Requires improvement

Oxford Health NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

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Date of inspection visit: 28 September to 2 October 2015
Date of publication: 15/01/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RNU10	Oxford Health NHS Foundation Trust - HQ	Aylesbury AMHT	HP20 1EG
RNU10	Oxford Health NHS Foundation Trust - HQ	City and North East AMHT	OX3 7JX
RNU10	Oxford Health NHS Foundation Trust - HQ	South AMHT	OX10 9DU

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement 
Are services safe?	**Good** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
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

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Summary of findings

Overall summary

We rated community-based mental health services for adults of working age as requires improvement because:

- The City and North East assessment function team had assessments and care plans which were in date, however some of the plans were not detailed enough and none were adequately person centred with clear goals. This applied to patients that the assessment function team had been working with for over their targeted time of four weeks.
- Aylesbury team had care plans that were not detailed enough. They did not address all the needs identified in the assessment stage. The care plans were not person-centred and did not have clear goals.
- The teams had a long waiting list for patients to receive psychological therapies recommended by National Institute for Health and Care Excellence as part of their treatment. There was a waiting list of over a year to receive specialised psychological therapies; some patients received psychological therapy interventions delivered by AMHT staff whilst waiting for more specialist support.
- The City and North East team told us that morale was low in the team due to staffing levels, workload and high staff turnover. Staff told us that they worked over their agreed hours weekly in order to cope with the workload.
- The management did not continuously review and adapt to respond to the changing needs of staffing levels.
- Records showed that the average rate for completed staff mandatory training for City and North East team was 68% for treatment function staff.
- The percentage of non-medical staff that received an appraisal in the last 12 months was 50% for City and North East team.

However:

- The units had clinic rooms equipped with all required emergency equipment such as automated external defibrillators and oxygen. Staff checked equipment regularly to ensure it was in good working order, so that it could be effectively used in an emergency.
- All teams carried out risk assessments on every patient at the initial assessment. This took account of previous medical history, risk, social and health factors. Staff regularly reviewed them.
- The teams had arrangements in place to respond to any sudden deterioration in a patient's mental state. The teams would provide an emergency assessment by two professionals from the assessment function team within four hours.
- The teams had an effective way of recording incidents, near misses and never events. They knew how to recognise and report incidents through the reporting system. Staff were open and transparent and demonstrated that the outcomes of incidents were explained to patients and their families.
- Records showed that the teams assessed and supported patients with their physical health care needs. They carried out health checks and monitored prescribed antipsychotic medication for any undesirable outcomes.
- Staff carried out a range of regular clinical audits such as care records, care programme approach and medicines to monitor the effectiveness of the service provided. The results were used to identify and address changes needed to improve outcomes for patients.
- Staff told us they had undertaken training relevant to their role. Staff had received training in areas such as autism awareness, psychosocial interventions, and clinical risk assessment.
- All teams had regular and effective multi-disciplinary team meetings that discussed patients' needs in detail to ensure that patients got the treatment they needed. These meetings involved doctors, nurses, social workers, occupational therapists, support workers and housing officers.
- We observed good interactions between staff and patients. Staff were polite, kind, respectful and compassionate.

Summary of findings

- Patients and their families were highly positive about the attitudes of staff and the support that they received. Staff showed that they understood the individual needs of patients and could describe how they supported patients with complex needs.
- Staff involved patients in their clinical reviews and care planning and encouraged them to involve relatives and friends if they wished.
- The teams could respond on time and effectively when patients required crisis and routine care. All teams could see patients on emergency referrals within four hours at any time of the day.
- Staff provided patients with accessible information on treatments, local services, patients' rights, advocacy services, carer support, how the services were run and how to complain.
- Patients knew how to raise concerns and make a complaint. Patients told us they felt they would be able to raise concerns should they have one and were confident that staff would listen to them
- Staff knew and agreed with the trust's values. Staff knew who the most senior managers in the trust were. These managers had visited the teams.
- Staff told us that they knew how to use the whistle blowing process and felt free to raise any concerns.
- The trust used key performance indicators and other measures to gauge the performance of the team. Where performance did not meet the expected standard action plans were put in place.
- Staff told us the board kept them informed about developments through emails and intranet.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- All units had interview rooms that were fitted with alarm systems. Staff took a personal alarm when using the interview rooms to call for help when needed. This helped to ensure the safety of patients and that of staff.
- The units had clinic rooms equipped with all emergency equipment such as automated external defibrillators and oxygen. Staff checked equipment regularly to ensure it was in good working order, so that it could be used effectively in an emergency.
- All teams carried out risk assessments on every patient at the initial assessment. This took account of previous medical history, risk, social and health factors. Staff regularly reviewed them.
- The teams had arrangements in place to respond to sudden deterioration in a patient's mental state. The teams would provide an emergency assessment by two professionals from the assessment function team within four hours.
- Training records showed that staff received safeguarding training. They demonstrated a good understanding of how to identify and report any abuse.
- The teams had an effective way of recording incidents, near misses and never events. They knew how to recognise and report incidents through the reporting system.

