and craft room.
- The bedrooms on Amber ward were single with ensuite bathrooms. Most of the rooms were single on Cherwell and Sandford, with shared bathrooms, but there was a programme of refurbishment underway.
- Patients could access the complaints process.

However

- Some patients were moved at short notice, which could be disruptive.

Are services well-led?

Good

We rated well-led as **good** because:

- There were systems for monitoring and taking action in response to incidents and gaps in the service. This included information collected by ward managers and submitted to the board centrally.
- Staff were positive about the teams they worked in.

Summary of findings

Information about the service

The wards for older people with mental health problems are provided by Oxford Healthcare NHS Foundation Trust as part of their older people directorate.

Wards for older people with mental health problems are provided across two sites: Amber ward at the Buckingham Health & Wellbeing Campus in Aylesbury, and Cherwell ward and Sandford ward at the Fulbrook Centre in Oxford.

Amber ward has 20 beds for older men and women with either a functional or organic illness, such as dementia.

Cherwell ward has 17 beds for older women with either a functional or organic illness.

Sandford ward has 16 beds for older men with either a functional or organic illness. Two of these beds were closed for refurbishment.

Our inspection team

The inspection team was led by:

Chair: Professor Jonathan Warren, Director of Nursing, East London Foundation Trust

Head of Inspection: Natasha Sloman, Head of Inspection for Mental Health, Learning Disabilities

and Substance Misuse, Care Quality Commission

Team Leader: Serena Allen, Inspection Manager, Care Quality Commission

The team that inspected this core service comprised a CQC inspector, a Mental Health Act reviewer, an expert by experience, a nurse, a psychiatrist and a psychologist.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

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

During the inspection visit, the inspection team:

- visited all three of the wards at the two hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 17 patients who were using the service
- spoke with seven carers of patients
- looked at 20 care records and 45 prescription charts of patients
- spoke with the matrons and managers or acting managers for each of the wards
- spoke with 40 other staff members including doctors, nurses and occupational therapists
- interviewed the divisional director with responsibility for these services
- attended and observed a hand-over meeting, a multi-disciplinary team meeting, and a bed management meeting

Summary of findings

- attended and observed four activity/therapy groups, four lunches, and a community meeting
- carried out a specific check of compliance with the Mental Health Act on Cherwell ward
- carried out a specific check of the medication management on all three wards and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

The patients and carers we spoke with were positive about the staff on all the wards and the care they received. They told us that staff knocked on the door before entering their rooms. The interactions and care we observed was friendly and respectful and demonstrated that staff were familiar with patient's individual needs and concerns.

We observed that staff prompted patients to eat and drink and even when they were not sat constantly with the patient, they were aware if drinks had been left not drunk. At lunch we observed that patients were given appropriate support to eat, and the atmosphere was pleasant and relaxed.

Patients and their carers were positive about the care they received, but most of those we spoke with did not feel they had been involved in determining their care or have copies of their care plans. However, the care the patients received was person-centred and tailored to their needs. Patients and carers were kept updated on the progress and changes to treatment and care.

Good practice

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- Amber ward was not compliant with gender separation guidelines. There were separate corridors for male and female bedrooms, but women were placed in bedrooms on the men's corridor.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The service should continue to review the management of environmental risks, particularly on Cherwell and Sandown wards.
- The service should ensure that the prescribing and use of as necessary medication is routinely reviewed.
- Care records were not consistently recovery or outcome orientated, and did not include patients and carers' views.
- The service should ensure its staff are familiar with the revised Mental Health Act code of practice
- The service should review the impact of moving patients between wards during their admission to hospital.

Oxford Health NHS Foundation Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location

Mental Health Act responsibilities

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

Training in the MHA was included as part of the staff induction. Staff had received training in the Mental Health Act, but were not all familiar with the new code of practice.

Detained patients had their rights under the Mental Health Act explained to them. However, it was inconsistent whether they had these repeated, even when it was recorded that the patient had not understood their rights.

Patients' capacity to consent was discussed in the multidisciplinary team meetings. The detention paperwork we reviewed was completed correctly and stored appropriately.

We carried out a specific Mental Health Act visit to Cherwell ward, where there were 13 detained patients, and the remaining four were informal. Patients had access to an independent Mental Health Act advocate (IMHA). Details of the advocacy service were on display on the wards. We looked at 4 care records of detained patients, and all had used the IMHA service.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had completed training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLs). Staff had a good understanding of DoLS and capacity.

