Oxford Health NHS Foundation Trust

Quality Report

Warneford Hospital,Warneford Lane
Headington, Oxford
OX3 7JX
Tel: 01865 741717
Website: www.oxfordhealth.nhs.uk

Date of inspection visit: 14-16 June 2016
Date of publication: 24/08/2016

Core services inspected	CQC registered location	CQC location ID
Community based mental health services	Oxford Health NHS FT Trust - HQ	RNU10
Long stay rehabilitation services, Acute wards for adults of working age and psychiatric intensive care units	Buckinghamshire Health and Wellbeing Campus, Bierton Road, Aylesbury, Buckinghamshire, HP20 1EG	RNU09
Acute wards for adults of working age and psychiatric intensive care units	Littlemore Mental Health Centre, Sandford Road, Littlemore, Oxford, OX4 4XN	RNU30
Acute wards for adults of working age and psychiatric intensive care units	Warneford Hospital Warneford Lane, Headington, Oxford, OX3 7JX	RNU03

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

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

Overall rating for services at this Provider	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

Contents

Summary of findings

Overall summary

Following this re-inspection, we have reconsidered the overall rating for the trust and have now rated it good because:

- When we undertook our comprehensive inspection in September/October 2015, we rated nine of the 14 core services provided by the trust as good and one (community health services for children, young people and families) as outstanding.This re-inspection assessed three of the core services that we had rated as requires improvement. We have now revised the ratings of these three core servces to good.
- Following our previous inspection, the trust managers developed an action plan and worked with stakeholders to address the areas that required improvement. A group chaired by the deputy director of nursing monitored progress.This work had resulted in significant improvements in the care and treatment of patients and in the care environments.
- The trust had developed a new estates dashboard. Any issues identified from daily environmental checks were passed to the facilities and estates management via the intranet system or telephone. The introduction of the estates dashboard had resulted in real improvements in the speed and efficiency of response.
- When we inspected the rehabilitation ward for working age adults in September/October 2015, we rated it as requires improvement for safe, effective, responsive and well-led.Following our re-inspection, we have rated this core service as good for all key questions other than safe.The improvements that staff had made include: changes to the ward to bring it in line with the guidance on the provision of same-sex accommodation; the introduction of more personalised and holistic care plans; the removal of unnecessary blanket restrictions and improvements in ward governance.
- In September/October 2015, we rated acute wards for adults of working age and psychiatric intensive care units as requires improvement for safe, effective, caring and well-led.Following our re-inspection, we have rated this core service as good for all key questions.The improvements include: better management of risks to patients from potential ligature anchor points; improved assessment and management of the physical health of patients and the introduction of a fuller schedule of ward activities.
- After our inspection in September/October 2015, we rated community-based mental health services for working age adults as requires improvement for effective and well-led.We have now rated this core service as good for all five key questions.Since the previous inspection staff had improved the quality of clinical assessments and care plans.
- Staff in all clinical areas that we visited during our recent re-inspection had high morale.
- CQC inspectors from the Primary Medical Services directorate undertook a follow up inspection of Luther Street medical practice in April 2016. Luther Street provides primary health care services for homeless people over the age of 16 and people vulnerably housed in Oxford. Overall the practice is now rated as outstanding. It was outstanding for provision of caring and responsive services. Good for safe, effective and well led services.

However:

- Following our comprehensive inspection in September/October 2016, we rated seven of the 14 core services as requires improvement for safe.We have not re-inspected four of these core services and have again rated the rehabilitation ward for working age adults as requires improvement for safe.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Following our comprehensive inspection in September/ October 2016, we rated seven of the 14 core services as requires improvement for safe. We have not re-inspected four of these core services and have again rated the rehabilitation ward for working age adults as requires improvement for safe.
- Some concerns were raised about medicines management where in some places there was insufficient recording and monitoring. For instance, the fridge temperature was not consistently recorded on Sapphire ward and the City and North East and Aylesbury AMHT staff were not following procedure to record fridge temperatures in the clinic room.
- On the long stay rehabilitation ward some gaps were noted in checking of emergency drugs, the cleaning rota and the safety testing stickers for electrical equipment.
- There was no money management policy available on the ward. This could leave patients at risk of money mismanagement and staff at risk of allegations.
- Staffing levels remained an issue and all staff reported staff shortages. The trust had implemented a safer staffing escalation protocol to ensure safe staffing levels were maintained. All wards were staffed to achieve safe staffing levels; however this was achieved in some wards by staff working additional hours and shifts, the high use of temporary staff both from the trusts bank 'staffing solutions' and external agencies, and reducing beds on some wards. Staff nurses had authority to request staff from the internal bank system when needed. If agency staff were needed this was escalated to a senior manager.

However;

- Staff were trained in, and understood, the trust safeguarding policy and procedures and knew how to make safeguarding referrals
- Following the last inspection the trust had carried out an extensive programme to reduce restrictive practices across mental health inpatient services, which was well received by patients and staff.

Summary of findings

- Ligature risks were identified and well managed and mitigated across the service. The trust had undertaken maintenance works to remove as many ligature risks as possible, including in the gardens and to install convex mirrors to aid with line of sight observations.
- Risk assessments were comprehensive and contained contingency and crisis plans to assist patients during a deterioration of health.
- There was a reduction in episodes of restraints month on month since November 2015 which reflected the trusts successful implementation of PEACE training.
- All Luther Street practice staff had received basic life support training after the inspection in September 2015. Luther Street staff were appropriately trained to undertake chaperone duties and had undertaken checks to ensure they were not barred from working with vulnerable adults. In September 2015 Luther Street nursing staff had not received updated training in administering immunisations. This training had been completed by April 2016.

Are services effective?

