Oxford Health NHS Foundation Trust

Inspection report

Trust Headquarters, Warneford Hospital
Warneford Lane, Headington
Oxford
Oxfordshire
OX3 7JX
Tel: 01865902288
www.oxfordhealth.nhs.uk

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We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Good
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

Oxford Health NHS Foundation Trust is a large NHS trust that provides a diverse range of services across a wide geographical area. The trust provides community health, mental health and specialised health services across Oxfordshire, Buckinghamshire, Milton Keynes, Berkshire, Swindon, Wiltshire, Bath and North East Somerset (BaNES).

In Oxfordshire, the trust is the main provider of community health services and delivers these in a range of community and inpatient settings, including eight community hospitals.

The trust provides mental health services in community and inpatient settings across Milton Keynes, Buckinghamshire, Oxfordshire, Wiltshire and BaNES. Additionally, the trust provides forensic mental health and eating disorder services across a wider geographical area including patients in Berkshire, the wider Thames Valley and patients from Wales.

In July 2017, the trust took over community, social care and inpatient services for people with a learning disability in Oxfordshire, which had previously been run by Southern Health NHS Foundation Trust.

The trust also provides specialist GP services and dental services in Oxfordshire including the Oxfordshire Out-of-Hours GP service.

The trust provides the following mental health and community health core services:

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Forensic inpatient/secure wards
- Child and adolescent mental health wards
- Wards for older people with mental health problems
- Wards for people with a learning disability or autism
- Community-based mental health services for working age adults
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people
- Community-based mental health services for older people
- Community mental health services for people with a learning disability or autism
- End of life care
- Urgent care services
- Community health services for adults
- Community health inpatient services
- Community health services for children, young people and families

The trust operates from 17 locations registered with CQC:

- Six community hospitals at Abingdon, Bicester, Didcot, Wallingford, Wantage and Witney.
- Seven inpatient mental health locations:

Summary of findings

- Buckinghamshire Health and Wellbeing Centre (Aylesbury)
- Cotswold House (Swindon)
- Fulbrook Centre (Churchill Hospital, Oxford)
- Littlemore Mental Health Centre (Oxford)
- Marlborough House (Milton Keynes)
- Marlborough House (Swindon)
- Warneford Hospital (Oxford).
- Community health services, community mental health services and the Oxfordshire Out of Hours GP Service operated under the Oxford Health Foundation Trust HQ location.
- Primary healthcare services for homeless people at Luther Street, Oxford.
- A minor injury unit (MIU) and rapid access care unit (RACU) at Henley.
- A care home for people with a learning disability in Headington, Oxford.

The trust has 555 inpatient beds across 35 wards.

The trust employs over 6,000 people (over 4,000 full-time equivalents) and has a total annual income of over £300 million.

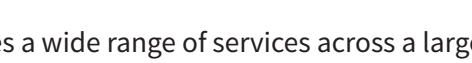
The trust works closely with a number of clinical commissioning groups (Oxfordshire, Chiltern, Nene, BaNES, Wiltshire, Swindon, Newbury District and Aylesbury Vale), County Councils (Swindon Borough, Buckinghamshire, Oxfordshire, Leicester City and Northamptonshire), NHS England (South area team and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

The trust is a specialist teaching, training and research trust and has close links with the Universities of Oxford, Oxford Brookes, Buckinghamshire, Reading and Bath.

The trust is part of the Oxford Academic Health Science Centre which is a collaboration between the NHS, industry and universities. Its aim is to get innovation into clinical practice to improve patient safety, outcomes and experience.

We carried out a comprehensive inspection of the trust in September and October 2015. Following this inspection, the trust was rated overall as requires improvement. A follow-up inspection was carried out in June 2016 which looked at the three mental health core services which had been rated as requires improvement. Following this follow-up inspection, the trust was re-rated overall as good, but remained rated as requires improvement for the safe key question.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Good 

What this trust does

Oxford Health NHS Foundation Trust is a large NHS trust that provides a wide range of services across a large geographical area. The trust provides community health, mental health and specialised health services across Oxfordshire, Buckinghamshire, Milton Keynes, Berkshire, Swindon, Wiltshire, Bath and North East Somerset (BaNES).

Summary of findings

The trust runs a care home for people with a learning disability in Oxford.

The trust also provides specialist GP services and dental services in Oxfordshire including the Oxfordshire Out-of-Hours GP service.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected eight community health and mental health services as part of our ongoing checks on the safety and quality of healthcare services:

- Acute wards for adults of working age and psychiatric intensive care units (PICU's)
- Wards for older people with mental health problems
- Wards for people with a learning disability or autism
- Community-based mental health services for working age adults
- Mental health crisis services and health-based places of safety
- Community mental health services for people with a learning disability or autism
- Urgent care services
- Community health inpatient services.

This inspection covered the trust's community health and mental health services only. The trust's primary medical services and care home have been inspected separately and have separate inspection reports. The trust's out of hours doctor service and care home (House 2, Slade House) were separately inspected in 2018 and were both rated as good. The aggregated ratings used in this inspection report are for the trust's community health and mental health services only. They do not include the separate ratings for the trust's out of hours doctor service, the Luther Street primary healthcare service or the care home for people with a learning disability.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed "Is this organisation well-led?"

What we found

Overall trust

Summary of findings

Our rating of the trust stayed the same. We rated it as good because:

- Of the eight core community health and mental health services that we inspected on this occasion, we rated five as good and three as requires improvement. When we include the previous ratings of mental health and community health core services at the trust that we did not inspect on this occasion, one is rated as outstanding, 12 are rated as good and three are rated as requires improvement. In rating the trust, we have taken into account the previous ratings of the eight mental health and community health core services not inspected this time.
- Incident reporting and investigation systems were robust in the trust.
- The Chief Executive actively promoted research in the trust to improve the care and treatment of patients. The trust ran one of only two mental health biomedical research centres in England.
- The trust had planned well the transfer of the learning disability services into the trust. The learning disability services were brought into the trust with care, compassion and respect for the patients, carers and staff involved.
- Leadership at directorate level was very strong. The directorates had clear plans and strategies to improve patient care and treatment. Trust governance systems supported and encouraged the development of strong, local leadership teams.
- The trust supported and encouraged wards and services to take part in external accreditation schemes.

However:

- Following this inspection, we have rated one key question – safe – as requires improvement. In rating the trust, we have taken into account the previous ratings of the eight mental health and community health core services not inspected this time.
- The trust continued to have significant issues with recruitment and retention of staff particularly qualified nurses but we were assured that the trust was undertaking key work to find new and innovative ways of attracting staff to work at the trust.
- The community health services operated by the trust were generally rated lower than the mental health services. Staff in the community health services did not feel as embedded in the trust structure or as well supported by the trust senior teams. This issue had been identified by the trust and the directorate re-organisation due to be completed by June 2018 planned to strengthen the management and support for community health services by establishing a community health directorate.

Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

- Seven of the 16 mental health and community health core services operated by the trust are now rated requires improvement for safe.
- We have changed the rating for safe for acute wards for adults of working age and psychiatric intensive care units from good to requires improvement.
- The two community health core services inspected at this inspection were both rated requires improvement for safe.
- Clinical risk assessments in the learning disability inpatient service and the community health services did not include all the clinical risks that had been identified for each patient.

However:

- Seven of the 11 mental health core services operated by the trust now have a good rating for safe.