However:

- Staff in the City and North East team told us that they worked over their agreed hours weekly in order to cope with the workload.
- Records showed that the average rate for completed staff mandatory training for City and North East team was 68% for treatment function staff.
- The South team did not consistently record the temperatures of the medicines fridge and clinic room. This meant that the storage of medicines was not effectively monitored to ensure that they were stored within the required temperatures.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

Summary of findings

- None of the eight records that we looked at for patients of the City and North East assessment function team had care plans in place that followed needs identified from the assessment. This applied to patients that the assessment function team had been working with for over their targeted time of four weeks.
- Aylsebury team had care plans that were not detailed enough. They did not address all the needs identified in the assessment stage. The care plans were not person-centred and did not have clear goals.
- The teams had a long waiting list for patients to receive psychological therapies recommended by National Institute for Health and Care Excellence as part of their treatment. There was a waiting list of over a year to receive psychological therapies.
- The percentage of non-medical staff that received an appraisal in the last 12 months was 50% for City and North East team.
- Records were not well organised and different team members could not access patients' records when needed. Staff had difficulties in identifying where certain care plans and records were located in the new electronic records system.

However:

- We looked at 32 records across all teams and they contained a comprehensive assessment of needs that had been completed when patients were admitted.
- Records showed that the teams assessed and supported patients with their physical health care needs. They carried out health checks and monitored prescribed antipsychotic medication for any undesirable outcomes.
- Staff carried out a range of regular clinical audits such as care records, care programme approach and medicines to monitor the effectiveness of the service provided. The results were used to identify and address changes needed to improve outcomes for patients.
- Staff told us they had undertaken training relevant to their role. Staff received training in areas such as autism awareness, psychosocial interventions, and clinical risk assessment.
- All teams had regular and effective multi-disciplinary team meetings that discussed patients' needs in detail to ensure that patients got the treatment they needed. These meetings involved doctors, nurses, social workers, occupational therapists, support workers and housing officers.

Summary of findings

- The teams had good working links with the external organisations. They had effective partnership working with GPs, acute hospitals, independent organisations, local authorities, police, housing associations and the citizens advice bureau.
- The teams demonstrated good practice in adhering to the Mental Health Act (MHA) and the MHA Code of Practice and applying the Mental Capacity Act.

Are services caring?

Good

We rated caring as good because:

- We observed good interactions between staff and patients. Staff were polite, kind, respectful and compassionate.
- Patients and their families were highly positive about the attitudes of staff and the support that they received. Staff showed that they understood the individual needs of patients and could describe how they supported patients with complex needs.
- Staff involved patients in their clinical reviews and care planning and encouraged them to involve relatives and friends if they wished.
- Staff carried out formal carers' assessments or referred carers to be assessed by an independent voluntary organisation. Families and carers were provided with support where it was appropriate.
- Staff gathered the views of patients through surveys and patient forums. The responses of patients were fed back to staff, to enable them to make service changes where needed.

However:

- Patients told us that staff did not give them copies of their care plans and we did not see copies of care plans signed by patients.
- Staff spoken with in the Aylesbury team were not aware of how to access advocacy services for patients. Patients and their families told us that they were not aware of how to access advocacy services when needed.

Are services responsive to people's needs?

Good

We rated responsive as good because:

Summary of findings

- The teams had clearly outlined referral pathways and set out clear lines of responsibilities, time-frames and actions to be taken. The referrals were triaged into three groups; emergency to be seen within four hours, urgent to be seen within seven days and routine to be seen in 28 days.
- The teams could respond on time and effectively when patients required crisis and routine care. All teams could see patients as emergency referrals within four hours at any time of the day. The teams achieved their targets to see patients that were on urgent and routine referrals.
- Staff rarely cancelled appointments and where there were cancellations patients were seen at the earliest possible opportunity. Staff maintained their appointment times and when they were running late patients were informed.
- Staff provided patients with accessible information on treatments, local services, patients' rights, advocacy services, carer support, how the services were run and how to complain.
- The teams had information leaflets in different languages that were spoken by patients. This meant that non-English speaking patients could be informed of how the services were run.
- Patients knew how to raise concerns and make a complaint. Patients told us they felt they would be able to raise concerns should they have one and were confident that staff would listen to them.

However:

- The Aylesbury and South teams did not record verbal complaints raised with the team so that trends and themes could be analysed.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The team at City and North East reported low morale due to pressure of workload and high turnover of staff. Staff told us they felt demoralised by concerns over staffing levels. The management did not continuously review and adapt to respond to the changing needs of staffing levels.
- The inspection team identified areas where improvements were needed. The areas that were not monitored effectively were care plans, staffing levels, staff morale, high staff turnover, mandatory training for staff, and staff appraisals.

However:

Summary of findings

- Staff knew and agreed with the trust's values. Staff knew who the most senior managers in the trust were. These managers had visited the teams.
- Staff told us that they knew how to use the whistle blowing process and felt free to raise any concerns.
- Staff told us that they were supported by their line managers at team level and were encouraged to access clinical and professional development courses. They told us that managers were accessible to staff, approachable and promoted a culture of openness.
- Staff were offered the opportunity to give feedback on services and input into service development through the annual staff surveys.
- The trust used key performance indicators and other measures to gauge the performance of the team. Where performance did not meet the expected standard action plans were put in place.
- Staff were open and transparent when things went wrong. Incidents were discussed with patients, their families and care managers.
- Staff told us the board kept them informed about developments through emails and intranet.

