Requires improvement

Oxford Health NHS Foundation Trust

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

Quality Report

Warneford Hospital
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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)
RNU03	Warneford Hospital	Vaughan Thomas Ward	OX3 7JX
RNU03	Warneford Hospital	Allen Ward	OX3 7JX
RNU03	Warneford Hospital	Wintle Ward	OX3 7JX
RNU09	Buckinghamshire Health and Wellbeing Centre	Ruby Ward	HP20 1EG
RNU09	Buckinghamshire Health and Wellbeing Centre	Sapphire Ward	HP20 1EG
RNU30	Littlemore Mental Health Centre	Phoenix Ward	OX4 4XN
RNU30	Littlemore Mental Health Centre	Ashurst Ward	OX4 4XN

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.

Summary of findings

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	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Requires improvement** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

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

Overall we rated this core service as 'requires improvement' because:

- Whilst staff were working hard to identify and manage individual risks, some ward environments had a high number of ligature risks. There is a programme of works to remove identified ligature risks but further work is needed to improve lines of sight ensuring the safety and dignity of patients.
- Restrictive practices were evident during our inspection. These included access to the gardens, patients not enabled to lock their bedrooms and secure their personal property.
- Care plans were not personalised and recovery focussed did not include patient's strengths and goals and did not include their views.
- Systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients who may be at risk were not effective. This meant that assessing, monitoring services to ensure quality was impaired. However:
- We found positive multidisciplinary work and observed staff were supporting patients.

Summary of findings

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

Are services safe?

Requires improvement

We rated this domain as 'requires improvement' because:

- We found numerous ligature risks withinthe ward environments which were not effectively managed.
- Some wards had a layout which did not allow staff to observe all areas with a clear line of sight.

However:

- There were systems in place on the wards for reporting incidents and learning from incidents that had taken place within the trust.
- We saw that on-going refurbishment work was happening to reduce the ligature risks in some wards

Are services effective?

Requires improvement

We rated this domain as 'requires improvement' because:

- Patient care plans were of a variable quality across the wards**.** Care plans were not personalised and did not include patients' views, nor were they recovery orientated, for example, they did not include the patients' strengths and goals.

However:

- Patients' physical health needs were being identified.
- Physical health examinations and assessments were documented by medical staff following the patient's admission to the ward.

Are services caring?

Requires improvement

We rated this domain as 'requires improvement' because:

- We received mixed feedback about the quality of the care being provided.
- A number of patients told us that they had not been involved in devising their care plan and 35 of 37 patients had not received a copy of their care plan. We saw limited evidence of patients' involvement in the care planning process in the care records we reviewed.

However:

Summary of findings

- We observed many examples of staff treating patients with care, compassion and communicating effectively. We saw staff engaging with patients in a kind and respectful manner on all of the wards.

Are services responsive to people's needs?

Good

We rated this domain as 'good' because:

- We saw there was a range of choices provided in the menu that catered for patients' dietary, religious and cultural needs
- There was a full activity programme
- There was good access to spiritual care and chaplaincy
- Patients were able to do gardening under supervision

However:

- When patients went on leave, their beds were used to admit other patients. Not all ward environments optimised patients' safety, privacy and dignity.
- Restrictive practices were evident during our inspection. These included restrictions around patients having keys for their bedrooms.

Are services well-led?

Requires improvement

We rated this domain as 'requires improvement' because:

- We were concerned about the robustness of the governance systems relating, particularly, to the assessment and management of ligature risks and the assessment of the quality of care.

However:

- Staff consistently demonstrated good morale.
- There was highly visible, approachable and supportive local leadership.

Summary of findings

Information about the service

The acute wards for adults of working age are based in three hospital sites, The Warneford Hospital in Oxford, The Buckingham Health and Wellbeing Centre in Aylesbury and in the Littlemore Mental Health Centre in Oxford. All acute wards provide inpatient mental health assessment and admission services for adults aged18 and over.

The trust also provides one psychiatric intensive care unit (PICU) called Ashurst Ward for adults aged 18 and over. This is based in The Littlemore Mental Health Centre in Oxford.

Our inspection team

The inspection team for the core service consisted of two CQC inspectors, two consultant psychiatrists, three mental health nurses, two Mental Health Act reviewers, a pharmacist and an expert by experience. Experts by experience are people who have direct experience of care services we regulate, or are caring for someone who has experience of using those services.

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 visiting, we reviewed a range of information we hold about Oxford Health NHS Foundation Trust and asked other organisations to share what they knew.

During the inspection visit, the inspection team:

- Visited all wards (seven) and looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with 37 patients who were using the service.
- Spoke with the ward managers for each of the wards.
- Spoke with 42 other staff members, including doctors, nurses and occupational therapists.
- Interviewed senior clinical and operational management staff with responsibility for these services.
- Attended and observed hand-over meetings and three multi-disciplinary meetings.
- Collected feedback from patients using comment cards.
- Looked at the medication charts of 101 patients.
- Carried out a specific check of the medication management on two wards.
- Looked at the care records of 43 patients.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider's services say

The majority of the patients we spoke with were positive about the staff and their experience of care on the wards.

Patients generally told us that night staff could be rude sometimes and they often felt ignored by them.