Summary of findings

- Care was provided in environments that were mostly clean and tidy. Environmental risk assessments were carried out and action taken to mitigate identified risks.
- Incidents were reported and investigated to ensure lessons to be learned were identified.
- Physical restraint of patients was used as a last resort and de-escalation techniques were widely used.
- Most staff received their mandatory training.
- Medicines were generally managed well and safely across the trust's services.
- There were no waiting lists in any of the adult community mental health teams, for either assessment or commencement of treatment at the time of our inspection.
- Staff in the urgent care service recognised and responded appropriately to patient risk including deteriorating health and medical emergencies.

Are services effective?

Our rating of effective stayed the same. We rated it as good because:

- Twelve of the 16 mental health and community health core services were rated good for effective and one was rated outstanding.
- The services monitored the effectiveness of the care and treatment they were providing and used the findings to improve the quality of service delivery.
- There was strong multidisciplinary team working across most services.
- Care planning was generally robust.
- The trust had effective systems in place to protect the rights of people subject to the Mental Health Act. The Mental Health Act administration team had a depth of specialist knowledge and provided high quality support to local teams.
- Most staff understood their responsibilities under the Mental Capacity Act and knew how to apply the Act and Code of Practice in their work.

However:

- Three of the 16 mental health and community health core services operated by the trust are now rated as requires improvement for effective.
- Two of the five community health core services operated by the trust are now rated as requires improvement for effective.
- Staff appraisal rates were low.
- Patients were at risk of not receiving effective care or treatment due to lack of pain assessment and personalised care planning in the community health inpatient service.

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- Fourteen of the 16 core services were rated as good for caring and two were rated outstanding.
- Staff across all core services inspected provided compassionate care and ensured that patients were treated with dignity and respect. We observed patients treated with kindness, courtesy and sensitivity by trust staff.

Summary of findings

- The vast majority of patients, families and carers we spoke with were positive about the way they were treated by staff members.
- Patients were regularly involved in developing their care plans.
- Support groups were available for families and carers. The trust developed a carers' strategy called "I care, you care" and had achieved two-star accreditation with the Triangle of Care. The patient experience adult directorate leads produced a handbook for family, friends and carers which provided useful information to help them understand the care and treatment being provided to their family member or friend.

Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

- Of the 16 core services, 15 were rated good for responsive and one was rated outstanding.
- We have changed the rating of responsive for mental health crisis services and health-based places of safety to good from requires improvement.
- Patients could access services when they needed to and few services had long waiting lists.
- Most patients received care in environments that promoted patient comfort, dignity and privacy.
- Patients could give feedback about the service they had received. There were regular ward meetings in the mental health inpatient services that provided patients with opportunities to ask questions, raise concerns or provide feedback to ward staff about any aspect of their care and treatment. The patient experience directorate leads produced experience and involvement newsletters for patients, families, friends and carers which included responses to feedback.
- The services took complaints seriously. Support was provided for those patients who needed assistance in raising concerns. Complaints were investigated and the services made improvements in response to learning from complaints.
- Staff encouraged patients to keep in contact with their families and carers. Dedicated child visiting rooms were available in all inpatient mental health services.

Are services well-led?

Our rating of well-led stayed the same. We rated it as good because:

- Following this inspection 12 of the 16 mental health and community health core services at the trust were rated as good, one was rated as outstanding.
- The trust executive and non-executive teams had an appropriate range of skills, knowledge and experience. The Chief Executive had been in post since 2012 and the Chair had been in post since 2010.
- Incident reporting and investigation systems were robust in the trust. The trust's patient safety team managed the incident reporting systems and provided specialist knowledge and support to local managers. Incident reports and investigations were reviewed at regular scrutiny panels and lessons to be learned were identified and communicated across the trust. The board received regular reports on serious incidents and both the incidents and learning from incidents were discussed at board meetings.
- The trust had good systems for recording and responding to complaints and the board had regular reports on trends in complaints and learning from complaints.
- The financial challenges the trust faced were understood by the board. The trust's senior finance team was experienced and provided clear financial information to the board. The trust received a significantly lower level of

funding per head of population than the national average for health services in general or mental health services. The national average allocation to clinical commissioning groups per head of population is £1,254. Of this amount, the national average clinical commissioning group allocation to mental health is 12.7% (£159 per head of population). In Oxfordshire the national allocation to the clinical commissioning groups is £1,040 per head of population. Oxfordshire clinical commissioning groups allocated 8.7% (£90 per head of population) to mental health, £69 per head of population less than the national average for mental health.

- The Chief Executive actively promoted research in the trust to improve the care and treatment of patients. The trust ran one of only two mental health biomedical research centres in England.
- The trust had established a Health Improvement Centre which was dedicated to developing improvement expertise across all levels of the trust. The Centre combined academic research into healthcare improvement with practical support and training for trust staff to enable staff to lead and deliver quality improvement.
- The trust had planned well the transfer of the learning disability services into the trust. The learning disability services were brought into the trust with care, compassion and respect for the patients, carers and staff involved.
- Leadership at directorate level was very strong. The directorates had clear plans and strategies to improve patient care and treatment. Trust governance systems supported and encouraged the development of strong, local leadership teams.
- The trust had a strong governance structure to oversee its Mental Health Act (MHA) duties. The executive lead for the MHA was the trust's medical director. The trust's effectiveness sub-committee received regular reports on the trust's performance against its MHA duties. Serious risks and issues were escalated to the board quality committee.
- Medicines safety was effectively integrated into the governance structure of the trust. The chief pharmacist led on medicine optimisation for the trust. The trust had appointed two medicine safety officers as a job share.
- The pharmacy service had developed and measured their progress against the full strategic plan for 2017-18. The medicines plan contained three key areas; keeping patients safe from harm and achieving their clinical outcome, improving efficiency and effectiveness and participation in research and innovation.
- Leadership training was available to relevant staff and the trust actively encouraged staff from all directorates and teams to attend the leadership training.
- Fit and proper person checks were in place for all board members and non-executive directors.
- The trust's governors told us that their involvement in the trust and the support they received had improved over the previous two years since the new trust company secretary had been in post.
- The trust had a clear vision for equality which was to be "the fairest and most inclusive mental health and community health provider and employer in the UK". The vision was supported by a strategy, annual objectives and meaningful oversight by the board. The trust had achieved Stonewall's "Diversity Champions" accreditation.
- The trust was one of seven mental health trusts to be named as a Global Digital Exemplar for its innovative use of technology to care for people who use mental health services.
- The trust supported and encouraged wards and services to take part in external accreditation schemes. Twenty-two of the inpatient wards had achieved accreditation in their specialist area. Four community mental health services had achieved accreditation.

However:

- Three of the sixteen core services operated by the trust are now rated as requires improvement overall.

Summary of findings

- The trust continued to have significant issues with recruitment and retention of staff particularly qualified nurses but we were assured that the trust was undertaking key work to find new and innovative ways of attracting staff to work at the trust.
- The community health services operated by the trust were generally rated lower than the mental health services. Staff in the community health services did not feel as embedded in the trust structure or as well supported by the trust senior teams. This issue had been identified by the trust and the directorate re-organisation due to be completed by June 2018 planned to strengthen the management and support for community health services by establishing a community health directorate.
- Staff appraisal rates were low across the organisation.

Ratings tables

The ratings tables in our full report show the ratings overall and for each key question, for each service, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account, for example, the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found outstanding practice in the acute wards for adults of working age and psychiatric intensive care units service and in the community mental health services for people with a learning disability or autism.

For more information see our Outstanding practice section of the report.

Areas for improvement

We found areas for improvement including breaches of six legal requirements that the trust must put right. We found 49 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information see the Areas for improvement section of this report.