Amber ward had made the highest number of DoLS referrals in the trust in the year to May 2015. They had made 30 out of the trust total of 73. Staff told us that this was because they were following requirements of the Mental Capacity Act and that many of their patients lacked the capacity to make decisions for themselves. Information was on display on Amber ward about DoLS and MCA and the five principles of capacity assessment. Staff told us that many patients were admitted from care homes, and the ward was told that the patient had agreed to be admitted.

Detailed findings

However, after admission it was not clear that the patient had the capacity to make the decision, so a DoLS referral was made. The ward developed its practice and reporting thresholds with the local authority.

When referrals were made to the DoLS lead at Buckinghamshire County Council, they were prioritised and an assessment was carried out within three weeks. In the Fulbrook Centre in Oxford (Cherwell and Sanford wards) we saw evidence of DoLS being implemented, and emergency authorisations being completed and referrals made. There were two patients subject to DoLS at the Fulbrook Centre at the time of our inspection.

Capacity was discussed at each multidisciplinary team meeting and recorded on the handover sheets. There was an example where capacity was not recorded. However, staff had documented that they were uncertain if the patient had capacity or not, and had set a review date or this.

There was an independent Mental Capacity Act advocacy (IMCA) service provided through the local authorities. This was only provided for patients who had no relatives.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

- At the Fulbrook Centre in Oxford there were separate wards for men and women (Sandford and Cherwell). Amber ward in Aylesbury cared for both sexes, with separate corridors for men and women. However, if there were uneven numbers of men and women on the ward, then patients had a room in a corridor with the opposite gender. On the day of our inspection there were three men with bedrooms in the female corridor. The trust had a protocol for managing this situation. Female patients also raised issues about male patients walking in their corridor or behaving inappropriately. This was addressed by the ward manager and was primarily dealt with by staff observing the corridor at all times.
- There were ligature points on the wards, particularly on Cherwell and Sandford wards. However, environmental risk assessments, which included a ligature audit, had been carried out. These identified ligatures and the level of risk presented by them. Steps taken to mitigate the risks was recorded, and included risk assessments and observation of patients. There was an on-going refurbishment plan for Cherwell and Sandford wards, which included the removal of ligatures.
- There were adequately stocked clinic rooms on each of the wards. The resuscitation boxes on Cherwell and Sandford wards did not contain all the items listed on the trust's checklist. However, these items were not likely to impact on care in the event of a medical emergency. For example there was one eye protector when the list said there should be four. Staff told us that this was a new checklist that had only been introduced the week of the inspection, and that the missing items were on order.
- The wards were clean and maintained. Equipment was labelled with "I am clean" stickers that included the date of cleaning. There were cleaning schedules, and medical devices and mattresses were routinely cleaned each week. There were stocked hand washing sinks, and posters displaying correct hand washing techniques. Protective equipment was available. This included gloves and aprons, which we observed staff using appropriately.
- There were no nurse call alarms in the ensuite bathrooms or bedrooms on Amber ward. There was a notice on the patients' information board stating that they were in the process of getting an emergency call bell system for patients. Staff carried emergency alarms.

Safe staffing

- There were 50 qualified nurse and 66 health care assistant posts across the three wards. There were 6 qualified nurse and 13 health care assistant vacancies. The trust used the NHS safer staffing tool to assess and monitor staffing levels. This included the recording of bank and agency staff. Managers could adjust staffing levels when required. Bank and agency staff were used, but these were usually staff that had worked on the ward before and were familiar with patients. The number of shifts filled by bank and agency staff over a three month period was 0.85% on Amber ward, 17% on Cherwell ward and 14% on Sandford ward. Staff told us there had been staffing problems on Amber ward in the summer, but this had now been resolved. On most occasions the number of staff on duty matched the stated staffing levels. There were enough staff to safely carry out physical interventions, and to carry out care of patients.
- There was adequate medical cover available across all three wards. Amber ward had a consultant psychiatrist for three days a week, and a full time senior doctor. There were three "F1" doctors, who were in training and worked full time on the ward.
- Amber ward had a consultant psychiatrist for 7 sessions a week. There were two F1 doctors and a Psychiatry CT1, who were in training and worked full time on the ward. There was a GPVTS trainee on maternity leave. Finally, there was a part time senior trainee (ST4), this post was regarded as supernumerary. The two Fulbrook wards had similar levels of consultant input with some input from an Associate Specialist and 3 junior doctors.

Assessing and managing risk to patients and staff

Requires improvement

Are services safe?