Some patients told us that staff wake them abruptly by pulling the quilt off them or wake them to try to get them to take medication.

Patients told us that medical staff were generally good but aside from the ward rounds they are not able to see their consultant.

Patients were admitted to hospital when required, but they told us there could be delays in finding a suitable bed within their home catchment area because of the on-going demand for beds across the trust.

There was information about the trust available for people who used the service. People could access advocacy and the Patient Advice and Liaison Service (PALS) to get information and give feedback about the trust's services.

Areas for improvement

Action the provider MUST take to improve

- The trust must review governance systems relating to the assessment and management of ligature risks. The trust must ensure that action is taken to remove identified ligature risks and to mitigate risk of patients harming themselves where they could not be observed.
- The trust are not effectively ensuring that the care and treatment of patients is appropriate, meets their needs, and reflects their preferences.
- There were blanket restrictions in place on some wards. These included access to the gardens, and ability to lock bedrooms.
- Overall, care plans were not personalised and did not include patients' views, nor were they recovery orientated, for example, they did not include the patients' strengths and goals.
- Patients were not routinely involved in devising their care plan and had not received a copy of their care plan. Systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients who may be at risk were not effective. This meant that assessing, monitoring services to ensure quality was impaired Systems were in place to check the quality of the care plans, for example, we saw evidence of care plan audits. However, such systems did not identify and remedy the limitations in the quality of the care plans.
- Systems were in place to identify and manage ligature risks in the patient care areas, for example, we saw evidence of ligature risk assessments and action plans. However, they did not identify all the risks relating to ligatures.

Action the provider SHOULD take to improve

The trust should review governance systems in relation to the way information is gathered from the electronic incident recording system, particularly in relation to prone

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Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Vaughan Thomas Ward Allen Ward Wintle Ward	Warneford Hospital
Ruby Ward Sapphire Ward	Buckingham Health and Wellbeing Centre
Phoenix Ward Ashurst Ward	Littlemore Mental Health Centre

Mental Health Act responsibilities

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

The systems in place to ensure compliance with the MHA and adherence to the guiding principles of the MHA Code of Practice were good.

Patients had received their rights (under section 132 of the MHA) and these were normally repeated at regular intervals. MHA paperwork had been completed correctly, was up to date and held appropriately. The MHA record keeping and scrutiny was satisfactory.

Posters were displayed informing patients of how to contact the independent mental health advocate (IMHA) and the CQC.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust did not offer regularly updated mandatory training in the Mental Capacity Act (MCA); it was included in the trust's corporate induction programme.

When we spoke with staff there was varying degrees of knowledge about the MCA and Deprivation of Liberty Safeguards (DOLS).

The ward has not made any applications under the Deprivation of Liberty Safeguards. However, none of the patients we met and whose notes we reviewed would have required such an application.

The care records we viewed showed that patients' mental capacity to consent to their care and treatment was regularly assessed on their admission.

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

- Littlemore Mental Health Centre and Warneford Hospitals are old hospitals and staff worked hard to mitigate risks, each ward had undertaken a ligature risk assessment. The ligature audits we saw only recorded actions as either "observation levels" or "environmental checks" These were generic statements repeated across all ligature audits checked. Control measures were in place to minimise the risk to patients. When we spoke to staff and reviewed care records we found that patient risk assessments and bedroom risk assessments were in place. The wards were also placing higher risk patients closer to the nursing offices and were locking activity rooms when not in use. Despite these mitigating actions there remained a number of ligature risks on the wards at Littlemore Mental Health Centre and Warneford Hospital.
- Staff were aware of the risks to patients' safety caused by the layout and had assessed patients' individual risks and increased their observation as needed. Each ward had ligature cutters available and accessible in the event of an emergency occurring. Staff members we spoke to were aware of where the ligature cutters were kept on the wards we visited.
- We saw a number of blind spots in the corridors of Vaughan Thomas, Wintle, Allen and Phoenix wards. This meant that there were places for patients to hide and not be immediately visible to members of staff. Whilst one blind spot on the corridor on Allen had been negated by mirrors, most had not.
- During the inspection on Phoenix Ward, while we were interviewing a patient in the temporary dining room, a member of staff came in to retrieve some sharp kitchen knives she had placed behind the microwave following a 'smoothie making' class earlier. We immediately spoke to the Ward Manager about this and he looked into it – he later told us that the worker would normally have been able to retrieve them soon after the group and would lock the door in between but that this was delayed on this occasion due to our interview. Many of the patients we spoke to told on Phoenix ward told us that they don't feel safe on the ward and feel threatened by some of the other patients. One told us that staff sometimes leave the door unlocked when they go into the bedrooms so that when they are sleeping other patients can enter the bedroom.
- All the wards visited during the course of our inspection were compliant with guidance on same sex accommodation. Ashurst PICU supported both male and female patients but the bedroom corridors were clearly defined and separated.
- The wards had medication dispensing rooms where medicines were safely stored. Most of the medication rooms were being managed at suitable temperature to keep the medication safely. In Wintle Ward the temperature of the medication room was over the safe levels required for storage. This issue had been escalated to the ward risk register and there was a plan in place from the pharmacist department to ensure that medication was being disposed of before the temperature affected the medication. This meant that patient's medications were being managed effectively.
- Practices were in place to ensure infection control was being maintained and staff had access to protective personal equipment such as gloves and aprons. All of the wards were clean and tidy and we were told by staff the cleaning services were generally good. We saw that there were cleaning schedules on the wards and that these were being regularly reviewed.
- Controlled drugs are medicines which are stored in a special cupboard and their use recorded in a special register. There were systems for ensuring that controlled drugs were being managed correctly and this was being overseen by the pharmacists.
- We found that the pharmacy team provided a clinical service to ensure people were safe from harm from medicines. Nursing and medical staff told us that they had good links with the pharmacy team and in addition to ward visits, they were available to provide advice including out of hours. They were also available to