Action we have taken

We issued six requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

Our action related to breaches of six legal requirements in four services.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

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

Summary of findings

- Staff engagement and morale in the service was excellent. All staff and managers we interviewed had felt well supported and communicated with by senior leaders throughout the transition process, and described a high level of confidence in their managers to continue improving the service. We found a culture of sharing and celebrating success, through staff awards and the trust social networking platform. The service director was well known among the staff team and visible within services.
- Staff on Sapphire and Phoenix wards had used their identity board as an opportunity to encourage positive interactions and build relationships with patients. The name and photograph of each member of staff was accompanied by a few pieces of biographical information (such as their likes, dislikes, hobbies and previous employment). Patients told us that it was good to get to know something of the people caring for them.
- All wards in this core service had gained national accreditation for demonstrating that they met a certain standard of best practice in their area. The six acute wards had gained accreditation for inpatient mental health services – working age units (AIMS – WA). Ashurst ward had gained accreditation for inpatient mental health services – psychiatric intensive care units (AIMS – PICU).
- Vaughan Thomas ward had been shortlisted for a national award in the Student Nursing Times Awards for 2018. The ward was one of several nominated for student placement of the year, and was the only mental health ward on the shortlist. The winner was due to be revealed at an upcoming awards ceremony.
- Staff on Sapphire ward were carrying out a project to reduce the amount of time patients spent on enhanced levels of observations. Staff proactively sought the preferences of each patient following admission, for how they liked staff to interact with them when they had enhanced observation levels imposed upon them. For instance, some patients said they preferred staff to adopt a passive role, whilst others said they preferred staff to interact with them, for instance by playing a board game together.
- The service promoted meaningful co-production and worked actively alongside patients to enable them to influence the running of the service. We observed patients being supported to re-design care planning tools and we told that they would be working directly with the trust's IT department to get it right.

Community mental health services for people with a learning disability or autism

- Staff engagement and morale in the service was excellent. All staff and managers we interviewed had felt well supported and communicated with by senior leaders throughout the transition process, and described a high level of confidence in their managers to continue improving the service. We found a culture of sharing and celebrating success, through staff awards and the trust social networking platform. The service director was well known among the staff team and visible within services.
- The service promoted meaningful co-production and worked actively alongside patients to enable them to influence the running of the service. We observed patients being supported to re-design care planning tools and we told that they would be working directly with the trust's IT department to get it right.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with six legal requirements. This action related to three services.

Summary of findings

Mental health services

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

The provider MUST ensure:

- That all staff receive the mandatory training necessary to perform their roles.

Wards for people with a learning disability or autism

The provider MUST ensure:

- That staff are receiving regular clinical supervision.
- That all patients have a fully completed, current and historic risk assessment which is regularly reviewed.

Community health services

Urgent care services

The provider MUST ensure:

- There is a separate waiting area for children in Witney MIU and sufficient and appropriate seating to meet the needs of patients.
- The side room in Abingdon MIU is fit for purpose and meets infection control standards.
- All staff are aware and adhere to the referral process for safeguarding adult concerns.
- Patient confidential information is not visible to other patients or visitors.
- Medicines must be stored at an appropriate temperature.
- Risks are appropriately identified, escalated and managed.
- There is a vision and strategy for the service and this is communicated to all staff.

Community health inpatient services

The trust MUST ensure:

- All medicines are stored at appropriate temperatures.
- All patients have their pain assessed and monitored appropriately using a recognised pain assessment tool.
- Deprivation of Liberty safeguard applications are completed appropriately and tracked effectively.
- A strategy for community hospitals inpatient service is developed and implemented
- Governance processes are effective.

Action the trust SHOULD take to improve:

We told the trust that it should take action either to comply with a minor breach that did not justify regulatory action, to avoid breaching a legal requirement in future or to improve services. These 58 actions related to the whole trust and seven services.

Trust wide

The trust SHOULD ensure:

- All efforts are made to reduce the level of vacancies, particularly of qualified nurses.

Summary of findings

- The management and support for community health services is strengthened in the planned directorate re-structure.
- That all staff receive an annual appraisal.

Mental health services

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

The trust SHOULD ensure:

- That staff are given feedback on the outcome of patient complaints.
- That the use of bank and agency nursing staff is minimised.
- That all staff receive an annual appraisal.
- That they protect the confidentiality of each patient.
- That a clock is visible from all seclusion rooms.
- That patients in all seclusion rooms have a clear view of staff outside the room, including when they are communicating on the intercom system.
- That staff are given feedback on incidents on different wards and at other trust locations.
- That all necessary checks of controlled drugs take place and that those checks are properly recorded.
- That all necessary physical observations are carried out after a patient is given rapid tranquilisation and that those observations are appropriately recorded.
- That all necessary monitoring checks of patients in seclusion rooms take place and that those observations are appropriately recorded.
- Patients from all wards have access to psychological therapies.
- That the legal rights of informal patients are upheld.
- That all ward areas are kept clean and free from unpleasant odours.
- That patient controls of all bedroom door vision panels are in working order.
- That all patients' care plans are up to date, personalised, holistic and recovery oriented, incorporating patients' strengths and goals.
- That staff are provided with detailed, up to date risk assessments of patients when providing care to patients in health-based places of safety.

Wards for older people with mental health problems

The trust SHOULD ensure:

- That they continue to follow their protocol if a patient is admitted to the bedroom corridor with patients of the opposite sex and monitor this closely.
- That staff across all wards carry out malnutrition and incontinence assessments within the required timeframe.
- That all staff keep their mandatory training up to date.
- That all staff receive an annual appraisal.
- That gaps in staff recruitment continues to be addressed.

- They should review how the policy relating to the use of photographs in medication administration is implemented on the wards.

Wards for people with a learning disability or autism

The trust SHOULD ensure:

- There is a structure for handover.
- There is a structure for multidisciplinary team meetings to include discussions around clinical risk management.
- The ward implements the trust's initiative for reducing restrictive practices.
- There is a planned progression from paper-based records to electronic records.
- That the ward is following the Positive Behavioural Support (PBS) Approach guidance from the Department of Health.
- Capacity assessments are routinely completed and recorded for patients when required.
- Information provided is available in an easy-read format

Community-based mental health services for working age adults

The trust SHOULD ensure:

- Staff know what emergency equipment is stored on site at the Valley and Elm centres.
- All staff at both the Elm Centre and the Valley Centre adhere to the lone working policy and ring in safe at the end of each day.
- A reference is made on the physical health section of the electronic care records system as to why a physical health assessment was not carried out.

Mental health crisis services and health-based places of safety

The trust SHOULD ensure:

- That the Interagency Joint Working Protocol is updated with the new Standard Operating Procedure.
- The section 12 doctors on the rota are aware of their responsibilities.
- That interpreters are available when needed.

Community health services

Community health inpatient services

The trust SHOULD ensure:

- All staff who are band 7 or above have completed multi-agency safeguarding adults training.
- Staff record patient consent in patient notes.

Urgent care services

The provider SHOULD ensure:

- Patients have adequate pain assessment and a pain tool is in place for patients who are unable to communicate their pain score.
- There is a process for formally recording and escalating patients' physiological observations in MIU.