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

- All patients had a risk assessment carried out on admission, and this was reviewed throughout their stay in hospital.
- Over a twelve month period there had been 15 incidents of seclusion on Amber ward and none on Cherwell or Sandford wards. There had been 17 incidents of restraint on Amber ward and 8 on Cherwell ward. None of these were in the prone or face down position. On Sandford ward there had been 85 restraints, five of which were in the prone position. Most of these restraints were of a patient with complex needs. The restraints were documented and their care reviewed regularly.
- Staff had had training in the prevention and management of violence. Restraint was only used after staff had attempted to calm patients by distraction or reassurance first. However, there were some patients who had complex behaviour, and had been restrained on several occasions. There were detailed care plans regarding this, which incorporated the views of family members. The trust had a prevention and management of violence team that provided advice and extra training to staff when necessary. Rapid tranquilisation was rarely used on the wards.
- Staff were aware of what may constitute a safeguarding concern, and how to make a referral. Safeguarding concerns were reported directly to social services, and logged on the incident database. This meant that safeguarding concerns were automatically emailed to the ward manager and matron, and to the trust's own safeguarding team. The trust's safeguarding team monitored instances of safeguarding, and provided advice to staff.
- Medication was ordered, stored and disposed of correctly. A pharmacist checked the medication every two weeks. Medication charts were completed correctly. However, where sedating and as necessary medication was prescribed, this was not always reviewed regularly. For example, on Cherwell ward it had not been reviewed on 12 out of 16 prescription charts, and on Sandford ward this had not been reviewed on any of the charts. We did not see evidence that patients had been put at risk, but staff acknowledged that this was an area that needed to be addressed. Nurses administering medication wore "do not disturb" tabards.
- Information was on display about a project to prevent pressure sores. This was called "SSKIN", (surface; skin inspection; keep patients moving; incontinence/ moisture; nutrition/hydration). Profiling beds, for patients at risk of developing pressure sores, were hired when necessary, and were delivered to the wards within 24-48 hours.
- There was information on the doors of Amber ward informing informal patients that they could leave if they wished. There were no signs on Cherwell and Sandford ward, but this was rectified before the end of the inspection.

Track record on safety

- There had been no serious incidents during the previous twelve months.

Reporting incidents and learning from when things go wrong

- Staff were familiar with the incident reporting policy and knew how to report an incident through the electronic system. When staff reported an incident, this automatically sent an email to the manager and the matron so that they could review the incident. Depending on the type of incident, specific information was requested and automatic emails were sent to different corporate teams to review. For example, if a fall was reported, staff would be required to complete a fall assessment, and an email would be sent to the falls team. The managers and falls team reviewed the incident, and fed back to staff any queries or actions. If a patient fell, in addition to meeting the immediate needs of the patient, staff would put a cross on a map of the ward so that they could easily see if there were any areas of the wards where fall where most likely to occur and take appropriate action.
- Families were informed when incidents occurred. Arrangements were made with carers regarding when they wanted to be contacted for non-emergency incidents. For example, if a patient had a fall at night but was not injured then a family member may choose to be informed of this the following day, or when they next visited.
- The trust established a debriefing team in March 2015, consisting of 12 staff from across the trust. Any member

Requires improvement

Are services safe?

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

of staff can contact the team online and request a debrief. The 12 staff have had specialist training in reflective practice. A debriefing had taken place for staff on Amber ward.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- Patients had a detailed assessment completed on admission an admission checklist was completed by the admitting nurse. For the first 3 days all patients had their blood pressure, temperature and pulse monitored daily, food and fluid charts were completed and an electrocardiogram (ECG) was carried out. Patients had a mental and physical examination completed, and were assessed by the occupational therapists and physiotherapists. Patients continued on-going monitoring of their physical health during their stay in hospital.
- Following the assessment, all patients had a care plan developed. However, the care plans were not consistently recovery orientated and did not include the patient's views. For example, some of the care plans contained information about the activities patients participated on the ward, but not what outcome needed to be reached so that they were ready for discharge.
- The main records for patients were electronic. This had recently transferred from one system to another, so not all historic information was uploaded. There were supplemental paper records, which included medication charts, and food and fluid balance charts. Records were stored securely, and were accessible by staff. The trust was part way through changing their electronic record system: whilst inpatient and community mental health teams were able to share records, this was not possible with the non-mental health services
- There was an electronic board with key information about patients, such as their level of observation, leave, and Mental Health Act status. This quickly provided staff with important information about patients, but was not visible from outside the office.