Summary of findings

Information about the service

The adult mental health teams were based at The Buckinghamshire Health and Wellbeing Centre (Aylesbury team), Wallingford hospital (South team) and Warneford hospital (City and North East team). The adult mental health teams operated seven days a week and provided both assessment and treatment service. The teams had two functions within the same team; one was assessment function team which was responsible for receiving referrals and would carry out a triage and assessment. The treatment team was responsible for providing care and treatment. The assertive outreach, crisis, home treatment, community mental health teams had been integrated into a single adult mental health team as part of remodelling work that started in April 2014. The team worked using a multi-disciplinary approach to support patients in their own homes to reduce inpatient admissions.

The teams worked closely with the psychiatric liaison services that were based at A&E department in John Radcliffe and Stoke Mandeville hospitals. They provided specialist assessment and treatment for patients that had medical and mental health problems who presented at A&E or were high users of acute hospitals.

The teams also worked with the street triage services that had a qualified mental health professional who worked alongside the police to provide an immediate assessment of anyone that presented as possibly having a mental health problem.

Our inspection team

The inspection team was led by:

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

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

and Substance Misuse, Care Quality Commission

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

The team that inspected this core service comprised one CQC inspector, one psychiatrist, one Mental Health Act reviewer, one expert by experience, one mental health specialist nurse and two social workers.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

Summary of findings

- visited Wallingford hospital, Warneford hospital, The Buckinghamshire Health and Wellbeing Centre and patients in their own homes and looked at the quality of the environments and observed how staff were caring for patients.
- spoke with 18 patients who were using the service and four of their relatives.
- spoke with the manager responsible for psychiatric liaison and street triage teams.
- spoke with 38 other staff members; including doctors, nurses, nursing assistants, psychologists, administrators, and social workers.
- interviewed six managers with responsibility for the community teams.
- attended and observed four handover meetings.
- looked at 32 care records of patients.
- attended three multi-disciplinary team meetings.
- attended one staff meeting.
- carried out a specific check of the medication management in the teams.
- looked at a range of policies, procedures and other documents relating to the running of the services.

What people who use the provider's services say

Patients told us that they were treated with respect and dignity. Staff were polite, kind and willing to help.

Patients and their relatives told us that staff always visited them on time for their appointments.

Patients said they felt able to ring the team when they needed them and staff always got back to them and were available in the evenings and weekends.

Patients told us that they discussed their care and treatment with staff but were not given copies of their care plans.

Patients told us that they attended their clinical review meetings and were encouraged to involve their relatives if they wished to.

Patients told us that they were given information about the services.

Good practice

There was nothing specific to note.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The trust must ensure that staffing levels are continuously reviewed and adapt to respond to changing needs to address staff morale, high turnover and workload to ensure patients' safety.
- The trust must ensure that all staff receive mandatory training and annual appraisals.
- The trust must ensure that all patients have care plans that have clear goals, up to date, person centred, holistic or recovery orientated that address needs identified in the assessment stage.
- The trust must ensure that patients have access to psychological therapies within a reasonable time frame.

Action the provider SHOULD take to improve

Action the provider Should take to improve

- The trust should ensure that temperatures of the medicines fridge and room in the Aylesbury AMHT are recorded consistently to ensure that medicines are stored within the required temperatures at all times.
- The trust should ensure that records are well organised and different team members can have easy access to patients' records when needed.

Summary of findings

- The trust should ensure that all staff know how to access advocacy services for patients.
- The trust should ensure that verbal complaints are recorded so that trends and themes can be analysed.

Oxford Health NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Aylesbury AMHT	Oxford Health NHS Foundation Trust - HQ
City and North East AMH	Oxford Health NHS Foundation Trust - HQ
South AMHT	Oxford Health NHS Foundation Trust - HQ

Mental Health Act responsibilities

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

Training records indicated that staff had received training and showed a good understanding of the Mental Health Act and the Code of Practice. Staff demonstrated awareness in relation to community treatment orders (CTO).

All teams had appropriately completed consent to treatment and capacity forms for patients on CTO and long term section 17 leave. The CTO documentation we reviewed was up to date, stored appropriately and compliant with the MHA and the Code of Practice. The community psychiatrist renewed and signed the section 17 leave forms for patients on long term leave.

Staff routinely explained patients' rights under the MHA and CTO. This ensured that patients understood their legal position and rights in respect of the MHA. Patients we spoke with confirmed that their rights under the MHA had been explained to them.

Staff knew how to contact the Mental Health Act team for advice when needed. This meant staff could get support and legal advice on the use of the MHA when needed.

Staff were aware of how to access and support patients to engage with the independent mental health advocacy when needed. Information on independent mental health advocacy services was readily available to support patients.