Summary of findings

- Completion of patient risk assessments such as the malnutrition and pressure ulcer scoring are completed.
- The environment takes into consideration patients' individual needs for example patients living with dementia or learning disabilities.
- Clinical guidelines are clearly referenced to indicate the evidence base used.
- All staff receive at least an annual appraisal.
- A review of the effectiveness of the process for sharing the learning from complaints with staff.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of well-led stayed the same. We rated it as good because:

- Following this inspection 12 of the 16 core services at the trust were rated as good, one was rated as outstanding.
- The trust executive and non-executive teams had an appropriate range of skills, knowledge and experience. The Chief Executive had been in post since 2012 and the Chair had been in post since 2010.
- Incident reporting and investigation systems were robust in the trust. The trust's patient safety team managed the incident reporting systems and provided specialist knowledge and support to local managers. Incident reports and investigations were reviewed at regular scrutiny panels and lessons to be learned were identified and communicated across the trust. The board received regular reports on serious incidents and both the incidents and learning from incidents were discussed at board meetings.
- The trust had good systems for recording and responding to complaints and the board had regular reports on trends in complaints and learning from complaints.
- The financial challenges the trust faced were understood by the board. The trust's senior finance team was experienced and provided clear financial information to the board. The trust received a significantly lower level of funding per head of population than the national average for health services in general or mental health services. The national average allocation to clinical commissioning groups per head of population is £1,254. Of this amount, the national average clinical commissioning group allocation to mental health is 12.7% (£159 per head of population). In Oxfordshire the national allocation to the clinical commissioning groups is £1,040 per head of population. Oxfordshire clinical commissioning groups allocated 8.7% (£90 per head of population) to mental health, £69 per head of population less than the national average for mental health.
- The Chief Executive actively promoted research in the trust to improve the care and treatment of patients. The trust ran one of only two mental health biomedical research centres in England.
- The trust had planned well the transfer of the learning disability services into the trust. The learning disability services were brought into the trust with care, compassion and respect for the patients, carers and staff involved.
- Leadership at directorate level was very strong. The directorates had clear plans and strategies to improve patient care and treatment. Trust governance systems supported and encouraged the development of strong, local leadership teams.

Summary of findings

- The trust had a strong governance structure to oversee its Mental Health Act (MHA) duties. The executive lead for the MHA was the trust's medical director. The trust's effectiveness sub-committee received regular reports on the trust's performance against its MHA duties. Serious risks and issues were escalated to the board quality committee.
- Medicines safety was effectively integrated into the governance structure of the trust. The chief pharmacist led on medicine optimisation for the trust. The trust had appointed two medicine safety officers as a job share.
- The pharmacy service had developed and measured their progress against the full strategic plan for 2017-18. The medicines plan contained three key areas; keeping patients safe from harm and achieving their clinical outcome, improving efficiency and effectiveness and participation in research and innovation.
- The trust provided leadership training for new managers.
- Fit and proper person checks were in place for all board members and non-executive directors.
- The trust's governors told us that their involvement in the trust and the support they received had improved over the previous two years since the new trust company secretary had been in post.
- The trust had a clear vision for equality which was to be "the fairest and most inclusive mental health and community health provider and employer in the UK". The vision was supported by a strategy, annual objectives and meaningful oversight by the board. The trust had achieved Stonewall's "Diversity Champions" accreditation.
- The trust supported and encouraged wards and services to take part in external accreditation schemes. Twenty-two of the inpatient wards had achieved accreditation in their specialist area. Four community mental health services had achieved accreditation.

However:

- Three of the sixteen core services operated by the trust are now rated as requires improvement overall.
- The trust continued to have significant issues with recruitment and retention of staff particularly qualified nurses but we were assured that the trust was undertaking key work to find new and innovative ways of attracting staff to work at the trust.
- The community health services operated by the trust were generally rated lower than the mental health services. Staff in the community health services did not feel as embedded in the trust structure or as well supported by the trust senior teams. This issue had been identified by the trust and the directorate re-organisation due to be completed by June 2018 planned to strengthen the management and support for community health services by establishing a community health directorate.
- Staff appraisal rates were low across the organisation.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018
Mental health	Requires improvement ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018
Overall trust	Requires improvement ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016
Community health services for children and young people	Good Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016	Good Jan 2016	Good Jan 2016	Outstanding Jan 2016
Community health inpatient services	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018
Community end of life care	Good Jan 2016	Requires improvement Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016
Urgent care	Requires improvement ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018
Overall*	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ↓ Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018
Long-stay or rehabilitation mental health wards for working age adults	Requires improvement Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016
Forensic inpatient or secure wards	Good Jan 2016	Good Jan 2016	Good Jan 2016	Outstanding Jan 2016	Good Jan 2016	Good Jan 2016
Child and adolescent mental health wards	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016
Wards for older people with mental health problems	Good ↑ Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018
Wards for people with a learning disability or autism	Requires improvement Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Requires improvement Mar 2018
Community-based mental health services for adults of working age	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018
Mental health crisis services and health-based places of safety	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good →← Mar 2018
Specialist community mental health services for children and young people	Requires improvement Jan 2016	Good Jan 2016	Outstanding Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016
Community-based mental health services for older people	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016
Community mental health services for people with a learning disability or autism	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Overall	Requires improvement →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Community health services

Background to community health services

Oxford Health NHS Foundation Trust is a large NHS trust that provides a wide range of services across a large geographical area. In Oxfordshire, the trust is the main provider of the majority of non-GP based community health services for the population of Oxfordshire. It delivers these in a range of community and inpatient settings, and in people's homes. The trust provides five community health core services. We last inspected community health services in October 2015.

In this inspection, we completed the trust's annual well led review and inspected the following core services:

- Urgent care services
- Community health inpatient services.

Summary of community health services

Requires improvement 

Our rating of these services stayed the same. We rated them as requires improvement because:

- The community health services operated by the trust were generally rated lower than the mental health services. Staff in the community health services did not feel as embedded in the trust structure or as well supported by the trust senior teams. This issue had been identified by the trust and the directorate re-organisation due to be completed by June 2018 planned to strengthen the management and support for community health services by establishing a community health directorate.
- The two community health core services inspected at this inspection were both rated requires improvement overall. This was a change in rating for Urgent care services.
- While there was a system in place to assess and monitor patient risk in the community health inpatient service there were instances where assessments and related care plans were not reviewed in a timely way.
- The sharing of information between staff and others was uncoordinated meaning people did not always have access to the information they required in the community health inpatient service.
- People were at risk of not receiving effective care or treatment due to lack of pain assessment and personalised care planning in the community health inpatient service.

However:

- Staff provided kind and compassionate care to patients and placed patients and their families at the centre of their work.
- Processes for incident reporting, recognising the deteriorating patient and record keeping were embedded into practice.

Summary of findings

- The service provided care and treatment planned around the needs of patients and ensured they could easily access the most appropriate service.

Community health inpatient services

Requires improvement 

Key facts and figures

Oxford Health provided community inpatient services for adults over eighteen who required rehabilitation. The service had a total of eight wards and 150 beds across six community hospitals. We inspected all community hospital wards at the five community hospitals open at the time of our inspection – Abingdon, City, Bicester, Didcot, Wallingford, and Witney. Wantage hospital was temporarily closed at the time of our inspection.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

During our inspection, we spoke with 45 staff including nurses, physiotherapists, occupational therapists, GPs and dieticians. We spoke with 23 patients and 10 relatives.

We reviewed 22 sets of patient records across all community hospitals.

We inspected the whole core service and looked at all five key questions.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service did not always follow relevant national guidelines around storing medicines.
- While there was a system in place to assess and monitor patient risk there were instances where assessments and related care plans were not reviewed in a timely way.
- The sharing of information between staff and others was uncoordinated meaning people did not always have access to the information they required.
- People were at risk of not receiving effective care or treatment due to lack of pain assessment and personalised care planning.
- Staff understanding of their roles and responsibilities under the Mental Capacity Act 2005 was variable. Staff did not always effectively support patients who lacked the capacity to make decisions about their care.
- The governance and culture did not always support the delivery of high-quality person-centred care. There was not a clear defined strategy for the service.