Requires improvement

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speak to patients individually if required. Nursing staff told us that patients were encouraged to attend these sessions which gave them an opportunity to discuss concerns.

- We looked at the prescription and medicine administration records for 101 patients on seven wards. Overall, appropriate arrangements were in place for recording the administration of medicines. If patients were allergic to any medicines this was recorded on their prescribing and medication administration record. There was a pharmacy service for managing ward stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them while in hospital.
- Staff had access to up to date information about medications through the electronic BNF (the British National Formulary, a book providing comprehensive information about all medications).
- All the wards had resuscitation bags that were clean and there were local audits in place to ensure they were checked on a regular basis by a nominated staff member on every shift. Staff described how they would use the emergency equipment and what the local procedures were for calling for assistance in medical emergencies.

Safe staffing

- On the seven wards we visited, staff told us that there were generally enough staff on duty to meet the needs of the patients but there was a heavy reliance on the use of bank and agency staff. We were told these bank and agency staff were regular staff who were familiar with the wards.
- Some of the staff members we spoke to told us that they were often moved from ward to ward at short notice to cover staffing shortages. The staff felt this was disrupting the consistency of care.
- We were told the trust monitored agency usage but were unable to provide us specific numbers of shifts per ward covered by bank and agency staff.
- The managers all told us they used the trust "safer staffing tool" which indicated they needed six staff in the morning six staff in the afternoon and four staff at night.
- When we looked at the information provided by the trust it showed that in the last twelve months, five of the wards had six or more months where 75% or less shifts were not fully staffed to expected levels. This had been highlighted as difficult on four of the wards in April 2015. This meant that there was an over-reliance on the use of bank and agency staff and, on occasion we were told wards operated short of staff, or the ward managers would undertake the shift.
- The ward managers told us that they were able to adjust staffing levels daily to take into account increased clinical needs. This included, for example, increased level of observation, to support patients attending Electroconvulsive Therapy (ECT) or general patient escort. Some of the requested hours of cover were due to existing staff sickness and vacancies.
- From the information provided by the trust, we saw the average qualified nurse vacancy rate, per ward, for the past twelve months, was 4.64%. For Health Care Assistants the figure was 3.11%. The average staff turnover rate for the same time period was 14.76%. These figures are what we would expect compared to the national averages for the same period.
- Staff told us, and the duty rotas we saw confirmed that there was always an experienced member of staff on duty on the ward. Most patients told us that there were not always enough staff on duty and they did not always receive one-to-one time with their nurse because of this. This was being mitigated on one of the wards by having diarised regular 1:1 time with patients every day, but this was not recorded on all the wards.
- We were informed by various members of staff and ward managers that the staffing difficulties arose from a combination of staff sickness, along with staff recruitment and retention. From the information we saw, the staff sickness average was 4.99% for past twelve months. This figure is in line with the national average of 4.78% for mental health services for March 2015
- Processes were in place to manage staff sickness, which included the involvement of the human resources and occupational health departments. We were told that recruitment to vacant positions was on-going and a

Requires improvement

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number of newly qualified nurses had recently been appointed. We were told by all of the managers that they felt the trust was trying to support the wards in managing the recruitment problems.

- There were enough staff on duty on the days we visited to ensure the physical observation charts on the wards we visited were being filled out effectively.
- We were told that there is adequate medical cover and we were not made aware of any issues in accessing medical cover out of hours. The wards have consultants allocated to them with the addition of out of hours duty Doctor cover.