Best practice in treatment and care

- Patients could access the acute hospital and community services when required. There were clear care pathways for the management of pressure ulcers, falls and most common physical health conditions. However, staff told us it was difficult to access specialist support for diabetes. The trust had identified this as a problem, and was working with its partners to address this. Staff told us they found it easier to access physical healthcare for their patients since they had become part of the older people's directorate.

·The trust's practice educators carried out specific skills training for staff when required. For example, Cherwell ward had a patient who needed to be fed through a tube (percutaneous endoscopic gastronomy or PEG feeding). The practice educators had provided specific training to ward staff, which gave them the skills to care for this patient.

- The occupational therapists and physiotherapists used outcome measures to measure where patients were on admission and to demonstrate and measure changes following interventions. For example, the physiotherapists used the elderly mobility scales, which determined if a patient's mobility had improved following their intervention.

Skilled staff to deliver care

- There were occupational therapists, physiotherapists, and an activity coordinator on all three wards. There were no social workers employed by the wards. Social work support was provided by key workers in the community mental health teams. Patients had limited access to psychology services. There were 1.7 wte clinical psychologists in Buckinghamshire and 4.7 wte in Oxfordshire across all older people's mental health services. The psychologists focused on neuropsychological assessments and referrals from the community mental health teams.
- Staff received regular supervision and appraisal. The frequency for nursing staff was every four to eight weeks. Most staff had had an appraisal. This was below the trust's target on Sandford ward, but there was a plan in place to achieve this.
- Most staff had received training in caring for people with dementia.

Multi-disciplinary and inter-agency team work

- Multidisciplinary team (MDT) meetings took place on the wards each week (twice a week on Amber ward). All patients were reviewed at least once every two weeks. Staff from the community mental health teams attended the MDT meetings.

Are services effective?

Good

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

- During an MDT meeting on Cherwell ward we saw that the summary of the meeting was projected onto the wall so that it could be seen and updated by all staff. It covered key areas that included mental and physical health care, capacity, and discharge planning.
- Handovers between nursing staff included a handover or "crib" sheet, which included a summary of any particularly concerns about a patient, or actions that needed to be carried out. For example, this included physical healthcare and hospital appointments. Patients mental and physical healthcare needs were discussed.
- The occupational therapy (OT) staff carried out assessments of patients on the ward, referred them to the community OT service, and did a joint visit and a handover. Staff told us this worked well for patients who lived in the area, but was problematic when a patient had a GP outside the area. This meant that there was not the same relationship or level of support from different teams.

Adherence to the Mental Health Act and the Code of Practice

- Training in the MHA was included as part of the staff induction. Staff had received training in the Mental Health Act, but were not all familiar with the new code of practice.
- Detained patients had their rights under the Mental Health Act explained to them. However, it was inconsistent whether they had these repeated, even when it was recorded that the patient had not understood their rights. Patients' capacity to consent was discussed in the multidisciplinary team meetings. The detention paperwork we reviewed was completed correctly and stored appropriately.
- We carried out a specific Mental Health Act visit to Cherwell ward, where there were 13 detained patients, and the remaining four were informal. Patients had access to an independent Mental Health Act advocate (IMHA). Details of the advocacy service were on display on the wards. We looked at four care records of detained patients, and all had used the IMHA service.

Good practice in applying the Mental Capacity Act

- Staff had completed training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLs). Staff had a good understanding of DoLS and capacity.
- Amber ward had made the highest number of DoLS referrals in the trust in the year to May 2015. They had made 30 out of the trust total of 73. Staff told us that this was because they were following requirements of the Mental Capacity Act, and that many of their patients lacked the capacity to make decisions for themselves. Information was on display on Amber ward about DoLS and MCA and the five principles of capacity assessment. Staff told us that many patients were admitted from care homes and the ward was told that the patient had agreed to be admitted. However, after admission it was not clear that the patient had the capacity to make the decision, so a DoLS referral was made.
- When referrals were made to the DoLS lead at Buckinghamshire County Council, they were prioritised as the highest priority on the ADASS screening tool and an assessment was carried out within three weeks. In the Fulbrook Centre in Oxford (Cherwell and Sanford wards) we saw evidence of DoLS being implemented and emergency authorisations being completed and referrals made. There were two patients subject to DoLS at the Fulbrook Centre at the time of our inspection.
- Capacity was discussed at each multidisciplinary team meeting and recorded on the handover sheets. There was an example where capacity was not recorded. However, staff had documented that they were uncertain if the patient had capacity or not and had set a review date or this.
- There was an independent Mental Capacity Act advocacy (IMCA) service provided through the local authorities. This was only provided for patients who had no relatives.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- The patients and carers we spoke with were positive about the staff on all the wards and the care they received. They told us that staff knocked on the door before entering their rooms. The interactions and care we observed was friendly and respectful and demonstrated that staff were familiar with patient's individual needs and concerns. Staff attempted to engage patients, even when they were confused.
- We observed that staff prompted patients to eat and drink, and even when they were not sat constantly with the patient they were aware if drinks had been left not drunk. At lunch we observed that patients were given appropriate support to eat and the atmosphere was pleasant and relaxed.
- There was a discharge tree on Cherwell ward, which had quotes from previous patients and carers.