However:

- Staff were supported in their development.
- Staffing levels were generally at safe levels.
- Incidents were well managed including investigations and the sharing of learning.
- Information about people's care and treatment was collected and used to improve the service.
- People were supported, treated with dignity and respect and involved in their care.
- People's needs were met through the way the service was organised and delivered.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Community health inpatient services

Is the service safe?

Requires improvement 

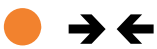
Our rating of safe stayed the same. We rated it as requires improvement because:

- Risks to people who used the service were assessed, monitored and generally reviewed regularly in a timely way. However, we found some instances where pressure care plans were not reviewed and patient escalation plans were not completed.
- Systems to manage and share care records were uncoordinated, and there were delays in sharing information between staff, carers and partner agencies. Staff did not always have access to the completed information they needed to provide care and treatment.
- Medicines were stored securely but they were not always stored at appropriate temperatures.

However:

- Staff received effective training in safety systems, processes and practices.
- Staff understood how to protect patients from abuse and were able to recognise the signs of abuse. The required number of staff had not completed for safeguarding adults level 2 multi-agency training
- The service controlled infection risk well and staff kept themselves, equipment and the premises clean most of the time.
- The service had suitable premises and looked after them well.
- Staffing levels were generally at safe levels. Although some senior staff raised concerns about the use of a high number of junior staff and agency staff impacting on the actual skill mix.
- The service carried out safety thermometer audits across all community hospitals.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- People's pain was not regularly assessed or effectively managed. Pain care plans when completed were not personalised to meet the needs of the patient.
- Staff understanding of their roles and responsibilities under the Mental Capacity Act 2005 was variable. Staff did not always effectively support patients who lacked the capacity to make decisions about their care.
- There was a risk staff were not following the most up to date polices. This was because in some areas paper copies of polices were found to not be the most current versions.

However:

Community health inpatient services

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- Information about people's care and treatment was routinely collected and monitored to improve the service.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff supported people to live healthier lives.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.

However:

At times families were not involved in discharge planning in timely way.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- The trust planned and provided services in a way that met the needs of local people.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit treat and discharge patients were in line with good practice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- The service generally took account of patient's individual needs.

However:

- We saw little evidence of personalised care planning to meet the needs of people in vulnerable circumstances.

Community health inpatient services

Is the service well-led?

Requires improvement 

Our rating of Well-led stayed the same. We rated it as requires improvement because:

- Governance structures were clear but there was a lack of assurance as to the effectiveness of governance processes.
- Staff we spoke with were not able to describe a defined vision or strategy for the service.
- The service had an up to date risk register but did not effectively manage and mitigate risks.
- There was little innovation or service development.

However:

- Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.
- Staff described an open and honest culture within the service and were confident to raise concerns with managers.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

There was some evidence of engagement with people who use services

Outstanding practice

Areas for improvement

Urgent care

Requires improvement 

Key facts and figures

Oxford Health NHS Foundation Trust provided physical, mental health and social care for people of all ages across Oxfordshire, Buckinghamshire, Swindon, Wiltshire, Bath and North East Somerset. The trust provided urgent care services to the population of Oxfordshire through a combination of Minor Injuries Units (MIU), First Aid Units (FAU), Emergency Multidisciplinary Units (EMU) and a Rapid Access Care Unit (RACU).

The MIUs were at Abingdon, Witney and Henley (Townlands Memorial Hospital). The FAUs were at Bicester and Wallingford. Minor injuries units and first aid units were able to treat a range of minor conditions such as, sprains and strains, broken bones, traumatic wound infections, minor burns and scalds, minor head injuries, insect and animal bites, minor eye injuries and injuries to the back, shoulder and chest. The three MIUs have x-ray facilities which were available at varying times. The FAUs did not have x-ray facilities.

The trust had two Emergency Multidisciplinary Units (EMU) at Abingdon and Witney. The EMUs are ambulatory care units and had been developed to provide assessment and treatment locally for adults with sub-acute care needs. There was a multi-disciplinary approach to care with inputs from medical and nursing staff and therapists. The unit in Abingdon was open from 8am to 8pm Monday to Friday and 10am to 4pm on weekends for referrals. The Witney EMU was open 10am to 8pm Monday to Friday. The Abingdon EMU had six inpatient beds available and Witney had four inpatient beds available for patients who required short stay care for up to 72 hours. On this occasion we did not visit the RACU based in Henley.

The urgent care service was last inspected in September 2015 where it was rated as good overall. For the five key domains it was rated: requires improvement for safe, and good for effective, caring, responsive and well-led.

The inspection team for this inspection consisted of a CQC lead inspector, a CQC inspector and a nurse specialist advisor with expertise in urgent care and quality assurance.

During this inspection, we spoke with approximately 23 patients and relatives and 16 members of staff. This included nursing staff, emergency practitioners, emergency nurse assistants and the senior leadership team. We reviewed five sets of patient records.

We also reviewed information from a wide variety of sources, before, during and after the inspection.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- Governance processes were not systematic and we found repeated areas of non –compliance which were highlighted in our 2015 report. Key areas of risk were not always identified and managed appropriately and the service did not have a vision or strategy to develop the service.
- Staff did not always understand or comply with essential policies and processes such as safeguarding referrals, medicines storage and staffing escalation. The environment in some areas did not meet the needs of patients and presented an infection control risk.

Urgent care

- Although staff respected their line managers, they did not always know senior management. Staff did not always receive appraisals and supervision and there was no evidence of succession planning for the service. Senior staff did not have assurance that all staff had completed the appropriate competency assessment. There was no competency assessment in place for adult trained staff who were caring for children.

However:

- Staff provided kind and compassionate care to patients and placed patients and their families at the centre of their work.
- Processes for incident reporting, recognising the deteriorating patient and record keeping were embedded into practice.
- The service provided care and treatment planned around the needs of patients and ensured they could easily access the most appropriate service.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- Although staff had a good knowledge of safeguarding children and the process to make a referral, not all staff could demonstrate a robust knowledge of the safeguarding adult referral process. We did not have assurance that all safeguarding concerns were reported to the local authority.
- There were significant concerns with the environment at some locations making it not fit for purpose for the patients in that area. There was no separate waiting area for children at one minor injury unit and the side room at another location was not fit for purpose but still accommodating patients.
- Although the service prescribed, gave and recorded medicines well, there was not always assurance that fridge medicines were stored at the correct temperature. This included high risk medicines such as insulin.
- Staffing levels and skill mix were planned across the service. However, in MIU were had concerns that the escalation policy was not embedded and the service did not always have enough resource to meet the demand of the service at busy times.
- The infection control risk in one side room had not been managed and there was significantly low compliance with some infection prevention and control modules.
- Computer screens were left unlocked in MIU which meant patient confidential information was visible to other patients and visitors.

However:

- The clinical areas we visited were visibly clean and tidy and the majority of staff complied with infection control policies.
- The service provided mandatory training to staff and the majority of staff completed this. However, there was low compliance in some essential modules.
- Staff recognised and responded appropriately to patient risk including deteriorating health and medical emergencies.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up to date and available to all staff providing care. Staff shared information appropriately with partner agencies.

Urgent care

- The service collected safety monitoring results and used this to monitor and improve the performance of the service and this information was shared with staff.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Mangers investigated incidents and shared lessons learned with the team. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service had a good system in place for managing and maintaining equipment.