Assessing and managing risk to patients and staff

- The records we reviewed showed us that most of the patients had individualised risk assessments completed on admission and these were mostly updated every two weeks.Staff told us that where particular risks were identified, such as a risk to self or to others,measures were put in place to ensure that the risk was managed. If risk levels changed, for example if there was a clinical incident then the risk assessments were updated sooner. Overall the individualised risk assessments we reviewed had taken into consideration a detailed account of the patient's previous history as well as their current mental state. Most patients' risk assessments covered aspects of their health including medication, psychological therapies, physical health and activities. These were usually updated at ward reviews, care programme approach (CPA) meetings or after an incident.
- There were blanket restriction around accessing the gardens on Vaughan Thomas, Wintle Phoenix and Ruby wards for safety reasons, but this was not identified as a risk in risk assessments
- All staff were able to describe what actions could amount to abuse. They were able to apply this knowledge to the patients who used the service and described in detail what actions they were required to take in response to any concerns.
- The trust provided information stating there had been 86 incidents of the use of seclusion within the last six months 49 of which were at the PICU at Ashurst Ward.
- Vaughan Thomas Ward, Sapphire Ward, Ruby Ward and the PICU at Ashhurst Ward, had seclusion facilities. Phoenix Ward, Allen Ward and Wintle did not have seclusion facilities. We looked at the seclusion records on the wards that had seclusion and found them to be satisfactory.
- The trust provided information stating that there had been 255 incidents of restraint in the last six months and that 41 of those had used restraint in the prone position. Prone position restraint is when a patient held in a face down position on a surface and is physically prevented from moving out of this position. The latest Department of Health guidance states if such a restraint is unintentionally used, staff should either release their holds or reposition into a safer alternative as soon as possible. Each incident of restraint was recorded using the trust's incident reporting system.
- When we discussed the use of prone restraint with the staff we interviewed, we received differing views on how frequently prone restraint was used. Most of the staff we spoke to told us that they did not regularly use prone restraint or had not witnessed it being used. When we spoke to one manager we were told that staff members tick the box on the incident reporting system that indicates prone restraint was used but when we reviewed the full descriptions of incidents in the notes it was clear on several occasions that it had not involved prone restraint. This meant that there may be an error in the way information is being taken from the incident recording system.

Track record on safety

- Most of the staff we spoke with told us that the trust had taken steps to actively review the training of restraint and we saw a paper the trust had completed indicating a planned move to a form of training that was much more focused on de-escalation. This meant that the trust had looked at how to improve this issue and make the wards safer for the patients and the staff. This new method of physical management was not being used by the staff at the time of the inspection.

Reporting incidents and learning from when things go wrong

Requires improvement

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- Staff we spoke with were able to describe Ulysses, the electronic system to report incidents and understood their role in the reporting process. We saw each ward had access to an online electronic system to report and record incidents and near misses.
- Staff were able to describe the various examples of serious incidents which had occurred within the services. The trust told us that there was a local governance process in place to review incidents. The staff on Vaughan Thomas ward described how an incident involving a patient bringing a replica weapon into the hospital environment had affected a change in local procedure and had instigated more joint working with the local police force to ensure the risk of this incident occurring again was minimised.
- Discussions had occurred locally at weekly" learning from incidents" meetings about trust-wide incidents. There were also weekly multi-disciplinary meetings which included a discussion of potential risks relating to patients and how these risks should be managed.
- Each of the ward managers we spoke with told us how they provided feedback in relation to learning from incidents to their teams on a weekly basis.

Are services effective?

Requires improvement

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

- We looked at 43 sets of care records for patients receiving care and treatment in the acute wards and Ashurst the psychiatric intensive care ward. Patients' needs were being assessed. However, 16 of the care plans we saw were not personalised and did not include patients' views. These care plans were not holistic, for example, they did not include the full range of patients' problems and needs. We found on all wards apart from Allen and Wintle that the care plans were not recovery orientated; for example, they did not include the patients' strengths and goals.
- On Allen ward we found the care plans we reviewed to be satisfactory. They were personalised including patients' views, holistic including the full range of the patient's problems and recovery orientated. The staff told us they had attended recovery star training and had focussed their care plans on the recovery star model. We saw on Allen ward, that it had been recorded that patients had been given a copy of their care plans. Half of the patients told us they had received a copy and half told us they had not.
- Of the 43 sets of care records, we saw 29 occasions where it had not been recorded that the patient had been given a copy of their care plan.
- Most of the 37 patients we spoke to told us they had not been offered and did not have a copy of their care plan in their possession.
- A new electronic records system had been recently introduced across the trust. Information, contained within this system was shared between the wards, home treatment teams and other community teams. However some paper records still existed on the wards. The combination of paper and electronic records was being managed effectively.
- Patient's physical health needs were being identified. The majority of patients spoken with told us, and records sampled showed, that patients had a physical healthcare check completed by the doctor on admission or soon after and their physical healthcare needs were met. Physical health examinations and assessments were documented by medical staff following the patient's admission to the ward.
- When physical health assessments were being refused by the patient the wards were making repeated attempts to engage the patient in the assessment and this was being recorded.
- On-going monitoring of physical health problems was usually taking place. All records we sampled included a care plan that showed staff how to meet patients' physical needs. These care plans tended to be in detail and specific to the patient. A system called Modified Early Warning System (MEWS) was being used across the wards to maintain checks on patient's physical health.

Best practice in treatment and care

- We saw multi-disciplinary team meetings and ward rounds were happening regularly and provided opportunities to assess whether the documented care plan was achieving the desired outcome for patients.
- We were informed by both medical and nursing staff that relevant national guidance was followed when providing care and treatment. This included guidance from the National Institute of Clinical Excellence (NICE) and national prescribing guidelines.
- Outcomes for patients using the services were monitored and audited by the service. This included the monitoring of key performance indicators such as length of stay, the use of control and restraint, and rapid tranquilisation. We received mixed feedback from the patients we spoke with about the quality of the care and treatment they had received. Overall, the feedback was positive. However, some patients we spoke with commented about the lack of one to one time with their nurse and lack of activities within the wards.
- Wards had physical health care leads and we were told by staff that there are regular meetings on the wards to discuss the delivery of physical health care with the patient group. On Vaughan Thomas ward there was a weekly physical healthcare clinic with a doctor and a nurse to see specific patients regarding their on-going healthcare needs but also for patients to be able to drop in to discuss any new issues.