Good

We rated effective as good because:

- We have revised the rating for effective, for all three core services that we re-inspected, from requires improvement to good.This means that we have now rated all ten mental health core services that the trust provides as good for this key question.
- All staff had training in the Mental Health Act and the Mental Capacity Act as part of mandatory training. We saw evidence in care records of capacity being assessed and best interest meetings taking place. These are meetings where all relevant people meet to decide a particular course of action for a person who lacks capacity. Clinicians across the trust demonstrated they understood, and adhered to, the principles of the Mental Capacity Act.
- The trust utilised an electronic record system called 'care notes' and all paper correspondence and documents for patients were scanned onto this electronic system, including detention papers, renewals and external appointment letters. This system allowed for safe storage of personal information and ensured patient notes could be accessible and shared between wards and community teams.
- The trust had developed a new care plan format and clinical practice educators had delivered training on care planning principles. This had led to significant improvement in care

Summary of findings

plans since the last inspection . Care plans demonstrated a broad range of goals relating to the assessed needs of patients, were focussed on patient recovery and had clear evidence of patient involvement.

However:

- Following our comprehensive inspection in September/October 2015, we rated two of the five community health core services (community health inpatients and end of life care) as requires improvement for effective. We did not include these core services in the recent re-inspection.

Are services caring?

Good

We rated caring as good for the following reasons

- Across all core services we rated the trust as good or outstanding for caring and found that people were treated with dignity, respect and kindness.
- Patients and carers we spoke with commented that the staff were extremely caring and reassuring even during times of restraint.
- In mental health inpatient services carers we spoke with said they felt highly involved and regularly updated by all of the MDT teams on the wards. Carers and family members, with patient consent, were invited to MDT meetings and ward rounds. Some wards offered family support group sessions and most held monthly carers groups. Carer assessments were offered to carers by the patients care coordinator.
- The majority of patients we spoke with were aware of their care plan and said that they were involved with devising one and felt they received sufficient information to make informed decisions about their care.

However:

- Due to the layout of the care notes system it was difficult to determine if patients had been offered a copy of their care plan or not. Some teams addressed this by writing in the comment box supplied if a patient accepted or refused a copy. Most patients also stated that they were offered a copy of their care plan.

Are services responsive to people's needs?

Good

We rated responsive as good for the following reasons

- Effective processes were in place at each community adult mental health team to manage referrals and plan assessments.

Summary of findings

Referrals were triaged into three response times dependent upon urgency. The triage decisions allowed for patients to have options about appointment times and venues which suited their circumstances.

- The long stay rehabilitation ward offered an inreach service to patients on the waiting list to help them prepare for admission. An outreach service was also offered to those patients on long term leave and ready for discharge to ensure continuity of care.
- Disabled access was good across the trust and there were many instances that showed the trust was meeting the diverse needs of all service users.
- There were appropriate complaints procedures in place and evidence that staff and patients knew how to raise concern. Ward and team managers logged local complaints with Patient Advice and Liaison service (PALS), including informal complaints and were able to analyse this information for themes and trends.

However;

- The adult acute mental health service was routinely admitting new patients into the beds of patients on leave and those who had gone Absent Without Leave.
- Several carers and patients said they were unhappy with the reduction of provision of the day services, from five to three days per week.

Are services well-led?

Good

We rated well led as good for the following reasons

- The trust had good leadership, with strong and effective leaders and managers. They were open and transparent. Executive directors and non-executive directors understood their roles and responsibilities. We found a trust that was able to be honest and reflect on where services needed to improve and had worked hard to put things right.
- Staff morale was high. All staff we spoke to reported a happy and supportive team atmosphere and good rapport with colleagues. All staff reported very good leadership at local level.
- Maintenance management systems had improved since the last inspection.
- All acute wards were Acccredited for Inpatient Mental Health Services from The Royal College of Psychiatrists. The acute service also sought other forms of accreditation.

Summary of findings

Our inspection team

Our inspection team was led by:

Serena Allen, Inspection Manager, Care Quality Commission.

The team included three inspectors and two assistant inspectors from the Care Quality Commission and five specialist advisors including mental health nurses with community and inpatient experience and an occupational therapist.

Why we carried out this inspection

We inspected this trust as part of our on-going comprehensive mental health inspection programme. The purpose was to re-inspect three of the mental health core services that we had rated as requires improvement when we undertook a comprehensive inspection of the trust between 28 September – 2 October 2015. The report from that inspection cane be found at

http://www.cqc.org.uk/sites/default/files/new_reports/AAAE6435.pdf.

The three core services that we re-inspected were:

- Acute wards for adults of working age and psychiatric intensive care units,
- Long stay/rehabilitation mental health wards for working age adults, and
- Community-based mental health services for adults of working age.

This re-inspection covered all of the issues that we normally assess during a comprehensive inspection and included assessment of the concerns and breaches of regulations that we identified in September/October 2015.

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 visiting, we reviewed a range of information we hold about the provider and asked other organisations to share what they knew. We carried out an announced visit 14-16 June 2016. During the visit we:

- Visited eight wards.
- Visited three community mental health teams.
- Spoke with 28 patients.
- Collected feedback from 62 comment cards completed by people using the trust's services.
- Talked to six carers.
- Reviewed 64 care records.
- Reviewed 62 medication charts.
- Spoke to managers of each ward/service.
- Spoke with 45 other staff members including modern matrons, consultants, junior doctors, pharmacists, occupational therapists, nurses and healthcare assistants.
- Observed an assessment.
- Attended and observed hand-over meetings, MDT meetings, planning meetings and community meetings.
- Reviewed information we had asked the trust to provide.

Summary of findings

Information about the provider

Oxford Health NHS Foundation Trust provides community health, mental health and specialised health services across Oxfordshire, Buckinghamshire, Milton Keynes, Berkshire, Swindon, Wiltshire, Bath and North East Somerset (BaNES).

In Oxfordshire, the trust is the main provider of the majority of non-GP based community health services for the population of Oxfordshire. It delivers these in a range of community and inpatient settings, including eight community hospital sites with ten wards. It also runs GP surgeries. Mental health teams provide a range of specialist healthcare services in community and inpatient settings across the geographic areas of Milton Keynes, Buckinghamshire, Oxfordshire, Wiltshire and BaNES. Additionally, the trust provides forensic mental health and eating disorder services across a wider geographical area including patients in Berkshire, the wider Thames Valley and Wales.