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good because:

- The service had systems in place to ensure national guidance was regularly reviewed. Services had clear clinical guidelines in place and staff followed these.
- Staff gave patients enough food and drink to meet their needs and improve their health. However, on EMU staff did not consistently complete malnutrition screening for patients.
- The service monitored the effectiveness of care and treatment and used the findings to improve the service.
- The service gave advice and information to help patients manage their own health needs.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and Mental Capacity Act 2005. Staff knew how to support patients who lacked capacity to make decisions about their care.
- The service offered staff additional training and competency assessment including training in the care of children and young people. . .
-

However,

- There were gaps in management and support arrangements for staff such as appraisal and supervision.
- Although staff did carry out an initial assessment of patients' pain, there was no evidence this was reassessed. There were no pain tools in place for young children or individuals who could not communicate their pain score to staff.
- Not all clinical guidelines produced by the trust were clearly referenced.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff provided compassionate care and ensured patients were treated with dignity and respect.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.

Urgent care

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- The trust planned and provided services in a way that met the needs of the local population
- The service had made provision for some patients' individual needs. However, there was no evidence that the environment in MIU had been considered for patients with dementia.
- People could access the service when they needed it, including appointments at home. Waiting times from treatment met the national target.
- The service treated complaints seriously and staff were aware of how to handle a complaint.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- There was no systematic approach to governance that ensured information was cascaded from board level to wards. We found repeated non-compliance with concerns raised in our 2015 report.
- The service did not escalate, manage and reduce risks effectively. Risks included on the risk register did not evidence appropriate action to mitigate the risk to patients. The service did not demonstrate progress against areas highlighted as a concern in our previous inspection report.
- While staff praised their immediate line managers, they did not consistently know who the senior managers for the service were or how to gain access to them. There was no succession planning to develop leaders and senior staff were not always clear about their roles and accountability for quality.
- The urgent care service was approaching a period of change and did not have a formal written strategy or vision for the service. There was inconsistency in the knowledge of senior staff about the strategy and vision for the service. Clinical staff did not feel involved in the vision for the service.
- Some staff did not always feel recognised for their contribution within the older person's directorate.

However:

- Staff felt there was an open and transparent culture which promoted teamwork in services.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients and the public to improve services.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Mental health services

Background to mental health services

Oxford Health NHS Foundation Trust has been a foundation trust since 2008. The trust provides mental health services in community and inpatient settings across Milton Keynes, Buckinghamshire, Oxfordshire, Wiltshire and BaNES.

In July 2017, the trust took over community and inpatient services for people with a learning disability in Oxfordshire, which had previously been run by Southern Health NHS Foundation Trust. The trust provides eleven core mental health services across eight registered locations

We last inspected the trust in June 2016. In this inspection, we completed the trust's annual well led review and inspected the following core services:

- Acute wards for adults of working age and psychiatric intensive care units
- Wards for older people with mental health problems
- Wards for people with a learning disability or autism
- Community-based mental health services for working age adults
- Mental health crisis services and health-based places of safety
- Community mental health services for people with a learning disability or autism.

Summary of mental health services

Good ➔➔

Our rating of these services stayed the same. We rated them as good because:

- We rated effective, caring, responsive and well-led as good. Our rating for mental health services took into account the previous ratings of services not inspected this time.
- Incident reporting and investigation systems were robust in the trust.
- The trust had planned well the transfer of the learning disability services into the trust. The learning disability services were brought into the trust with care, compassion and respect for the patients, carers and staff involved.
- Leadership at directorate level was very strong. The directorates had clear plans and strategies to improve patient care and treatment. Trust governance systems supported and encouraged the development of strong, local leadership teams.
- The trust supported and encouraged wards and services to take part in external accreditation schemes.

However

- Following this inspection, we have rated one key questions – safe – as requires improvement.

Summary of findings

- Clinical risk assessments in the learning disability inpatient service did not include all the clinical risks that had been identified for each patient.
- The trust continued to have significant issues with recruitment and retention of staff particularly qualified nurses but we were assured that the trust was undertaking key work to find new and innovative ways of attracting staff to work at the trust.

Health-based places of safety

Good

Key facts and figures

Health-based places of safety are small staffed units on the site of a mental health service. They provide a service for people who have been found by the police in a public place and who are deemed to need a mental health assessment in hospital (section 136 of the Mental Health Act). Section 135 may also be used by the police with a warrant to bring someone into hospital from a private location.

The Police and Crime Act 2017 introduced significant changes to section 135 and section 136 of the Mental Health Act. Amongst other changes it is now unlawful to use a police station as a place of safety for anyone under 18 years old in any circumstances, and a police station can only be used for adults in special circumstances. The maximum detention has been reduced to 24 hours, unless a doctor certifies that an extension of 12 hours is necessary.

Oxford Health NHS Foundation Trust has four health-based places of safety at three locations:

- Littlemore Hospital in Oxford - the place of safety is attached to Ashurst ward (a psychiatric intensive care unit for men).
- Warneford Hospital in Oxford – the place of safety is attached to the Vaughan Thomas ward (an acute ward for men).
- The Whiteleaf centre in Aylesbury – there are two places of safety, one attached to Sapphire ward (an acute ward for men) and one attached to Ruby ward (an acute ward for women).

All the trust's places of safety were able to receive patients of all ages, including children and young people.

The previous inspection of the places of safety took place in September to October 2015 as part of the comprehensive inspection of Oxford Health NHS Trust. Safe, effective, caring and well-led were all rated good and responsive was rated as requires improvement. This gave an overall rating of good.

We undertook this inspection as we had concerns about the lack of information provided by the trust following our annual provider information request. Trust data for this service was combined with information about their crisis service which forms part of the trust's community-based mental health services for adults of working age.

This inspection was announced at short notice to the trust. A brief period of notice was given to the provider to ensure that everyone we needed to speak to was available.

During the inspection visit, the inspection team:

- visited four health-based places of safety at three hospital sites to review the quality of the environment and to observe how patients were cared for by staff
- spoke with four patients who had been admitted through the places of safety and who remained subject to the Mental Health Act
- spoke with one person who was in the place of safety at the time of our inspection under section 136 of the Mental Health Act
- spoke with 10 staff members, including qualified nurses, health care assistants, ward managers and a senior matron
- spoke with one carer

Health-based places of safety

- spoke with two approved mental health professionals
- spoke with the police, who had contact with the service
- spoke with the ambulance service, who had contact with the service
- looked at statistics concerning 76 patients in Buckinghamshire and 66 in Oxfordshire
- looked at a range of policies, procedures and other documents relating to the running of the service
- looked at 22 admission documents of patients who had been recently admitted to a health-based place of safety across the trust.

Summary of this service

Our overall rating of this service stayed the same and we rated it as good. We rated it as good because:

- The places of safety were well maintained, discreet, quiet and secure.
- The trust provided a safe and patient-focused place for assessment, by ensuring appropriate facilities, such as safe furniture that should not cause injury, courtesy packs for patients and televisions and game consoles.
- Patients were able to keep their mobile phones and electronic devices after an individual risk assessment was completed by staff.
- The monthly problems in practice meetings were well attended by the police and the trust. These meetings ensured there was an appropriate setting to discuss problems and to improve and maintain their relationship.
- The trust had a clear and comprehensive standard operational procedure, which had been reviewed in December 2017, and a new form in order to extend the period of detention in the place of safety following the change in the law.

However:

- There were concerns that the ambulance services were not more engaged in the problems in practice meetings. In recent months the attendance at meetings had improved.
- The Interagency Joint Working Protocol for the Management of Mental Health in the Thames Valley Area had not been updated with the recent change of the law.

Is the service safe?

Good 

We rated safe as good because:

- The places of safety were on the whole well maintained. Staff told us that they were cleaned weekly and after each use. The places of safety at Ruby ward and Sapphire ward both had a television and games console for patients. Patients also had direct access to showers and dimmable lights.
- The places of safety were discreet, quiet and secure. All the places of safety had air-conditioning. None had direct access to outside space.