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- The wards had a programme of scheduled audits which were being carried out in line with the trust wide audit programme. We also were told by medical staff on the wards that they were involved in specific best practice audits in relation to physical healthcare requirements such as venous thromboembolism audits.

Skilled staff to deliver care

- The wards had a full range of mental health disciplines providing input into the wards including nursing and health care assistants, occupational therapists, activity workers, consultant psychiatrists and junior doctors, pharmacists and pharmacy technicians. The wards also all had one day a week available from the psychology team.
- We were told that there was a variety of mandatory training available for staff. This included courses in, for example, care programme approach (CPA) and clinical risk management, dual diagnosis and information governance. We noted that there was no specific training in relation to the Mental Capacity Act 2005 but we were told this was covered in the induction training for new staff.
- New permanent staff underwent a formal induction period. This involved attending a corporate induction, learning about the ward and trust policies and a period of shadowing existing staff before working alone. A number of newly qualified nurses told us of a well-structured and in-depth preceptorship programme. Preceptorship is a period of time in which to guide and support all newly qualified practitioners to make the transition from being a student. This helps to develop practice.
- The staff were enthusiastic about the amount of additional training available to them through the trust and we spoke to several support workers who had been supported to carry out phlebotomy training. This meant they could take bloods when required. There was also access to physical health care training, a supporting self-harm course, a supporting bereavement course and a course in supporting people suffering from emotionally unstable personality disorder.
- We were told that bank and agency staff underwent a basic induction including orientation to the ward, emergency procedures such as fire and a handover about patients and current risks.
- The information provided by the trust indicated that across the whole of the adult directorate 84% of staff had an up to date appraisal in place at the time of our inspection.
- Most of the staff told us they had access to supervision on a regular basis, although the data available from the trust indicated this had been not been happening regularly for most staff. Figures provided by the trust showed that in September 67 out of 184 staff had supervision. The ward managers and staff also told us that informal supervision took place regularly, though this was not documented.
- Staff described receiving support and debriefing from within their team following any serious incidents.
- All staff told us there were regular team meetings and reflective practice sessions and staff felt well supported by their immediate managers and colleagues on the wards. Staff across the majority of the wards had high moral and enjoyed working for the trust.

Multi-disciplinary and inter-agency team work

- All wards had a multi-disciplinary team handover meeting at 09.00 daily and a twice weekly ward round.
- We observed multi-disciplinary meetings during our inspection and found these effective in enabling staff to share information about patients and review their progress. Professionals worked together effectively to assess and plan patients' care and treatment.
- Occupational therapists and psychologists worked as part of each team and we saw that they worked closely with patients. The patients we talked with spoke positively about this. We were told that patients can self-refer to the psychologist.
- The consultant and medical staff were a regular presence on the wards and were present at all times during our inspection. We observed good interaction between the ward staff and medical teams on the wards.
- We saw how community teams were invited and attended discharge planning meetings and patients we spoke with told us these were supportive. The wards work closely with the community Stepped up care model which has replaced the community crisis teams,

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to help to prevent re-admission to hospital. This means that the majority of mental health services are being provided in the community in people's homes, GP surgeries or in community clinics.

- We observed several well-structured and detailed handovers from one day shift to another. Each ward had replaced patient white boards with electronic "patient safety at a glance" monitors in the offices. This alerted staff to vital information about the patient group and this information was reviewed during the handover process. The wards also used the "situation, background, assessment, recommendation" (SBAR) tool for handover. The SBAR handover is an NHS initiative designed to frame critical conversations, to develop teamwork and foster a culture of patient safety.

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

- We checked whether systems were in place to ensure compliance with the Mental Health Act 1983 (MHA) and adherence to the guiding principles of the MHA 1983 Code of Practice 2015.
- We saw evidence across most of the wards that patients had received their rights (under section 132 of the MHA) regularly and that these were being repeated at regular intervals. However on Vaughan Thomas ward we found two examples of rights not being read until six weeks and three weeks respectively after a person had been detained. This meant that people were not always being informed of their rights under the mental health act after admission. This had not been picked up during mental health administration audits which meant that paperwork was not always being reviewed effectively...
- On each ward, we found that MHA paperwork had been completed correctly. There was administrative support to ensure paperwork was up to date and held appropriately. There was a clear process for scrutinising and checking the receipt of MHA paperwork. We found overall that the MHA record keeping and scrutiny was satisfactory.
- We saw posters on all wards which displayed information telling patients of how to contact the independent mental health advocate (IMHA) and how to complain to the Care Quality Commission.
- The staff we spoke with had a good working knowledge of the MHA in relation to the patient group they were supporting.
- All wards visited had information available on all exits informing patients not detained under the MHA what to do if they needed to exit the wards. We observed staff member having discussions with informal patients when they wanted to exit the ward.

Good practice in applying the Mental Capacity Act

- Mental Capacity Act (MCA) training is included in the trusts mandatory corporate induction programme, and this is updated as part of the Mental Health Act (MHA) refresher training every 3 years
- When we spoke with staff there was varying degrees of knowledge about the MCA and Deprivation of Liberty Safeguards (DOLS).
- None of the patients receiving care and treatment during our inspection were under a DOLS however we saw evidence in care notes of when DOLS authorisations had been considered.
- The care records we viewed showed that patients' mental capacity to consent to their care and treatment was always assessed on their admission or an on-going basis. There was good documentation of the assessment of mental capacity in all care records.