Detailed findings

The teams had not conducted any recent audits to ensure that the MHA was being applied correctly.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training records showed that staff had received training in the Mental Capacity Act. Staff demonstrated a good understanding of Mental Capacity Act and could apply the five statutory principles.

Staff were aware of the policy on Mental Capacity Act and knew the lead person to contact about Mental Capacity Act to get advice.

All teams assessed and recorded patients' capacity to consent. These were done on a decision – specific basis with regards to significant decisions. The teams documented detailed information on how capacity to consent or refuse treatment had been sought.

Staff supported patients to make decisions where appropriate. We viewed documents where patients lacked the capacity to consent. The teams conducted best interests meeting and decisions were made in patients' best interest, recognising the importance of their wishes, feelings, culture and history.

The teams did not have arrangements in place to monitor adherence to the Mental Capacity Act to ensure that it was being applied correctly.

Good

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 ward environment

- All units had interview rooms that were fitted with alarm systems. Staff took a personal alarm when using the interview rooms to call for help when needed. This helped to ensure the safety of patients and that of staff.
- The units had clinic rooms equipped with all required emergency equipment such as automated external defibrillators and oxygen. Staff checked equipment regularly to ensure it was in good working order, so that it could be used effectively in an emergency. They had rooms with examination couches to carry out any physical examinations.
- The units were clean, with appropriate furniture that was well maintained. The teams maintained a record of their cleaning schedule that showed that the environments were cleaned regularly.
- Staff practiced good infection control and hand hygiene procedures to protect patients and staff against the risks of infection. Staff carried out regular checks of infection control and prevention.
- Portable appliance tests were carried out regularly and consistently for all equipment used. This ensured that all equipment was safe to use and in good working order.

Safe staffing

- All teams consisted of care coordinators with a range of professional backgrounds such as social workers, nurses and occupational therapists. All teams were led by two band eight managers, one with operational and the other clinical responsibilities. The Aylesbury team had 33 care coordinators and six support workers. It had two vacancies for care coordinators and two for support workers. The South team had 29 care coordinators and five support workers. It had one care coordinator vacancy. The City and North East team had 38 care coordinators and seven support workers. It had four care coordinator vacancies.
- The sickness rate in the 12 month period for Aylesbury team was 6%, for South team 3% and for City and North East team was 8%. The staff turnover rate in the last 12 months for Aylesbury team was 2%, for South team 4% and for City and North East team was 20%.There were arrangements and use of bank and agency staff in place to cover staff sickness, leave and vacant posts. The City and North East team used 55%, Aylesbury 8% and South none of bank and agency to cover shifts in their assessment function team in the last three months. This showed that the City and North East assessment function team relied more on bank and agency staff compared to other teams. The City and North East team used 7% of bank and agency staff in their treatment function team compared to South and Aylesbury teams which used none in the last three months. The Aylesbury team had two agency staff and the City and North East team had four agency staff to cover shifts. Two of them had been with the team for over a year. Staff told us that staff did not stay within the City and North East team due to the amount of workload.
- The teams told us that they did not know how the number and grade of staff required had been estimated for each team. The Aylesbury and South teams felt the staffing levels in each team were appropriate to ensure patients' safety. The City and North East team told us that their staffing levels were not adequate to ensure patients' safety. Staff told us that they worked over their contracted hours weekly in order to cope with the workload. Some staff came to work on their days off, arrived early or left late and were regularly working over 60 hours a week due to workload. The managers told us that there had been a number of occasions when agency staff did not turn up for work without any notice and they had to pick up the workload urgently. Staff told us that they were burnt out and stressed. Staff told us that they were very busy that they could not attend training or complete the monitoring of all contacts with patients to demonstrate all activities carried out. The last NHS staff survey for the trust showed 89% of mental health nurses and other mental health professionals were working extra hours compared to the national

Good

Are services safe?

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

average of 71%. The survey also showed that pressure of work felt by staff was above national average. The staffing issues in this team were on the trust's risk register.

- The average caseload varied within the teams. The South and Aylesbury teams had an average caseload of 25 allocated per care co-ordinator in the treatment function team. The City and North East team ranged from 25 to 32 depending on the needs of the patients. The managers told us that one staff had 42 patients because the needs of the patients were not very high. Staff from City and North East team told us that the patients within the city had more complex needs and higher rates of acuity compared to other teams. They told us that this meant staff spent a lot of time on one patient to ensure that their needs were met. The assessment function team would allocate cases to each individual per shift. These were based on the needs of the patients and the cases were allocated to members of the team with the most appropriate skill set to meet the needs. The teams allocated their cases each shift when the referrals were made depending on how urgent the cases were. None of the teams had patients on waiting list to be allocated for assessment. The City and North East team had two weeks waiting time compared to other teams for patients to be allocated to the treatment function team from the assessment function team. Caseloads and case allocations were discussed and regularly reviewed in staff handover meetings and staff meetings.
- All of the teams told us that there was quick access to a psychiatrist when required. The psychiatrists were available during working hours and out of hours there was an on-call psychiatrist to ensure that patients had quick access to one when needed.
- Records showed that the average rate for completed staff mandatory training for City and North East team was 83% for treatment function and 68% for assessment function staff. Staff in Aylesbury and South teams were up to date with their mandatory training.