Having been granted foundation trust status in April 2008, the trust provides 562 inpatient beds over 34 locations. It employs 4,822 full time equivalent staff members (6,500 headcount). Its total income for the 2014/15 year was £288.3 million.

The trust works closely with a number of clinical commissioning groups (Oxfordshire, Chiltern, Nene, BaNES, Wiltshire, Swindon, Newbury District, Aylesbury Vale) County councils (Swindon Borough, Buckinghamshire, Oxfordshire, Leicester City, Northamptonshire), NHS England (south area team & Wessex area team) and the Welsh health specialist services committee. Additionally, The trust has partnership agreements in place for adult and older adult mental health services in Oxfordshire and Buckinghamshire with the county councils.

Oxford Health NHS Foundation Trust has had seven previous inspections at three registered locations (Littlemore mental health centre, Warneford hospital and Oxford Health NHS Foundation Trust HQ) At the time of the last inspection there were three mental health services that were not compliant with the Health and Social Care Act 2008 (2014). We issued twenty requirement notices against ten locations and the provider took steps to respond to this positively.

CQC inspectors from the Primary Medical Services directorate undertook a follow up inspection of Luther Street medical practice in April 2016. Luther Street provides primary health care services for homeless people over the age of 16 and people vulnerably housed in Oxford. Overall the practice is now rated as outstanding. It was outstanding for provision of caring and responsive services. Good for safe, effective and well led services.

What people who use the provider's services say

We received 62 comment cards from people who used services.

With few exceptions the patients we met spoke positively about the support they received from the staff and the treatment they received. Patients and their carers told us that staff treated them with respect and dignity.

Patients told us that attending the recovery college and the carers groups had been a positive experience.

Good practice

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

- The acute service recently implemented a new procedure to address patients failing to return from leave. This had reduced the incidence of patients failing to return from leave by up to 80% and was to become the basis of a local university research project due to its success.

Summary of findings

- The acute service had good facilities to promote an effective programme of activities. This meant that patients could gain skills in horticulture, pottery, woodwork and music.
- The acute service had very good links with the local charities "Men in Sheds" and 'Restore'. This link enabled patients to gain valuable skills and formal qualifications to aid reintegration into the community and this education was fully encouraged by members of staff on the ward.

Community mental health teams

- Referrals were triaged into three response times dependent upon urgency. The triage decisions allowed for patients to have options about appointment times and venues which suited their circumstances. The service could respond flexibly to peoples changing needs by offering more intensive support. This was available between 7am to 9pm seven days a week. Team doctors protected appointment times Mon-Fri for patients needing to see a doctor urgently.
- Teams were trialling a new telephone service with GPs to make contact with the teams quicker. A GP calling the team was given a choice to speak to either a doctor or a care coordinator then the phone system would keep searching until the appropriate person picked up the call. We were told that the feedback from GPs had been positive.

Areas for improvement

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

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

- The provider should consider a garden access policy to ensure patients have the same night access to gardens across all wards.
- The provider should document where care plans are given to patients or reasons why they were not.
- The provider should ensure consistent recording of clinic room temperatures across all wards.
- The provider should consider their use of leave and AWOL patient beds for new admissions.

Long stay/rehabilitation mental health wards for working age adults

- The provider should ensure care plans reflect the work being done with patients.
- The provider should ensure a money management policy for the ward is implemented.
- The provider should ensure gaps in checking of emergency drugs are addressed.
- The provider should ensure all electrical equipment has up to date safety testing stickers.

Community based mental health services for adults of working age:

- The provider should ensure that the fridge temperatures at the City and North East AMHT and the Aylesbury AMHT, are correctly checked and recorded to ensure that medicines are stored safely.

Oxford Health NHS Foundation Trust

Detailed findings

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.

Overall the application and management of the Mental Health Act 1983 (MHA) was good. This was overseen by a senior team which included the head of information governance and a non-executive director. The 'effectiveness committee' monitored the use and operation of the MHA. This took place every quarter and there was a legislation group which met monthly to discuss operational issues.

The trust worked well with other agencies such as police, social care and ambulance services. Concerns affecting people subject to detention was discussed at the problems in practice group and there was evidence of learning being shared across all partners from this group.

All new staff received training on the MHA on induction and then received refresher training every three years. Since the introduction of the new Code of Practice (which accompanies the Mental Health Act) in April 2015, the refresher training had focussed on the changes in the new code.

The trust also provided training to section 12 doctors and approved clinicians and appraisals of doctors included knowledge and skills of using the MHA.

The new code required the review of a number of policies. The trust had reviewed all policies affected.

The operation of the MHA was supported by a team which provided reminder systems to clinical staff, scrutinised documents and organised tribunals and hearings. The MHA team provided weekly data on the operation of the act to senior medical staff to enable them to discuss how the Act was being used.

There were work streams in place which reviewed the use section 17 leave, community treatment orders and consent to treatment. These reported into the 'effectiveness committee'.

The trust had changed to a new electronic patient recording system shortly before our previous inspection and this had created some challenges for clinical staff. We heard how the MHA team had supported clinicians during this change and about the benefits that the new system provided now it was fully implemented. This included better monitoring of the Mental Health Act, for instance, the system generated reminders when further assessments were needed.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff knowledge of the Mental Capacity Act and its 5 key guiding principles was varied across the acute service. Training in the MCA was mandatory and taught in conjunction with the MHA and Deprivation of Liberty Safeguards.

Detailed findings

In community mental health teams and on the long stay rehabilitation ward staff we spoke to were aware of the principles of the MCA and capacity was discussed at team meetings and ward reviews. We saw evidence of capacity for treatment and admission being assessed. Staff were able to give other examples of when capacity may need assessing such as money management, accommodation issues, safeguarding referrals.