Health-based places of safety

- The furniture on all sites was of a design which should not cause injury and was comfortable and well maintained. Patients were provided with bedding and a pillow and these were of a non-rip style. This meant that patients were safer and could not harm themselves with the bedding.
- Staff working in the places of safety carried alarms to alert colleagues to any concerns and there was an intercom system from the places of safety to the main nurses' station on Ruby ward and Sapphire ward.
- A staffing rota was in place when the place of safety was occupied. Staff felt that they were able to ask for assistance from staff from adjoining wards if needed or request agency or sessional staff. A daily telephone conference was held between the wards, including approved mental health professionals, and there were floating staff, consisting of one healthcare assistant and one nurse, at the Whiteleaf centre, ready to help out on either ward if needed.
- On most occasions, the police notified the ward by telephone that they were bringing someone to the place of safety. This gave ward staff time to prepare and the staff we spoke with were generally positive about the interaction with the police.
- Patients' baseline physical assessments were carried out by staff on arrival. Emergency equipment was available from the main nurse's office and we saw that the response time on Vaughan Thomas ward to bring the emergency equipment to the health-based place of safety was 32 seconds. This was within the three minutes recommended by the Royal College of Psychiatry.
- Staff were aware of the process of reporting any safeguarding concerns and were able to identify the safeguarding lead.
- There were monthly problems in practice meetings, which discussed operational issues. Both the trust and the police were positive about the discussions and outcomes of these meetings.
- Staff were aware of how to report incidents using the trust's online system. Staff said that de-briefs were held with patients and staff following any incidents.
- Medicines were not stored in the places of safety. Doctors could prescribe medicines and staff could access medicines from neighbouring wards when required.

However:

- There were some dirty marks on the blind spot mirrors and walls at the places of safety at Ashurst ward and Vaughan Thomas ward. There were also blind spots in their closed-circuit television cameras.
- The place of safety on Ashurst ward was isolated from the rest of the ward. Staff on Ashurst ward told us that they mitigated this risk by ward staff carrying out an observation of the place of safety every 10 to 15 minutes.
- At Ashurst ward place of safety there was a counter sunk screw missing from the door handle which left the door handle loose and a potential risk. This was pointed out to staff during the inspection who said that they would request this was fixed.
- At Ashurst ward there was no access to a shower in the place of safety, which meant that patients needed to be escorted to a separate shower in the seclusion suite or de-escalation suite next door to the place of safety, when they needed it. This posed a risk to staff escorting patients.
- The only exit route from the Ashurst ward place of safety was through a door with a key lock, which could potentially slow a staff member's exit in an emergency.
- There was no bed in the place of safety attached to Sapphire ward. Staff told us it had been removed as it was unable to be cleaned after being soiled. There was a bed available in the de-escalation room next door and the Matron confirmed that they were in the process of ordering a new one.

Health-based places of safety

Is the service effective?

Good

We rated effective as good because:

- The places of safety had a booking-in form which was used from the time of arrival. It enabled staff to capture information about the patient, information from the police about the incident, time of arrival and departure of the police officers, searches, explanation of their rights, and initial nursing assessment as well as details of the Mental Health Act Assessment.
- Following the recent change in the law, following the Police and Crime Act 2017, the trust also created a form to authorise the extension of the person's detention under section 136 or section 135 over the initial 24 hours, for up to 12 additional hours. Staff reported that it was very unusual for a period of detention to be extended.
- Staff spoke positively about the Positive Engagement and Caring Environment training (PEACE) that they had received and the positive impact that this training had had in relation to patient interaction and the use of restraint. Staff reported that they were rarely using restraint.
- Staff were aware of the recent change in the law (Police and Crime Act 2017) and reported that they had received on-the-job training following the recent change in the law, rather than formal training.
- Staff told us that they were regularly appraised and given clinical supervision.
- Staff told us that they had a positive relationship with the police and felt able to discuss any issues at the problems in practice meetings and come to a resolution. The approved mental health professionals reported a mutual understanding between the trust and the police about each other's demands.
- The police we spoke with said that they felt that the meetings were a good opportunity to discuss any issues and reported a good relationship with the trust.
- We saw staff adhering to the Mental Health Act and the Code of Practice. We were able to observe that a patient who was currently in the place of safety had been given an explanatory leaflet explaining their rights under the Mental Health Act in relation to section 136.
- Staff reported that patients had access to an Independent Mental Health Advocate (IMHA) or a solicitor if they wished to speak to them.
- Staff that we spoke to informed us that they had yearly online mandatory training in both the Mental Health Act and the Mental Capacity Act and classroom training every three years and those staff we spoke to were up to date with this training.

However:

- There were concerns that the ambulance service were not more engaged in the problems in practice meetings. In recent months the attendance at meetings had improved.

Is the service caring?

Good

We rated caring as good because:

Health-based places of safety

- Staff were professional, caring and supportive. Two patients that we spoke to reported that they had been given, at their request, colouring and painting equipment whilst they were in the place of safety.
- Patients in the places of safety were observed by staff at all times.
- Anyone admitted to any of the places of safety was offered food and a hot or cold drink. We observed that a patient had been given a cup of tea and they reported that they had been offered food. The units also had spare clothing if needed.
- Two patients we spoke with confirmed that they had a nurse allocated to them when they were admitted to the place of safety and both found the nurse to be kind and caring. Patients were provided with courtesy packs on arrival, containing personal hygiene products.
- Subject to individual risk assessments, patients were allowed to keep their mobile phone and any other electronic equipment. There was also a ward phone which they could use.
- On Ashurst ward place of safety there was a box of religious texts for the patients and the ward staff reported that they made every effort to meet people's spiritual and religious needs.
- Information on how to complain was provided to patients on the information forms given on arrival. Staff reported that there was a very low rate of complaints.
- There was information on the noticeboard in the Vaughan Thomas ward and Ashurst ward places of safety for patients, including information regarding using the telephone and shower
- Family members were able to visit patients at the places of safety.

However:

- We spoke to one carer who did not feel that they had been kept up to date with their relative's treatment since their relative had been admitted via the place of safety.

Is the service responsive?

Good ↑

We rated responsive as good because:

- The places of safety were open 24 hours a day, seven days a week. All ages were accepted in all the trust's places of safety.
- There were no exclusions for being admitted, other than those who required medical treatment for physical health issues and they were taken to a local hospital accident and emergency department.
- The approved mental health professionals who we spoke to reported that there was no target time for completion of mental health assessments and that it was on an individual basis. The time of arrival at the place of safety and the completion of the Mental Health Act assessment varied from two hours to 18 hours.
- We looked at recent admission statistics for Oxford and Buckinghamshire health-based places of safety and found that most had the start times and outcomes recorded.
- All of the places of safety had their own separate entrances.
- Staff reported that the patient information leaflet, which provided information about patients' rights whilst detained in the place of safety, could be printed out in a wide variety of languages.

- The section 136 patient information form, given to all patients, had a section in the back about how to complain.

However:

- The places of safety across the trust were occasionally used for other purposes, meaning they were unavailable if needed for someone detained under section 135 or 136 of the Mental Health Act. They had been used for seclusion for inpatients at times and, during our inspection visit, a patient was accommodated in the place of safety whilst they waited for a specialist bed to become available.
- Some staff reported difficulties in obtaining an interpreter. On one occasion when an interpreter could not be found a member of staff from the hospital had to assist. Following our inspection, the trust informed us that they were aware of this problem and were considering alternative providers of interpretation services.
- The Approved Mental Health Professionals informed us that there had been some difficulty getting a doctor trained and qualified in the use of the Mental Health Act (section 12 doctors) for assessments; there was a rota but sometimes the doctors were not aware that they were on the rota.