The involvement of people in the care they receive

- Patients had access to an advocacy service. The advocates attended CPA meetings, tribunals, and multidisciplinary team meetings. They told us that sometimes patients were told that parts of the ward round were going to take part without them and these were the only wards where that happened.
- There was limited evidence of patients being involved in the development of their care plans. For example, although one of the five care plans we looked at on Cherwell ward was very personalised and clearly identified the person's needs, this was less evident in the other four. None of the five care plans included the patient's own comments.
- Patients and their carers were positive about the care they received, but most of those we spoke with did not feel they had a lot of involvement in determining their care or have copies of their care plans. However, the care the patients received was person-centred and tailored to their needs. Patients and carers were kept updated on the progress and changes to treatment and care.
- Patients on all three wards had access to an advocacy service. Information about this was on display, and patients, carers or staff could ring them directly. The same advocacy service provided general advocacy services, independent Mental Health Act advocacy and independent Mental Capacity Act advocacy. The advocacy service visited the wards once a fortnight on a drop-in basis, or referrals could be made directly.
- Patients told us that their families were involved in their care. Amber ward ran a carers group every month.
- Community meetings took place on all three wards and the notes from these were made available to patients. Actions were taken as a result of the meetings. For example, on Amber ward patients had asked for pictures on the walls and access to the occupational therapy room outside groups and these had been implemented. There had been problems with food on Amber ward, which they were continuing to address by taking photographs of the food to send to the catering department. Patients had asked for a different newspaper to be provided and this was actioned the following day. Patients were able to express their views. Patients were provided with information about work being carried out on the ward and staff changes.
- All three wards had a photo board with staff names and roles.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- There were two delayed transfers of care on Amber ward. Every day there was a conference call where bed management was discussed. This included the matrons from both hospital sites and the community teams, which looked to facilitate discharges where possible. The teleconference discussed potential admissions and discharges. This included how urgently a person required admission, and where they could be admitted to, which included consideration of private beds if necessary. Potential discharges were discussed, and what needed to happen to facilitate this. Discharge plans, and any action or delays in this, were also discussed so that action could be taken.
- During our inspection there were no empty beds across the three wards and when a patient was transferred out another patient was admitted. There were patients waiting to be admitted. The service did not have any patients in private hospital beds.
- Patients from other parts of the trust and sometimes from out of the trust's catchment area might be admitted. Staff told us that they tried not to move patients around, but this did happen, including during our inspection. Patients were not moved at night, but patients were not always given adequate notice about being transferred. We saw an example of this during our inspection. Staff told us that because of the pressure on beds, plans to move patients may be changed at short notice because priority was given to another patient.
- Potential admissions and discharges were also discussed in the handover. The care coordinator liaised with the ward about the discharge of the patient.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a therapy/activity room on all the wards. There was a small physiotherapy gym at the Fulbrook Centre in Oxford, which was used only with supervision. Patients had a risk assessment carried out prior to use. There was a reminiscence room on Amber ward, which was set up like a pub.
- There was a group and activity programme on all three wards. Groups were provided by the occupational therapists (OT), activity coordinators, and physiotherapists. An assessment was carried out by the OT or the physiotherapists, to determine was activities or therapies were suitable for patients. Groups were provided seven days a week. Activities available included cooking, bingo, gardening, exercise and walking. There was a group programme, which was adapted to meet the needs of patients.
- Feedback from patients, carers and staff was that although Amber ward was a newer building, it was not designed for older people or people with dementia, and the layout and high ceilings were potentially disorientating for patients. A painting of a tree was on one of the walls to attempt to create a distinguishing feature. The Fulbrook Centre was an older building, but was more established with murals, artwork and photographs on the walls. Feedback from patients and carers was that the building felt more welcoming. There were quiet areas on the wards for patients who did not want to watch television, or who wanted to meet visitors.
- The bedrooms on Amber ward were all single with ensuite bathrooms. Cherwell and Sandford ward were single sex wards. Most of the bedrooms on these wards were single without ensuite facilities, but there was a shared bedroom on each ward. Some of the bedrooms had shared "Jack and Jill" style bathrooms, which were unsuitable for confused patients. The wards were undergoing refurbishment, and this included the removal of the Jack and Jill bathrooms. There was a refurbishment plan underway, which had started in started in May 2015, and was due to continue into 2016.
- There was outdoor space on all three wards. The gardens for Cherwell and Sandown wards looked onto a nature reserve. However, this limited the type and height of fence, so patients were supervised in the garden at all times.
- Patients had access to food and drinks. Opinions on the quality of the food varied. There had been complaints about the food on Amber ward, which the managers had raised with the catering services. Mealtimes were fixed, but there was some flexibility in what patients could eat.