In acute and psychiatric intensive care wards patient's mental capacity assessments were completed where appropriate and good documentation evidenced this. However, the capacity assessment documentation did not clearly detail whether carers, family members or independent mental health or independent mental capacity advocates had been involved in the best interest decisions for the patients deemed to lack capacity.

Requires improvement

Are services safe?

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

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

Summary of findings

Our findings

Safe and clean care environments

- The acute and psychiatric intensive care unit inpatient service had placed new wardrobes into all bedrooms a week before our inspection. We had concerns that these wardrobes posed a ligature risk as the doors were not angled and were very heavy. The wardrobe doors easily held the weight of a member of the inspection team. Staff and managers immediately identified the wardrobes as a ligature risk and informed the trust. The trust demonstrated to us that the wardrobes had been placed onto the trust risk register, and that plans were imminent with the manufacturer to secure an agreement to modify them. Additionally, we saw good evidence of thorough risk assessments and management plans of patients in the interim, with all potential ligatures removed from high risk patient possessions and the allocation of suitable levels of observations.
- The Buckingham Health and Wellbeing Campus was a newly, purpose built building and the ward layouts on this site were better designed to allow good observation.However some blind spots still remained. The wards at Littlemore Mental Health Centre and Warneford Hospital were much older buildings and contained many blind spots. Most areas had been mitigated by the strategic placement of convex mirrors across the wards including garden areas. Staff worked hard to ensure observation levels mitigated the risks.
- All wards conducted annual ligature risk audits and reviews, changes were made if a new risk was identified. We saw evidence of ward managers highlighting any major risks from these audits to ward staff via team meetings and e-mail correspondence and they encouraged all new and temporary staff to read the ligature risks identified. Ligature risks were also identified on local risk registers, which all members of staff could access on each ward. All wards mitigated ligature risks within areas of unsupervised patient access via patient levels of observation and staff presence. All staff had quick and easy access to ligature cutters kept on the ward.
- All clinic rooms on the wards were well equipped and emergency equipment was present and checked daily. The clinic rooms on Ruby, Ashurst and Sapphire wards recorded temperatures that were above ideal temperatures to safely store medicines. Medicines stored at higher temperature can affect chemical composition and shelf life of the product. This was mitigated by opening a window to the clinic room, however this had to be closed whilst patients were in the room. The trust provided us with a risk management of medicines document which detailed how medicines were managed in the event that temperatures rose too high. This included a calculation available to the ward teams to reduce the shelf life of medicines based upon the period stored at a high temperature.
- Previous issues on the long stay rehabilitation ward with unpleasant smells in individual rooms from drains had been dealt with. However, problems with the drains continued occasionally in communal areas. On the day of inspection the communal bathroom was closed off due to this issue. It was inspected and reopened while we were there. Two administrators were responsible for reporting maintenance issues to estates. A robust process was in place for recording what was reported, when it was sent, when it was actioned and any follow up needed. This ensured actions were implemented.
- Infection control was monitored and the audit was in date and action plan noted. Mattress and bed audits on the whole were being completed regularly and four new mattresses had recently been ordered. Some pillows were in need of replacement and 16 new ones were ordered as a result. Hand washing audits took place and there was 100% compliance. However some bedrooms we inspected were untidy and dirty. Patients were responsible for their own rooms, but staff should have encouraged them to manage hygiene. This was immediately brought to the attention of the manager.

Requires improvement

Are services safe?

Safe staffing

- As of May 2016, data from the trust indicated a high number of vacancies across the acute inpatient service. There were 33 Whole Time Equivalent (WTE) vacancies for qualified staff, and 12 for unqualified staff. Wintle, Phoenix and Ashurst had the highest number of WTE vacancies for qualified staff (eight each). Allen ward had the highest vacancies for WTE unqualified staff (six). We saw evidence that the trust was actively seeking to fill vacancies through open days, recruitment fairs, preceptorship programmes, engagement with return to practice campaigns and the development of an internal staff bank.
- The long stay rehabilitation ward'ssafer staffing report to the board showed less than 75% of shifts in March 2016 were staffed to expected levels by permanent staff. This had been a consistent finding over the last 18 months.
- All wards were staffed to achieve safe staffing levels; however this was achieved in some wards by staff working additional hours and shifts, the high use of temporary staff both from the trusts bank 'staffing solutions' and external agencies, and reducing beds on some wards

Assessing and managing risk to patients and staff

- At our previous inspection we issued a requirement notice in respect of the long stay rehabilitation ward. This was because we were concerned about patients being moved between wards for non clinical reasons to create beds for other users.This could have a detrimental impact on patients and continuity of care could be disrupted. The trust responded to this requirement notice by issuing a directive immediately ceasing the policy of using short term leave beds for inpatients from other wards.
- At our last inspection we issued a requirement notice relating to the use of blanket restrictions in acute and psychiatric intensive care units and long stay rehabilitation wards. Action had been taken by the trust to review restrictive practices and all blanket restrictions noted at the last inspection had been lifted. Any restrictions still in place were for health and safety reasons.
- At our last inspection we found risk assessment was poor in long stay rehabilitation, with staff describing a recognised risk assessment tool but having no evidence of its use within patient notes. During handovers, patient risks were also not fully explored and discussed. On this inspection all staff reported good knowledge of risk and good liaison with the multi disciplinary team in discussing risk and agreeing strategies to manage individual risks, this was corroborated by documentation in patient records. Care records contained risk assessments. However not all risk assessments were up to date.
- Across the long stay rehabilitation andacute and psychiatric intensive care wards there were 318 uses of restraint for 109 patients in a six month period from November 2015. Of these incidents of restraint 84 of 41 patients were in the prone position. There was a reduction in episodes of restraints month on month from 67 in November 2015 to 44 by the end of April 2016 which reflected the trusts successful implementation of PEACE training. The department of health guidelines (Positive and Proactive Care, reducing the need for restrictive interventions.) states that prone restraint should not be used. When it is used it should be for the least time possible and it should not involve the application of pain.
- At our previous inspection In September 2015 Luther Street nursing staff had not received updated training in administering immunisations. This training had been completed by April 2016.
- Across most services there was good understanding of safeguarding. Staff knew how to report abuse and there were policies in place to support staff. Staff had been trained in safeguarding and there were safeguarding leads within the trust to offer support and advice. The trust had both a named doctor and named nurse for safeguarding both adults and children. The safeguarding committee fed directly to the trust board and the trust was represented on the local safeguarding local authority boards.
- Safeguarding issues were observed to be shared between staff at staff meetings, handovers and emails. There appeared to be sufficient information readily available on wards and in community teams regarding safeguarding and good links with the local safeguarding teams were noted.
- Luther Street staff were appropriately trained to undertake chaperone duties and had undertaken checks to ensure they were not barred from working