Assessing and managing risk to patients and staff

- All teams carried out risk assessments on every patient at the initial assessment. This took account of previous medical history, risk, social and health factors. Staff regularly reviewed them.
- The records reviewed showed that patients had detailed emergency plans in place that informed staff what to do in the event of a crisis.
- The teams had arrangements in place to respond to sudden deterioration in a patient's mental state. The teams would provide an emergency assessment by two professionals from the assessment function team within four hours. If the patient was known to services, the treatment function team would respond. The teams had on-call psychiatrists out of hours and a staff team that worked at night so that patients could access the service anytime. Patients likely to call due to signs of relapse or increased risk were handed over to night staff to ensure quick response. Patients told us that they were able to get assistance out hours and the teams responded quickly most of the time.
- The City and North East team had a two week waiting list for patients to be moved from assessment to treatment. The teams had a way of monitoring and responding to patients' needs in a way that that took into account the level of risk presented by patients. The teams operated a 'RAG' rating system on duty board. This highlighted patients according to risk and they were grouped as red, amber or green. Response was prioritised according to risk presented.
- Training records showed that staff received safeguarding training. They demonstrated a good understanding of how to identify and report any abuse. There was information about awareness and how to report safeguarding concerns displayed around the team bases. Staff knew who the designated lead for safeguarding was and knew how to contact them for support and guidance.
- Safeguarding issues were shared with the staff team through staff meetings, handover and emails. Information on safeguarding was readily available to inform patients, relatives and staff on how to report abuse. Patients and their relatives told us that they felt safe with staff from all the teams.
- All staff were aware of the lone working policy and told us that they followed it. The teams had established systems for signing in and out with expected times of return so that staff whereabouts were known at all times. Staff saw patients in pairs where the risk was deemed high.

Good

Are services safe?

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

- The teams had appropriate arrangements for the management of medicines. We reviewed 18 medicine administration records across all teams and the recording of administration was complete and correctly recorded as prescribed. The medicines were appropriately stored. However, we found that the South team did not consistently record the temperatures of the medicines fridge and room. The trust's policy stated that a daily record should be maintained of the maximum and minimum internal refrigerator temperature and the time of recording. Patients were provided with information about their medicines.

Track record on safety

- In June 2014 a serious untoward of a patient's death occurred. The patient was also known to an independent drug and alcohol service. The clinical team investigated the incident and developed an action plan to address the key issues from the investigation. They recommended changes to ensure that lessons learnt resulted in changes in practice.
- The root cause analysis identified that there was a lack of robust communication between the community team and the drug and alcohol services. The teams had improved information sharing and communication with the drug and alcohol services. They now attended regular clinical reviews and share risk assessments for all patients known to both services.
- We saw that recommendations made following the root cause analysis had been acted upon. The learning from this incident was shared across all teams in staff team meetings and intranet.

Reporting incidents and learning from when things go wrong

- The teams had an effective way of recording incidents, near misses and never events. Staff reported incidents via an electronic incident reporting form. They knew how to recognise and report incidents through the reporting system.
- Staff were open and transparent and explained the outcomes of incidents to patients and their families. Any discussions with patients and families about incidents were recorded. Patients told us that they discussed any changes with staff after an incident.
- There was a clear structure used to review all reported incidents. Incidents sampled during our visit showed that thorough investigations had taken place, with clear recommendations and action plans for staff and sharing lessons with the teams.
- Staff could explain how learning from incidents was shared within the team. Learning from incidents was discussed in staff meetings and handovers. We saw that the teams also learnt lessons from incidents that had occurred in other trusts as a way of improving practice. The teams received information through 'key learning' that focussed on changes in practice as a result of incidents from other trusts.
- Staff were offered debrief and support after serious incidents.

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 32 records across all teams and they all contained comprehensive assessments that had been completed when patients were admitted.
- The eight records we looked at in the City and North East assessment function team had care plans that were not detailed enough and were not adequately person centred. This applied to patients that the assessment function team had been working with for over their targeted time of four weeks. The Aylesbury team had care plans that were not detailed enough. They did not address the needs identified in the assessment stage and lacked clear guidelines on how staff should support patients to meet their needs. The care plans were not person-centred and did not have clear goals. The South team had detailed care plans that were patient and outcome focussed.
- All teams stored information and care records securely in locked cupboards and secure computers. Records were not well organised and different team members could not access patients' records when needed. This was as a result of moving electronic records from 'Rio' to 'Care Notes'. Staff had difficulties in identifying where certain care plans and records were located.