Requires improvement

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

- We spoke with 37 patients receiving care and treatment in the acute wards and PICU. We observed how staff interacted with patients throughout the three days of our inspection. We received mostly positive feedback from patients, through speaking with them and reviewing the comments cards, about the care they received.
- On all of the wards we found relaxed and friendly environments.
- On Vaughan Thomas Ward and Wintle Ward most of the viewing panels in the doors to patient's bedrooms were found to be left open, meaning that patients were able to see into each other's rooms when passing which impacted on their privacy and dignity when they were in their rooms.
- On Allen Ward some patients told us that the staff were nice, friendly and approachable whereas others told us that staff can be patronising at times. At night it was reported that staff usually knock at bedroom doors before entering. We saw evidence on the ward of positive interactions between staff and patients, with staff engaging patients in a respectful and inclusive way.
- On Phoenix ward we didn't observe a lot of interaction between staff and patients happening on the ward. We observed that patients were congregating outside the nursing office. Some staff and patients commented that many staff spend too long in the office. Patients generally told us that staff were nice, friendly and observant but one patient told us night staff could be rude sometimes and they often felt ignored by them. One patient felt that there was no encouragement on the ward and staff needed to involve people more. Some patients told us that staff wake them abruptly by pulling the quilt off them or wake them to try to get them to take medication. Patients told us that medical staff were generally good but aside from the ward rounds they are not able to see their consultant.
- On Wintle Ward we did not observe patients to be engaged in therapeutic activity with staff. When we spoke to patients they told us that they found items missing from their rooms as they kept their doors unlocked as they didn't have a key to their room. We were told that staff members always knocked on their door before coming in and that staff were kind and respectful.
- On Ashurst Ward the PICU the majority of patients told us they felt safe on the ward and they felt the ward was clean and tidy. Most of the patients we spoke to felt the staff woke them up during the night when performing night checks by turning their main light on, but they understood the reason why the staff had to check.
- On Vaughan Thomas Ward the patients told us they were happy with their care and felt the staff were kind and supportive. The patients reported concerns around not being able to lock their bedroom doors without staff support. The patients told us there was always lots of activity happening on the ward and that they felt supported to access the chaplain regularly.
- On Ruby Ward the patients told us they felt the ward was not clean. We were told by several of the patients that they felt there were too many temporary workers and staff spent too much time in the office. We were told that one patient had money go missing from their room and they had stopped asking for their bedroom to be locked as you had to "find a member of staff" and they were always "too busy" and would tell you "in a minute".
- On Sapphire Ward the patients told us they felt supported by the staff and were able to hold their own mobile phones on the ward. People told us they felt safe on the ward and staff were quick to manage a situation when it occurs. Patients told us that it can be a problem finding a staff member to lock their door when they leave their room.
- During the inspection week we observed many examples of staff treating patients with care, compassion and communicating effectively. We saw staff engaging with patients in a kind and respectful manner on all of the wards.
- Staff had an understanding of the personal, cultural and religious needs of patients who used the service and we saw examples of actions taken to meet these needs such as making arrangements for patients to visit their local religious centres and ensuring there was culturally appropriate food available when it was required.

The involvement of people in the care they receive

Requires improvement

Are services caring?

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

- Patients received orientation to the wards when they were first admitted and most wards had a dedicated welcome pack which staff went through with the patient and an additional pack was available for parents or carers if applicable. On the wards where patient packs were not available we saw there was information leaflets around the ward and in prominent positions in the communal areas of the ward. The patient pack contained information relating to the care programme approach (CPA) process, access to advocacy, and guidance about the philosophy of the ward as well as information about spiritual and pastoral care.
- We saw very limited evidence of patients' views in their care plans. We received mixed feedback from patients about their involvement in the care they receive. The majority of patients told us that they had not been involved in their care planning and 35 of the 37 patients told us they had not received a copy of their care plan.
- All patients spoken with told us they had opportunities to keep in contact with their family where appropriate. Visiting hours were in operation. We saw dedicated areas for patients to see their visitors.
- Information about the independent advocacy service was available on notice boards across all wards apart from Phoenix ward where this was not evident. On Phoenix ward we were told by staff that the patients were routinely approached and informed about how to access an advocate. There was a nominated advocate who visited the ward. Patients told us that they had not been approached regarding access to advocacy.
- We saw that patients were actively involved in the "you said we did" meetings on the wards which showed that patients were able to actively participate in decision making processes on the wards. Issues around meal choices on the wards were regularly brought up and we could see evidence that the wards were taking steps to make changes based on the patient requests.