with vulnerable adults. When we visited in September 2015 the chaperone service was not promoted. In April 2016 there was evidence confirming the service was advertised to patients.

- Medicines were well managed across the trust with regular audits that ensured safe transport, storage, reconciliation and dispensing of medicines. Where controlled drugs were administered, there was an appropriate policy in place for the service and two nurses signed for the medication. The pharmacist visited the ward weekly and met with doctors. A medicine management technician also visited weekly and checked drug charts, drugs, stocks of medication and orders. However, the inspection team had concerns about medicines management where in some places there was insufficient recording and monitoring. For instance, the fridge temperature was not consistently recorded on Sapphire ward and the City and North East and Aylesbury AMHT staff were not following procedure to record fridge temperatures in the clinic room. On the long stay rehabilitation wardsome gaps were noted in checking of emergency drugs.

Track record on safety

- In the period 1 November 2015 – 30 April 2016 the trust reported 32 serious incidents for these three core services, 13 of which concerned serious self-inflicted harm by patients. A further 10 incidents were unexpected deaths, nine of which were patients in receipt of community mental health services. There were no reported never events.

Reporting incidents and learning from when things go wrong

- Across the trust there was strong evidence that staff knew how to recognise and report incidents using the trust's electronic reporting system. The trust used an online reporting system called 'Ulysses' and staff could confidently describe how to report an incident using the system. Managers produced a team action plan based on logged incidents. The system also allowed the managers to identify themes occurring within lower level incidents and help them take actions to limit risk.This system ensured senior management within the trust were alerted to incidents in a timely manner**.**
- There was clear evidence of cascading information to team members following incidents via team meetings, email correspondence and handovers. Team meeting minutes showed a dedicated agenda item to discuss learning from incidents. The trusts central Risk Team also cascaded 'risk notes' from incidents across the trust to each team and we saw evidence of these being discussed with staff.
- On the long stay rehabilitation ward some staff found it difficult to identify what they would report as an incident. Management recognised this and there was a plan to bring incident reporting to the reflective practice group to improve knowledge.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- The trust was meeting their responsibilities under duty of candour and was open and honest when things went wrong. We saw evidence that the trust had a duty of candour policy and saw examples of letters sent to patients and relatives post a serious incident. The trust kept a spread sheet so it could monitor that they were completing to timescale and had taken all necessary action.

Anticipation and planning of risk

- At our previous inspection we issued a requirement notice in respect of the long stay rehabilitation ward. This was because we were concerned about patients being moved between wards for non clinical reasons to create beds for other users. This could have a detrimental impact on patients and continuity of care could be disrupted. The trust responded to this requirement notice by issuing a directive immediately ceasing the policy of using short term leave beds for inpatients from other wards .
- At our last inspection we issued a requirement notice relating to the use of blanket restrictions in acute and psychiatric intensive care units and long stay rehabilitation wards. Action had been taken by the trust to review restrictive practices and all blanket restrictions noted at the last inspection had been lifted. Any restrictions still in place were for health and safety reasons.
- At our last inspection we found risk assessment was poor in long stay rehabilitation, with staff describing a

recognised risk assessment tool but having no evidence of its use within patient notes. During handovers, patient risks were also not fully explored and discussed. On this inspection all staff reported good knowledge of risk and good liaison with the multi disciplinary team in discussing risk and agreeing strategies to manage individual risks and care records contained risk assessments. However not all risk assessments were up to date.

- Across the long stay rehabilitation and acute and psychiatric intensive care wards there were 318 uses of restraint for 109 patients in a six month period from November 2015. Of these incidents of restraint 84 of 41 patients were in the prone position. There was a reduction in episodes of restraints month on month from 67 in November 2015 to 44 by the end of April 2016 which reflected the trusts successful implementation of PEACE training. The department of health guidelines (Positive and Proactive Care, reducing the need for restrictive interventions.) states that prone restraint should not be used. When it is used it should be for the least time possible and it should not involve the application of pain.
- At our last inspection we were concerned about the management of ligatures in acute and intensive care inpatient wards. Not all ligatures had been identified and therefore were not being mitigated. Ligature points can pose a risk to patients who may use ligature points to harm themselves. Following our inspection a comprehensive programme of works had addressed the management of ligatures, removing or mitigating risks and we saw the evidence of this during our visit.
- Our intelligent monitoring flagged suicide as an area of risk for the trust in relation to those people detained under the Mental Health act 1983. Regarding this, the trust has developed some key actions:

1. To develop suicide awareness and prevention strategies, in teams across the trust and review the impact on practice.
2. Carry out benchmarking against other providers for common indicators.
3. Implement recommendations and share learning with safeguarding children's boards from Oxford Health Foundation Trust internal report into children's and young people's suicides.
4. Key measures have been introduced, such as:
5. measuring days between probable suicides in individual adult mental health teams (target 300 days)
6. measuring days between probable suicides in inpatient services (target 300 days)
7. Ten teams were to receive suicide awareness/ prevention training in line with the interpersonal theory of suicide.