Best practice in treatment and care

- 18 medicines charts sampled showed that the National Institute for Health and Care Excellence (NICE) guidance was followed when prescribing medicines used for mental health problems such as olanzapine and clozapine. Patient records we looked at showed that physical health checks were carried out and blood samples were regularly taken for tests.
- The teams had a long waiting list for patients to receive psychological therapies recommended by NICE as part of their treatment. The majority of patients had to wait over a year to receive psychological therapies particularly in South and City and North East teams.
- The teams offered practical support for patients with employment, housing and benefits. The teams had strong links with employment organisations, citizens advice bureau, benefits offices and housing schemes in order to support patients. The Aylesbury team had a housing officer within the team.
- Records showed that the teams assessed and supported patients with their physical health care needs. The teams carried out health checks with support from the GPs to ensure that physical health needs were being monitored. They monitored prescribed antipsychotic medication for any undesirable outcomes.
- All teams used the health of the nation outcome scales and recovery star as clinical outcome measures. This meant that staff had standard ways to monitor changes in a patient's presentation.
- Staff carried out a range of regular clinical audits to monitor the effectiveness of the service provided. They conducted a range of audits on a monthly or quarterly basis including care records, the care programme approach, medicines, national audits of schizophrenia and lithium. The findings were used to identify and address changes needed to improve outcomes for patients

Skilled staff to deliver care

- The teams consisted of doctors, nurses, social workers, occupational therapists, psychologists and support workers. The teams did not have direct input from a pharmacist into clinical care. The teams did not have enough access psychologists to deliver psychological therapies. Patients told us that there were able to see a wide range of professionals depending on their needs.
- All of the teams had experienced and appropriately qualified staff. The teams were mostly made up of band six and seven nurses. The teams included nurse prescribers and staff that were approved mental health professionals.
- We saw evidence from records that staff received appropriate induction which involved shadowing experienced staff before they could be given a caseload. Staff told us that they received a three week induction.
- We saw records that showed all staff received supervision regularly. Staff could review their practice and identify training and continuing development needs in these sessions.

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.

- The percentage of non-medical staff that received an appraisal in the last 12 months was 50% for City and North East team, Aylesbury 100% and South 93%. Staff in the Aylesbury and South teams told us that they received annual appraisals.
- The nurses had regular staff team meetings to discuss operational and clinical issues. Staff said they felt that team meetings gave them an opportunity to share information together.
- Staff told us they had undertaken training relevant to their role. Staff received training in areas such as autism awareness, psychosocial interventions, and clinical risk assessment. The teams told us that they had two away days a year where they could receive further training specific to their roles.

Multi-disciplinary and inter-agency team work

- All teams had regular and effective multi-disciplinary team meetings taking place. These meetings involved doctors, nurses, social workers, occupational therapists, support workers and housing officers. We attended three multi-disciplinary team meetings and looked at records that showed discussions held addressed the identified needs of the patients.
- We attended four handover meetings in all teams and found them to be effective. Staff discussed each patient in depth about any changes in treatment plan and risk, patients' presentation, progress and details of family support. Staff demonstrated an understanding of their patients' needs and how they were to be supported.
- The teams had a good working relationship with inpatient wards, street triage, psychiatric liaison team and the emergency department psychiatric service. They shared information effectively about patients likely to move between services. The teams received handover information in the morning regarding any patients that they had been in contact with out of hours services. The teams gave the out of hours teams any information on patients that were high risk and likely to be in crisis. Patients transferred between teams had clear discharge plans in place.
- The teams had good working links with the external organisations. They had effective partnership working with GPs, acute hospitals, independent organisations, local authorities, police, housing associations and the citizens advice bureau. The teams invited external professionals where appropriate to review the risk assessments and crisis plans within the care programme approach process and to facilitate safe discharge. Patients and their families told us that other professionals who were involved in their care and treatment attended their meetings.

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

- Training records indicated that staff had received training and showed a good understanding of the Mental Health Act and the Code of Practice. Staff demonstrated awareness in relation to community treatment orders (CTO).
- All teams had appropriately completed consent to treatment and capacity forms for patients on CTO and long term section 17 leave. The CTO documentation we reviewed was up to date, stored appropriately and compliant with the MHA and the Code of Practice. The community psychiatrist renewed and signed the section 17 leave forms for patients on long term leave.
- Staff routinely explained patients' rights under the MHA and CTO. This ensured that patients understood their legal position and rights in respect of the MHA. Patients we spoke with confirmed that their rights under the MHA had been explained to them.
- Staff knew how to contact the Mental Health Act team for advice when needed. This meant staff could get support and legal advice on the use of the MHA when needed.
- Staff were aware of how to access and support patients to engage with the independent mental health advocacy when needed. Information on independent mental health advocacy services was readily available to support patients.
- The teams had not conducted any recent audits to ensure that the MHA was being applied correctly.

Good practice in applying the Mental Capacity Act

- Training records showed that staff had received training in the Mental Capacity Act. Staff demonstrated a good understanding of Mental Capacity Act and could apply the five statutory principles.
- Staff were aware of the policy on Mental Capacity Act and knew the lead person to contact about Mental Capacity Act to get advice.

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.