Are services responsive to people's needs?

Good

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

- There was a projects and activities board at the entrance to the Fulbrook Centre. This included patients' art work, such as a mosaics and clay work. There were photographs of staff on display, to help patients identify who they were.

Meeting the needs of all people who use the service

- There were accessible bathrooms, bedrooms and other areas such as activity rooms on the wards.
- There were noticeboards and information leaflets available for patients. Most patients spoke English as a first language. However, interpreters could be provided when necessary.
- There was a chaplaincy service within the trust, and there were quiet/multi-faith rooms on the wards.

Listening to and learning from concerns and complaints

- Patients and their carers either knew how to make a complaint, or would speak to a member of staff or contact the patient advice and liaison service if they wished to make a complaint so. Some patients had heard of the patient advice and liaison service (PALS), which provides support to patients and carers who want to make a complaint, other had not but said they would complain directly to staff.
- Staff were familiar with the complaints process. The examples of complaints we looked at had responded to the complainant, investigated the complaint, and taken action revisiting the issue with the complainants where necessary.
- Oxford patients had access to a complaints advocate, to support them when complaining about the service. A patient advice and liaison service (PALS) worker visited Cherwell and Sandford wards every other week.
- In the past twelve months there had been three complaints submitted to Amber ward, and 1 to Sandford ward. Two of the Amber ward complaints had been upheld, and none of the complaints had been referred to the Parliamentary and Health Service Ombudsman.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- The trust's values were "caring, safe and excellent" and were part of the trust logo on staff uniforms.
- The trust did not have a dementia strategy. However, the trust was a member of the dementia partnership boards in Oxfordshire and Buckinghamshire, and stated that it aimed to implement their strategies across the trust.

Good governance

- There were systems for monitoring and taking action in response to incidents and gaps in the service. This included information collected by ward managers and submitted to the board centrally. For example, staffing information, and reporting incidents, complaints and safeguarding. Local services took immediate action in response to concerns, and also responded to analysis received from corporate teams within the trust.
- Ward managers and matrons told us they thought they had the authority to do their job, and they had administrative support on the wards.
- Ward managers and matrons had management meetings to discuss concerns and practices issues, and share information. These fed into the staff meetings.
- Staff could access the local risk register, and feed into this through the health and safety meetings.

Leadership, morale and staff engagement

- Two older people's wards were merged 18 months ago to create Amber ward. This reconfiguration was disruptive for staff, and created a mixed functional and organic ward, whereas previously these had been separate. The consensus was that this has now been resolved, and staff have developed new ways of working. Most staff we spoke with told us they felt supported by the trust, and were able to raise concerns.
- Staff on all three wards told us they felt they worked well together as a team. Staff were positive about the current ward managers, but said there had been lots of changes in managers, which led to inconsistency. At the time of our inspection the manager on Amber ward was about to leave after a three month secondment, and there was an acting ward manager on Cherwell ward.

Commitment to quality improvement and innovation

- A physiotherapist in the service had carried out a research project into falls in older people with mental health problems. This had identified patients at risk, and aimed to use this information by taking proactive action. For example, following a fall a falls assessment was completed, and staff were advised on the care of the patient to reduce the risk of them falling again. This included balance, medication, and posture. Patients at risk of falls had a falls plan developed.
- The electroconvulsive therapy (ECT) suites at both the Whiteleaf Centre in Aylesbury and the Warneford Hospital in Oxford were accredited through the Royal College of Psychiatrists.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10(2)(a) HSCA 2008 (Regulated Activities) Regulations 2014** **Dignity and respect** Re gender segregation This was a breach of regulation 10(2)(a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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