- At our previous inspection In September 2015 Luther Street nursing staff had not received updated training in administering immunisations. This training had been completed by April 2016.
- Medicines were well managed across the trust with regular audits that ensured safe transport, storage, reconciliation and dispensing of medicines. Where controlled drugs were administered, there was an appropriate policy in place for the service and two nurses signed for the medication. The pharmacist visited the ward weekly and met with doctors. A medicine management technician also visited weekly and checked drug charts, drugs, stocks of medication and orders. However, some concerns were raised about medicines management where in some places there was insufficient recording and monitoring. For instance, the fridge temperature was not consistently recorded on Sapphire ward and the City and North East and Aylesbury AMHT staff were not following procedure to record fridge temperatures in the clinic room. On the long stay rehabilitation ward some gaps were noted in checking of emergency drugs.
- Luther Street staff were appropriately trained to undertake chaperone duties and had undertaken checks to ensure they were not barred from working with vulnerable adults. When we visited in September 2015 the chaperone service was not promoted. In April 2016 there was evidence confirming the service was advertised to patients.

Good

Are services caring?

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

Summary of findings

Our findings

Assessment of needs and planning of care

- At our last inspection we issued a requirement notice regarding the lack of person centred care and the lack of patient involvement in care plans in community mental health teams, long stay rehabilitation, acute and psychiatric intensive care wards. Since our last inspection the trust had produced an action plan to ensure that care plans were person centred and recovery focused, we did not have any concerns about care plans or patient involvement at this inspection. The requirement notice is met.
- Information including care plans and progress notes was securely stored on the trust's electronic records system. All staff had access via desktop computers and some community staff told us they had access to mobile devices which allowed them to log on to the system when away from base.
- We found that the information was well organised and updated regularly. Information had been stored in the appropriate sections of the records. Staff told us that there had been problems when the trust migrated information from the previous care records system to the Carenotes system. Staff told us that these issues were resolved and we found staff were confident in using the current electronic records system.
- In community mental heath teams we reviewed the care records of 29 patients. The majority of records contained a comprehensive assessment and a broad range of issues addressed in care plans. Goals included leisure and vocational activities, managing physical health and medicines, developing coping mechanisms, diet and exercise, education and work, communicating with friends and family and managing the use of alcohol and substances. All care plans that we saw were less than 12 months old and we saw that the plans were being reviewed every six months. Many care plans reflected patient involvement in developing goals, their involvement was reflected in a comment on the electronic record.
- The managers at all three community mental health teams showed us recent team development activities to improve the quality of care plans which included a care programme approach 'back to basics' training, a team training day which included patients describing what made an effective care plan for them, and additional training on using the recovery star. This learning was supported by managers and senior clinical staff offering guidance and extra support, including care plan audits at regular intervals.
- When we last inspected the trust they were in the process of transitioning the patient information system from RiO to a new electronic health record system called Care Notes. Mental health services had switched in March 2015 and community health services in October 2015 (just post our inspection.) There were numerous examples from across the trust that there had been some risks associated with this. For example, some staff found it difficult to easily locate care plans and assessments. Not all records had been migrated. The trust had identified this as a risk and it was on the corporate risk register. On this inspection we saw and staff told us that these issues were resolved and we found staff were confident in using the current electronic records system.

Best practice in treatment and care

- The trust had a recovery college; this was launched in September 2015. The recovery college manager and coordinator employed to run the college had lived experiences of a mental health illness. Peer support workers run every class offered at the recovery college. All the courses had been designed and are available to people who use mental health services, their families, carers as well as staff and volunteers

Skilled staff to deliver care

- Across all services there was good input by different professional groups who all contributed to the multi-disciplinary team. This proved positive for the delivery

of care. As part of a strategy to improve access to psychological therapies, each of the AMHTs had been allocated 2 clinical psychologists as part of the core team. This was a staged plan which would see adult mental health psychological therapies sited within the AMHTs by January 2017. Staff reported that this was positive for the team, and they now had quick access to psychology colleagues to help with formulation and planning the care and treatment of people using services. However recruitment to these posts had been difficult and not all positions were filled at the time of our visit.

Multi-disciplinary and inter-agency team work

- We found strong evidence of regular, effective and fully inclusive multi-disciplinary meetings taking place throughout all services. Handovers and team meetings happened frequently and good working relationships were noted between partners.
- Partnership arrangement with GPs, acute hospitals, local authorities and independent organisations were good. Additionally, we found partnership working a real strength of this particular trust and this can be found in their commitment to working with joint management arrangements with the independent sector. The street triage service had shown to effectively reduce the numbers of section 136 patients liable to be detained.
- All community mental health teams had good links with inpatient services and received daily updates regarding the progress of people's admissions. We observed the team making plans based on inpatient services updates at the Aylesbury treatment team multi-disciplinary meeting. This ensured that issues that might affect someone's smooth discharge from hospital could be addressed by the team ahead of time.
- There were also close connections with psychiatric liaison team and street triage team. Information was shared effectively about people who may cross over and use the services of more than one team. Teams were trialling a new telephone service with GPs to make contact with the teams quicker. A GP calling the team was given a choice to speak to either a doctor or a care coordinator then the phone system would keep searching until the appropriate person picked up the call. We were told that the feedback from GPs had been positive.
- In long stay rehabilitation links with other teams within the organisation were good. Care coordinators were routinely invited to care programme approach reviews and generally attended. Relationships with community teams regarding discharge planning were good. Referrals were generally from the acute ward and relationships with these wards were also good. The ward manager attended a rapid review meeting with the acute wards to discuss potential referrals when possible.
- Working relationships with external teams were effective. The social worker had direct links with the local authority and good working relationships with housing providers and placement panels. We observed minutes of the criminal justice mental health panel which the consultant attended and minutes of a problems in practice meeting with senior managers, police and social care which looked at current issues affecting the ward for example if a patient was absent without leave.
- In acute and psychiatric intensive care units we witnessed regular and effective multi-disciplinary team (MDT) meetings occurring that made use of a multitude of health professionals. These meetings were personalised, caring and holistic with patients social, emotional, mental and physical health needs discussed. All members of the MDT team took an active role in discussions.