- All teams assessed and recorded patients' capacity to consent. These were done on a decision – specific basis with regards to significant decisions. The teams documented detailed information on how capacity to consent or refuse treatment had been sought.
- Staff supported patients to make decisions where appropriate. We viewed documents where patients lacked the capacity to consent. The teams conducted best interests meeting and decisions were made in patients' best interest, recognising the importance of their wishes, feelings, culture and history.
- The teams did not have arrangements in place to monitor adherence to the Mental Capacity Act to ensure that it was being applied correctly.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed good interactions between staff and patients. Staff spoke to patients in a way that was respectful, clear and simple. They showed positive willingness to support patients.
- Patients and their families were highly positive about the attitudes of staff and the support that they received. Our observations and discussions with patients and their families confirmed that they had been treated with respect and dignity. Staff were polite, kind and compassionate.
- Staff showed that they understood the individual needs of patients and could describe how they supported patients with complex needs. Patients and relatives told us that staff had a good understanding of their needs. Patients felt they were supported in a way they were pleased with.
- Staff showed a good understanding of how to maintain confidentiality when they held discussions about people's care.

The involvement of people in the care they receive

- Patients told us that staff discussed their care and treatment with them. The teams involved patients to participate in the care programme approach and clinical reviews. We observed four clinical reviews and patients were given time to express their views. Their views were taken into account. However, patients told us that staff did not give them copies of their care plans and we did not see copies of care plans signed by patients.
- The teams involved patients' carers in the assessment and discussion of care and treatment where appropriate. Patients were encouraged to involve relatives and friends in care and treatment discussions if they wished. Families and carers were provided with support where it was appropriate. Staff carried out formal carers' assessments or referred patients for carers' assessments
- The teams had information on advocacy services available. However, staff spoken with in the Aylesbury team were not aware of how to access advocacy services for patients. Patients and their families told us that they were not aware of how to access advocacy services when needed.
- The teams conducted regular patient surveys to gather their views. The results were analysed every three months to formulate trends and themes. They also carried out monthly patients and carers forums so that they were involved in decisions about their service. The information was used to improve services.

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, discharge and bed management

- All new referrals were received through the assessment function team. The treatment function team picked up referrals of known patients that had been discharged from the team in the last 12 months. Referrals came from GPs, families, self-referrals and other health care workers. Following a triage referrals were prioritised according to risk and identified needs. The referrals were classified into three groups; emergency to be seen within four hours, urgent to be seen within seven days and routine to be seen in 28 days. The referral pathways were clear, outlining clear lines of responsibilities, time frames and actions to be taken. The assessment function team operated a triage system and were responsible for appointments to carry out assessments. The assessment function worked with patients for up to four weeks however, patients could stay longer than that. The team would then handover patients to the treatment function or any other appropriate or discharge.
- The percentage of patients seen for emergency assessment within four hours of referral was 100% in all teams in the last three months. The City and North team achieved 98%, Aylesbury team 99% and the South team 100% for urgent referrals. The City and North team achieved 93%, Aylsebury team 98% and the South team 97% for routine referrals in the last three months. The teams told us that they did not have set targets from assessment to treatment as patients could start receiving treatment from the assessment function team depending on their needs.
- The teams responded on time and effectively when patients required crisis and routine care. The teams worked from 7am to 9pm everyday. They had night staff that worked from 9pm to 7am and was responsible for responding to all out of hours calls. Where the team could not visit patients in their homes they asked them to be seen at the teams' bases. They also worked collaboratively with the street triage team that could respond to patients' home at night if a patient could not visit the base. Patients who attended the local Emergency Department were seen by the emergency department psychiatric service.
- The teams had clear criteria that ensured all patients that required treatment were responded to and signposted to the right services. The out of hours services could see all patients in crisis and refer them to the appropriate teams during working hours. Out of hours they also covered for older adult and early intervention teams.
- The teams took active steps to engage with patients that were not willing to engage with their services. The teams offered patients opportunities to be seen where they felt most comfortable such as at home, the team base or at the GP surgery. These patients were discussed in team meetings and strategies were put in place on how to best engage them. For example, in one meeting we attended the team discussed about a place where one patient was known to frequent and had arranged to meet there. The team also discussed patients who did not attend appointments and proactive steps to re-engage with these patients such as cold calling, repeated phone calls and follow up discussions with the referrer.
- Staff set up appointments in a way that showed responsiveness to patients who had the highest needs. The teams used an assessment calendar to book appointments into an available time slot. Appointments were discussed with patients to check the best suitable times for them.
- Appointments were rarely cancelled and where there were cancellations, people were seen at the earliest possible opportunity. Patients told us that they were always seen on time and any cancellations were explained to them and seen at the next available appointment.
- The teams maintained their appointment times and when they were running late patients were informed. Patients told us that staff were reliable and arrived on time to their appointments.

The facilities promote recovery, comfort, dignity and confidentiality

- The teams had equipment such as defibrillators, oxygen cylinders and masks for emergency use and an appropriate place to examine patients with medical

Are services responsive to people's needs?

Good

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equipment. All teams had a day hospital facilities where patients spent the day engaged in therapeutic programmes. There were enough therapy rooms to conduct one to one or group sessions.

- The interview rooms were appropriately designed and located for the purposes of clinical interviews.
- The teams provided patients with accessible information on treatments, local services, patients' rights, advocacy services, carer support, how the services were run and how to complain.