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

- Staff told us that there was often a problem finding beds for patients who needed an admission. Our intelligent monitoring flagged this as a risk as bed occupancy across the trust stood at 85%, occupancy levels for individual wards were:
  - Ashurst ward 88%
  - Vaughan Thomas 95%
  - Wintle 97%
  - Ruby, Allen and Phoenix ward 98%
  - Sapphire ward 99%
- It was frequently necessary to admit other patients into the beds of patients who were on short term leave.
- All wards confirmed that leave beds were being used for admission. This meant that if someone had to return from leave in an emergency they would not necessarily be able to return into the bed on the ward nearest to their catchment area.
- Staff told us there could be delays if patients needed to be transferred to more appropriate care facilities, such as Ashurst Ward, the psychiatric intensive care unit (PICU) if there were no beds available there.
- On most wards staff told us there was a high rate of delayed discharges due to difficulties in finding appropriate accommodation. There were eight patients in across the acute wards who had been on the ward for over one year waiting for discharge. This was an improving situation. and we were told that the trust had initiated working with the private and voluntary sector to move people back in to the community. Social workers regularly visited the ward rounds and supported with the challenges faced by the wards in relation to finding appropriate "move on" services.

The facilities promote recovery, comfort and dignity and confidentiality

- We saw the gardens leading from each ward. There were blanket restriction around accessing the gardens on Vaughan Thomas, Wintle Phoenix and Ruby wards. This meant that patients were not able to access fresh air or a garden space unless there was a member of staff free to support them. Patients on these wards told us that there were not always staff available to enable this to happen. Some of the wards operated a plan to allow the gardens to be opened for half an hour every two hours with a member of staff supervising; again patients told us that there were not always enough staff to enable this to happen. Managers told us that the reason for the blanket restriction was due to the risk of ligatures in the garden areas and the risk of patients absconding. Only the ligature audit for Ashurst identified the garden area as having ligature risks and all other wards were rated as low risk so this needed to be reviewed by the trust.
- Across all the wards patients told us they were unable to lock their rooms. All bedrooms, including those in the newer building at The Buckingham Health and Wellbeing Centre, were key locked and staff members carried master keys to enable them to access all rooms. This was a blanket restriction as none of the wards enabled patients to have risk assessed access to a key for their room. This meant that patients had to find a staff member when they left their room to ensure it was locked. Patients told us they felt their property was not safe in their rooms and that items had gone missing from their rooms.
- Whilst patients had access to lockable storage spaces on the wards, they did not have the keys for such storage and had to approach a member of staff. This blanket rule was not based on individually assessed risk.
- We saw each ward had a full activity programme. This programme included activities such as yoga, relaxation, employment, creative writing, gym, walking group, Tai Chi, community meetings, baking, gardening and managing emotions. The OT and activity co-ordinators worked across shifts to enable them to plan and provide evening and weekend activity across all wards. We observed inclusive and appropriate activity sessions happening in Ruby and Sapphire wards. Most of the patients told us they were happy with the choice and amount of activity available to them.
- Not all wards had activity rooms and those that didn't had a dedicated space allocated in the lounges and made available for this purpose. On Phoenix ward we saw good resources available to patients including a Kiln, music room and an arts and crafts room.
- Wards had locks on the main entrances with entry and exit controlled by staff. Staff carried personal alarms.

Are services responsive to people's needs?

Good

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

During our inspection, we were offered personal alarms on some wards, but not on other wards. On Phoenix ward this was due to their being not enough alarms available for staff and visitors.

- The wards had different protocols in place in relation to patients accessing personal mobile phones. This meant that access to mobile phones, for instance, could be available on one ward and limited on another. This was not based on individual risk assessment but was because different wards had different policies on this.
- All wards had a portable phone for patients to be able to access when required to make personal calls.
- Patients told us the food on the wards was generally good but they would like more choice. We were told by domestic staff that due to the ordering requirements, the wards over ordered food to ensure that there was enough of the two hot meal choices for patients. However, food was served on a first come, first serve basis. This meant that patients were not able to make a real choice as to what they wanted for a meal. We were told that staff knew what patients liked so ordered those choices for them. Even though staff felt they were doing this in the best interests of patients it meant that people were having their choices restricted. The trust should consider how to make this more of an inclusive process.
- Staff told us that there was a dietician available within the trust that they could refer to regarding appropriate dietary needs for the patient group.
- All wards had areas available to patients where they could make hot or cold drinks 24 hrs. a day and during the inspection we saw patients were freely accessing these areas. Patients confirmed that they were able to make drinks or snacks in this kitchen area when they wanted.
- We saw very little personalisation of bedrooms across any of the wards. Some patients had a small number of photos in their rooms but little else. We were told by staff that patients were not discouraged from personalising their rooms but patients told us they felt they were not able to and were concerned about their photographs and property going missing from their rooms as they were unable to lock them.
- Patient led assessment of the care environment (PLACE) is the NHS system for assessing the quality of the patient environment. The assessments involve local people go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job.
- Littlemore Mental Health Centre scored above the national average for their PLACE scores. Warneford Hospital scored below the national average in organisational food and privacy, dignity and wellbeing. The Buckingham Health and Wellbeing Centre scored below the national average in food overall and organisational food.

Meeting the needs of all people who use the service

- Spiritual care and chaplaincy was provided when requested. We saw there was a range of choices provided in the menu that catered for patients dietary, religious and cultural needs.
- Staff told us that interpreters were available using an interpreting service. These services had been used to assist in assessing patients' needs and explaining their care and treatment.
- The trust communication team can provide leaflets in a range of languages on an adhoc basis when required by the wards.