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

- In primary medical services patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. They described having access to immediate advice from the specialist mental health worker when they had any concerns relating to patients who may not have the capacity to make decisions about proposed care and treatment.
- In acute mental health services and long stay rehabilitation the care records we viewed showed that patients' mental capacity to consent to their care and treatment was always assessed on their admission and on an on-going basis. There was good documentation of the assessment of mental capacity in all care records. Consent to treatment forms were present for all patients and attached to their medicine charts

Good

Are services caring?

Good practice in applying the Mental Capacity Act

- There were good procedures and support in place to ensure all Mental Health Act documentation was correct. This included dedicated support from a central Mental Health Act administration team.
- Patients' Section 132 rights were routinely read to them on admission and regularly updated thereafter. Documentation that patients rights were being read was clearly evidenced within their patient notes.

Good

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

- Luther Street medical practice was rated outstanding for caring. In every other service, we have rated caring as good.

The involvement of people in the care they receive

- In community mental health teams the majority of the 29 care plans that we viewed were person centred, recovery focussed and reflected the personal goals of the person using the service. Goals included leisure and vocational activities, managing physical health and medicines, developing coping mechanisms, diet and exercise, education and work, communicating with friends and family and managing the use of alcohol and substances. It was evident that staff were supporting patients to complete self-assessments such as the recovery star and this had been incorporated in to the overall care plan goals.
- Patients had attended the City and North East team away day to share their views about care plans and help the team make improvements. The result of this work was displayed on notice boards in the team areas, and included examples of good quality care plans.
- Family members and carers involvement was actively encouraged throughout the trust. The acute and psychiatric intensive care unit inpatient wards organised regular groups to facilitate their involvement and invited them to all meetings regarding their patients care. The carers who attended the community adult mental health team carer groups were very positive about the impact of this support
- On admission to the wards, all patients were orientated by a member of staff who gave them a tour and explained the procedures of the ward. Most of the wards gave information packs to patients that contained information such as staff roles, what to expect, daily routine, contraband items and visiting hours. These packs were also available for family members and carers. All patients were assigned a named nurse who was responsible for the patients 1:1 therapeutic work and all patients we spoke with knew who their named nurse was.
- There was good emotional support for people. The chaplaincy service was strong and visible force across many of the services, offering spiritual guidance and support to people of all faiths. This service also offered support to staff, if they wanted this, for instance, post a serious untoward incident.
- Staff we spoke to were able to describe the individual needs of the patients. Staff demonstrated a good rapport with more complex patients in challenging circumstances.

Good

Are services responsive to people's needs?

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

Summary of findings

Our findings

Service planning

- Effective processes were in place at each community adult mental health team to manage referrals and plan assessments. Referrals were triaged into three response times dependent upon urgency. The triage decisions allowed for patients to have options about appointment times and venues which suited their circumstances.
- Discharge planning would start at admission and included the involvement of family, carers, community teams and care providers. Discharges and admissions for long stay rehabilitation were well planned and did not happen at short notice.
- Several carers and patients said they were unhappy with the reduction of provision of the day services, from five to three days per week

Access and discharge

- In the long stay rehabilitation service in the last 12 months four patients had been discharged to supported accommodation and two to home addresses with a package of support in place. There were three delayed discharges. This was due to a lack of specialist placements. A part time social worker was recently employed to help with discharge planning and to establish further links with providers and the trust placement coordinator. Between December 2015 and May 2016 there had been no emergency readmissions within 28 days of discharge.
- The long stay rehabilitation ward offered an inreach service to patients on the waiting list to help them prepare for admission. An outreach service was also offered to those patients on long term leave and ready for discharge to ensure continuity of care.
- There were 87 delayed discharges in acute and psychiatric intensive care unit inpatient wards for the 6 months prior to May 2016. The number of delayed discharges declined month on month, with Wintle and Ashurst wards reporting no delayed discharges. The highest number of delayed discharges occurred on Allen ward with 28 for the entire period.On most wards, staff told us that the delayed discharges were predominantly due to accommodation difficulties. Social workers were working within the teams to help to address this by finding appropriate services and accommodation to support patients with their discharge.
- Staff on all acute wards confirmed that there was pressure on bed spaces and the adult acute mental health service was routinely admitting new patients into the beds of patients on leave and those who had gone Absent Without Leave. This meant staff were reluctant to allow patients on long term or overnight leave to aid discharge as staff were aware a new admission would fill their bed.
- Effective processes were in place at each community mental health team to manage referrals and plan assessments. Referrals were triaged into three response times dependent upon urgency. The triage decisions allowed for patients to have options about appointment times and venues which suited their circumstances. The service could respond flexibly to peoples changing needs by offering more intensive support. This was available between 7am to 9pm seven days a week. Team doctors protected appointment times Mon-Fri for patients needing to see a doctor urgently.

The facilities promote recovery, comfort, dignity and confidentiality

- The long stay rehabilitation ward had a full range of communal rooms including an activity room, an occupational therapy kitchen, visitors rooms, quiet room, a spirituality room and a separate female lounge, male lounge plus a communal lounge.
- Patients were able to personalise their rooms and all patients with capacity had keys to their bedrooms. Only those patients identified as at risk would not have a key to their rooms. Patients were allowed access to their rooms at all times unless there was a specific reason in their care plan as to why this should not be the case.

Good

Are services responsive to people's needs?

The ward needed to provide small lockable safes for patients who could not lock their belongings in their room and this was being sourced and was part of an agreed action plan.