Meeting the needs of all people who use the service

- All the teams had an environment that had full disabled access.
- The teams had information leaflets in different languages that were spoken by patients. This meant that non-English speaking patients were informed of how the services were run. Staff told us that leaflets in other languages could be made available from patient advice and liaison services when needed.
- The teams had access to interpreters when needed. Staff could to tell us how they could access interpreting services.

Listening to and learning from concerns and complaints

- The units displayed information on how to make a complaint and patients were given this information. Patients could raise concerns with staff anytime. Staff told us they tried to resolve patients' and families' concerns informally at the earliest opportunity. Patients told us that they could raise any concerns and complaints freely.
- Patients knew how to raise concerns and make a complaint. Patients told us they felt they would be able to raise concerns should they have one and were confident that staff would listen to them.
- Staff were aware of the formal complaints process and knew how to support patients and their families when needed. We observed that staff responded appropriately to concerns raised by relatives and carers of patients and received feedback. The City and North East team recorded all verbal complaints, analysed trends and discussed them as a team.
- Our discussion with staff and records observed showed that any learning from complaints was shared with the staff team through the handovers and staff meetings

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

- The teams had the vision and values of the trust displayed. Staff agreed and were familiar with the trust's values. They told us that these values link in well with the team's objectives.
- Staff demonstrated a good understanding of their team objectives and how they linked in to the trust's values and objectives.
- Staff knew who their senior managers were and told us that they visited the teams.

Good governance

- The managers felt they were given the independence to manage the teams and had administration staff to support the team. They also said that, where they had concerns, they could raise them. The managers at City and North East team felt that the senior managers were not responding on time to their concerns about staffing levels. Where appropriate the concerns could be placed on the directorate's and trust's risk register.
- The teams had systems and methods to assess and monitor performance around quality, safety and risk. The inspection team identified areas where improvements were needed. The areas that were not monitored appropriately were care plans, review of staffing levels, low staff morale, high staff turnover, mandatory training for staff, and staff being appraised particularly in the City and North East team.
- Managers provided data on performance to the trust consistently. All information provided was analysed at team and directorate level to come up with themes and this was measured against set targets. The teams captured data on performance such as care programme approach caseloads, referral time response, waiting list, discharges, appointments and patient clusters. The performance indicators were discussed weekly at business meetings and monthly in the quality and risk meeting. Staff and patients did not have accessible information on service performance but was discussed in staff meetings as a way of improving performance in any areas identified.

Leadership, morale and staff engagement

- At the time of our inspection there were no grievances being pursued within the teams, and there were no allegations of bullying or harassment.
- Staff told us that they were aware of the trust's whistleblowing policy and that they felt free to raise concerns.
- Staff told us that they were supported by their line managers and were encouraged to access clinical and professional development courses. They told us that managers were accessible to staff, approachable, had an open culture and willing to listen.
- Our observations and discussions with staff confirmed that both the Aylesbury Team and the South Team work very well and both reported good staff morale. They all spoke positively about their roles and demonstrated their dedication to providing high quality patient care. The City and North East reported low morale due to pressure of workload and high turnover of staff. Staff told us they felt demoralised by ongoing problems of staffing levels. Staff spoke highly about their work; although they told us that lack of support from senior management was an issue for them. They communicated clearly to us that staff supported each other within the team but felt that the senior management did not listen to their concerns. They told us that senior management were aware of the staffing issues but they seemed not to act on time. The management did not take action to address staff concerns about staffing levels, low staff morale, pressure of workload and high staff turnover.
- Staff were open and transparent and explained to patients if and when something went wrong. Incidents were discussed with patients and their families. Patients told us that they were informed and given feedback about things that had gone wrong.
- Staff told us the board informed them about developments through emails and intranet and sought their opinion through the annual staff survey.

Commitment to quality improvement and innovation

- The teams were part of the Oxfordshire Recovery College which used an empowering and educational approach to support mental health recovery. This was run by patients that had lived experience of mental health problems, alongside people with professional

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Requires improvement

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experience. This provided an innovative shared learning environment for patients with mental health problems, their families, carers, staff and volunteers from other partner organisations.

- The teams employed research assistants that worked with clinicians in the teams to ensure that research opportunities were known to both staff and patients.

The researches carried out ranged from studies using questionnaires, interviews and procedures such as carrying out brain scans. Each study looked for new and innovative ways to improve understanding of mental health problems such as depression, anxiety and schizophrenia.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (Regulated activities) Regulations 2014 Person-centred care The care and treatment of patients must be appropriate and meet their needs. The Aylesbury and City and North East teams did not have care plans that had clear goals, up to date, person centred, holistic or recovery orientated that addressed needs identified in the assessment stage. This was a breach of Regulation 9(1)(a)(b)(c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated activities) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed and receive appropriate training and appraisal. Staffing levels must be reviewed continuously and adapted to respond to changing needs. The trust did not adapt to respond to changing needs of staffing levels, low staff morale, workload and high staff turnover in the City and

This section is primarily information for the provider

Requirement notices

North East team so that staff could cope with the workload to ensure patients' safety. Not all staff had received mandatory training and appraisals. Patients could not receive psychological therapies on time.

This was a breach of Regulation 18(1)(2)(a)