Listening to and learning from concerns and complaints

- All the wards accessed the trust's electronic system for complaints management. This Information about the complaints process was then made available on notice boards. Patients we spoke with knew how to make a complaint both through the ward based local complaints processes and through the Patient Advice Liaison Service (PALS).
- Complaints were recorded using the trust's computerised incident reporting system. We saw it evidenced how the issues were investigated, what outcomes and any learning were. The ward managers told us they shared learning amongst their staff via staff meetings and communications.

Are services well-led?

Requires improvement

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

- Few of the staff we spoke with were aware of the trust vision and values. We were told by staff that these were available on the trust's intranet system.
- Staff we spoke with were able to tell us who the most senior managers in the trust were. Staff told us that senior staff within the trust had visited the wards. These included the chief executive and various executive directors.

Good Governance

- The June 2015 directorate quality improvement plan identified that areas for improvement will be highlighted with the directorates clinical governance forums, clinical management and team meetings. Progress on the plan will be monitored on all areas performing below the above threshold mark. During the inspection the ward managers were not able to provide us with an up to date picture of how the wards were performing and could not provide a plan of where improvements were required. We did not see evidence on the wards that the quality improvement plan was being addressed.
- Incidents were reported through Ulysses (the trust's electronic incident reporting system). We saw examples of incident records to show that this recording was not always accurate particularly in the case of information relating to the recording of prone restraint. We saw how the process of incident reporting was reviewed by the local governance structures with the modern matrons.
- The ward managers confirmed that they have sufficient authority to manage their ward and some managers received administrative support in human resources and in electronic rostering.
- All managers and staff told us that they received a good level of support from their immediate manager and other local senior managers.
- Local governance arrangements were not robust. We had concerns about the governance of this core service, we saw from reviewing the local business meeting minutes that issues were identified by patients and staff at a ward level and discussed with the ward based teams. It was not evident in the minutes of the business meetings how the trust agenda for improvement was being rolled out and how the ward staff were being involved or whether staff had the opportunity to comment back to the board of directors of the trust. We had concerns about the robustness of the governance arrangements in relation to monitoring and mitigating risks of ligatures in the patient care areas. Whilst ligature risk assessments and action plans were in place, the associated action plans were generic and the actions were identified as "observation levels and environmental checks"
- We had concerns about the robustness of the governance arrangements in relation to assessing, monitoring and improving the quality of care plans. Whilst we saw regular care plan audits were undertaken and information extracted from the care notes system. The actions did not seem to improve practice. For example, we saw limited evidence of patient's involvement in care plans and almost all of the patients reported that they did not have a copy of their care plan.
- We found the governance system, in place, relating to the Mental Health Act 1983 (MHA) was robust. MHA paperwork had been completed correctly, was up to date and held appropriately. The MHA record keeping and scrutiny was satisfactory.
- Staff told us they received individual email bulletins from the trust detailing key points from investigations across the trust but there was little evidence in the business meetings that this information was being discussed within teams.
- The trust provided information from their "essential standards" self-assessment tool which indicated that they were taking steps to identify key areas requiring improvement however we were not provided with any action plans detailing how the wards were intending to improve in the areas identified.

Leadership, morale and staff engagement

- On a day to day basis,the wards appeared to be well managed. We were told by staff that the ward managers were highly visible on the wards, approachable and supportive. We were impressed with the morale of the staff we spoke with during our inspection and found that the local teams were cohesive and enthusiastic. We were impressed with the support from the local modern

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matron structure and were told this new level of management was having a positive impact on the wards. We saw a positive working culturewithin the teamswhich we inspected.

- Staff we spoke with told us that they felt part of a team and received support from each other.
- The ward managers on all wards confirmed that there were no current cases of bullying and harassment involving the staff.
- We were told by the ward managers and the staff that there was a positive standpoint from the trust in relation to training for all staff and in particular the development of the “Leading the way 2” leadership development training for nurses and managers.

Commitment to quality improvement and innovation

- All wards had achieved Royal College of Psychiatrists accreditation for inpatient mental health services.

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 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Person-centred care.** The trust are not effectively ensuring that the care and treatment of patients is appropriate, meets their needs, and reflects their preferences. · Overall, care plans were not personalised and did not include patients' views, nor were they recovery orientated, for example, they did not include the patients' strengths and goals. · Patients were not routinely involved in devising their care plan and had not received a copy of their care plan. · There were blanket restrictions in place on some wards. These included access to the gardens, and ability to lock bedrooms. **Regulations 9(1)(a)(c), 9(3)(a)(b)(d)(f).**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Good Governance.**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Staffing** · For September 2015: 67 out of 184 staff had a supervision recorded. This meant that people employed were not receiving appropriate supervision. **Regulation 18 (1)(a)**

The systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients who may be at risk which arise from the carrying on of the regulated activity, and systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services), are not operating effectively.

· Systems were in place to check the quality of the care plans, for example, we saw evidence of care plan audits. However, such systems did not identify and remedy the limitations in the quality of the care plans.

· Systems were in place to identify and manage ligature risks in the patient care areas, for example, we saw evidence of ligature risk assessments and action plans. However, such systems were generic and did not identify specific management strategies relating to ligatures.

Regulations 17(1), 17(2)(a)(b)(f).

This section is primarily information for the provider

Requirement notices