- The long stay rehabilitation ward had many group activities and a well structured activity programme. We observed a music group which was well planned and a good example of a level one activity using the model of creative ability model. The psychology team ran a hearing voices group and a managing emotions group was planned. Patients were encouraged to join in external activities and one patient had music lessons off site and another was at college a few sessions per week. The occupational therapists were sourcing voluntary work placements for patients. Patients also had access to an allotment off site.
- There were leaflets and notices available at all community adult mental health team bases which provided patients with information on treatments, local services, patient rights including how to make a complaint, advocacy and carers resources. The interview rooms were appropriate and well located with comfortable furnishings. Patients and carers told us that they thought the rooms at the AMHTs were clean and well maintained.

Meeting the needs of all people who use the service

- Disabled access was good across the trust and there were many instances that the trust was meeting the diverse needs of all service users.
- A range of information leaflets were available for people across all services detailing available languages on the back for alternative languages to be requested if needed.
- Staff had good access to interpreters when required, and local faith representatives visited the wards and held services of worship on site and could be contacted to request a visit

Listening to and learning from concerns and complaints

- We found copies of the complaints process displayed in the wards and information leaflets for patients explaining how to make a complaint on all wards. Most patients we spoke to told us they knew how to complain both formally and informally. Welcome packs provided information on how to make a complaint. Patients felt that changes were made as a result of their complaints and we saw evidence of 'have your say' meetings whereby patients could raise concerns.
- Trust bulletins were sent to staff which shared learning from incidents and complaints from across the whole trust. The patient and advice liaison service visited each ward weekly and met with patients. Feedback on the issues they had raised was given at subsequent meetings with patients.
- There were appropriate complaints procedures in place and evidence that staff and patients knew how to raise concern. Ward and team managers logged local complaints with Patient Advice and Liaison service (PALS), including informal complaints and were able to analyse this information for themes and trends.

Good

Are services well-led?

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.

Summary of findings

Our findings

Vision, values and strategy

- The vision of the trust is 'outstanding care delivered by outstanding people' underpinning this are the trust values of:

Caring

- Privacy and dignity are at the heart of care. Treating people with respect and compassion and listening to what people say and acting upon this.

Safe

- Services are to be delivered to the highest standards of safety and in an environment that is safe and ensuring that there are effective systems and processes in place.
- Excellent
- They aspire to be excellent and innovate in everything they do and continually improve recognising those who deliver excellent care.
- The aims of their strategic plan are:

1. To continuously improve.
2. To work in partnership.
3. To fully involve patients and carers.
4. Translating innovation and putting technology into practice.

- The achievements of these aims are set out in a wheel which describes how the organisation will meet its objectives.
- Across all teams and services, staff were able to articulate the vision and values of the organisation. They told us that these values were linked to local objectives.

Good governance

- At local level across all teams and services, we found good systems which provided assurance that relevant meetings were taking place. These meetings reviewed quality, safety, performance and finance. Meetings with key stakeholders were also in place and the trust had a good structure of committees which reported directly to the board. Training had been completed, supervision and appraisals were happening. We found that risk was being adequately managed.Services had local risk registers that were reviewed and kept up to date. There was a corporate risk register and the board were sighted on both.
- All policies we reviewed were up to date and had a review date noted.
- There was good recording of serious incidents, monitoring and reviewing incidents and associated action plans put in place. Performance of teams was monitored at regular performance meetings. Where performance did not meet the expected standard, actions plans were put in place.

Fit and Proper Person Requirement

- The trust is meeting the fit and proper person requirement. They have a comprehensive policy in place and all staffed are check using the barring and disclosure service (DBS) The trust policy sets out best practice in regards the requirements of directors to meet this duty. Staff had undergone recent DBS checks. We looked at records kept by human resources department which also confirmed this.

Leadership and culture

- Staff of all grades across the service were aware of the whistleblowing policy and how to act on any concerns.All staff we spoke with felt happy and comfortable in raising issues or concerns regarding their experiences on the ward and would be confident to take issues to a more senior team.
- Morale on the wards was generally good. Staff worked hard to care for their patients and appeared to work well in their teams. However, two staff on different wards mentioned that there was a 'core' of negative staff members that lowered morale.

Good

Are services well-led?

- Ward managers were visible on the wards and approachable at any time and staff said their learning and development was fully supported by managers. We were told that the modern matron structure had driven some real improvements on the wards.

Engaging with the public and with people who use services

- The trust has a communications team and a 5 year communication strategy in place as well as a media policy. Currently it engages the public through a variety of mediums such as :
- The Oxford Health website.
- The Oxford Health intranet for staff. A weekly e-bulletin for staff.
- A quarterly Insight magazine for public, members and staff, with a monthly e-supplement featuring the latest developments.
- A suite of literature for internal and external audiences, including service leaflets.
- Media releases to print, radio, television and trade publications.
- Social media engagement through Twitter, YouTube and Facebook.

Quality improvement, innovation and sustainability

- The trust has joined many accreditation schemes including: inpatient mental health services and psychiatric intensive care units and inpatient rehabilitation units.
- The trust had a recovery college; this was launched in September 2015. The recovery college manager and coordinator employed to run the college had lived experiences of a mental health illness. Peer support workers run every class offered at the recovery college. All the courses had been designed and will be attended by people who use mental health services, their families, carers as well as staff and volunteers.
- At our last inspection we found the long stay rehabilitation ward was operating a restrictive regime which we felt would not support rehabilitation. Patients reported a lack of involvement and unhappiness at the lack of contact with staff. On our follow up inspection we saw the trust action plan had been successfully implemented. A large range of activities were available and a comprehensive programme of activities ran daily including weekends. Examples included games, sewing, life skills, music group, cooking sessions. There were many group activities and a well structured activity programme. We observed a music group which was well planned and a good example of a level one activity using the model of creative ability model. The psychology team ran a hearing voices group and a managing emotions group was planned. Patients were encouraged to join in external activities and one patient had music lessons off site and another was at college a few sessions per week. The occupational therapists were sourcing voluntary work placements for patients. Patients also had access to an allotment off site. This was a significant positive change in the ethos of the ward.