Is the service well-led?

Good 

We rated well-led as good because:

- Each ward was managed by the team manager of the ward to which it was attached, and they were supported by the modern matron and senior managers.
- There was an Interagency Joint Working Protocol for the management of mental health in the Thames Valley area, which contained a degree of operational guidance and was informed by the Mental Health Act, the Code of Practice, Police and Criminal Evidence Act (PACE) and Royal College of Psychiatrists' guidance. It was a comprehensive and informative document.
- Staff told us that they felt supported and valued by managers and colleagues in delivering their specialist place of safety service.
- Staff said that there was a positive and supportive culture. Staff from different wards supported each other in the event that more staff were needed to assist on the place of safety. There was a joint matron across Ashurst ward and Phoenix ward (an adjoining ward), which resulted in joined-up working and helped if additional staff were needed in the Ashurst ward place of safety.
- The trust actively participated in the problems in practice meetings with the police.
- There was an up-to-date standard operating procedure following the recent change in the law (Police and Crime Act 2017).
- We were informed on Ashurst ward that an internal audit had been carried out of the places of safety and the trust was working towards making the necessary improvements with the assistance and engagement of the ward managers. For example they were waiting for an estates quote for closed circuit television installation and had asked the estates team if a dimmer switch function could be applied to the lighting.

However:

- The Interagency Joint Working Protocol has not been updated since the recent changes in law (Police and Crime Act 2017).

Health-based places of safety

Outstanding practice

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Wards for people with a learning disability or autism

Requires improvement

Key facts and figures

Oxford Health NHS Foundation Trust provides a medium secure inpatient service for adult men with learning disabilities who have a history of offending behaviour or are at risk of offending. The trust provides 10 beds at one ward at Littlemore Mental Health Centre in Oxford.

We inspected this core service as part of our next phase mental health inspection programme.

We spoke with six patients, six relatives, and 15 members of staff. We observed care and treatment and looked at care records for five people and prescription cards for eight people. We also observed ward meetings, handovers and patient group activities.

Before the inspection, we reviewed information that we held and asked other organisations to share what they knew about the trust. These included NHS Improvement, local Health Watch organisations, local clinical commissioning groups and local authorities.

The ward for people with a learning disability had not been inspected as part of the previous Oxford Health NHS inspection as this service was previously run by Southern Health and only became part of Oxford Health NHS Foundation trust in July 2017.

Summary of this service

We rated the service as requires improvement overall because:

- We looked at the risk assessments for five patients, the risk assessments were fully completed to a good standard for one out of five patients, the remaining four were identified as present but not completed to a good standard.
- Staff we spoke with were not aware of the trust having any initiatives to reduce restrictive practices. The ward had a number of blanket restrictions in place that were not being constantly reviewed.
- The wards used a combination of paper-based records and electronic records.
- This was a high reliance on agency staff supporting the ward and there were no long-term contracted agency staff allocated to the ward so staff consistency could not always be maintained.
- Staff were not receiving regular clinical supervision and the trust did not record centrally the ward's compliance with their policy of supervision being completed every 6-8 weeks.
- The service had developed its own person centred approach to ward care planning that did not specifically follow the Positive Behavioural Support (PBS) Approach guidance by the Department of Health. Care plans were not recovery oriented and there were not clear goals set to support patients through their care and treatment pathway.
- Information was displayed on communal noticeboards on the ward however it was not always presented in an accessible and easy–to-read format.

However:

- Patients were not on any high-dose antipsychotic medication or multiple medications for psychosis. The clinical team tried to reduce the use of medications alongside other interventions. This meant that patients were not being overmedicated.

Wards for people with a learning disability or autism

- We found evidence of inter-agency working taking place, with care-coordinators and representatives from NHS England attending ward meetings as part of patients' admission and discharge planning.
- When we discussed care plans with the patients, we found they were all aware and had been involved in the development of their care plans along with their primary nurse. There was evidence in the care plans that patients' personal choices had been taken into consideration.
- Leave arrangements were carefully and comprehensively arranged between the clinical team and the patient and recorded accurately on the patients' section 17 leave forms.
- There was occupational therapist input to the ward and daily schedules of activities for patients including art, cookery, music, gym sessions, games, mindfulness and a regular yoga session which patients felt was extremely valuable.
- Staff morale was high despite concerns with high use of agency staff. The core staff team had worked on the wards for many years and were happy with the current management structure and the development of the ward.
- The service was in transition from Southern Health into the forensic directorate of Oxford Health NHS Foundation Trust. Oxford Health NHS Foundation Trust has made improvements since taking on the service and we recognise the ward was an improving service at the time of our inspection.

Is the service safe?

Requires improvement

We rated safe as requires improvement because:

- This was a high reliance on agency staff supporting the ward and there were no long-term contracted agency staff allocated to the ward so staff consistency could not always be maintained and agency staff were not always familiar with the ward.
- We looked at the risk assessments for five patients. Risk assessments were not fully completed for any of the patients. Only one patient out of the five sets of notes had a historic clinical risk assessment (HCR-20) in place. This is a comprehensive set of professional guidelines for the management of violence risk. For patients in medium security there should be an evidence-based risk assessment of this nature or equivalent in place to ensure a clear risk history is completed.
- The ward round was unstructured and did not refer to any elements of behavioural management that was evident in the care plans for the patients. The discussions of risk were not part of any structured discussion about risk management and reduction.
- There was no formal structure to the handover which meant that information relating to risk was not routinely handed over between teams.
- Staff we spoke with were not aware of the trust having any initiatives to reduce restrictive practices. The ward had a number of blanket restrictions in place that were not being constantly reviewed.
- The wards used a combination of paper based records and electronic records. The paper based records were not regularly uploaded onto the electronic system and it was not clear that all regular staff knew where documents should be saved. This meant that electronic information was not available to all relevant staff to deliver patient care while on the wards and when the patients were transferred between teams.

Wards for people with a learning disability or autism

- An incident occurred on the night of one of the inspection days that had not been reported on the system by the agency staff member on duty overnight. The incident was not reported as the agency nurse was not able to access the incident reporting system and required a permanent member of staff to input the information.

However

- The clinic room was fully equipped and emergency medications were all available and in date. There were effective recorded checks in place to make sure that resuscitation equipment was in good working order and could be used safely in an emergency.
- The ward had no incidents of rapid tranquilisation, this is the use of medication, usually intramuscular, if oral medication is not possible or appropriate, and urgent sedation with medication is required. Patients were supported using verbal de-escalation techniques.
- Patients were not on any high dose antipsychotic medication or multiple medications for psychosis. The clinical team tried to reduce the use of medications alongside other interventions. This meant that patients were not being overmedicated.

Is the service effective?

Requires improvement

We rated effective as requires improvement because:

- The service had developed its own person-centred approach to ward care planning that did not specifically follow the Positive Behavioural Support (PBS) Approach guidance by the Department of Health. Care plans were not recovery oriented and there were not clear goals set to support patients through their care and treatment pathway.
- Staff were not receiving regular clinical supervision and the trust did not record centrally the ward's compliance with their policy of supervision being completed every 6-8 weeks.
- The weekly multidisciplinary team meeting was very person-centred in its focus. However it did not follow a structured approach to each of the patients and there was no consistent approach towards discussing patient behaviours and risk management.
- We found little evidence of capacity decisions being recorded in the patient's electronic notes.

However:

- Each patient had a health action plan (HAP) in place. HAP is a personal plan about what the patient needs to do to stay healthy, including a record of past and future medical appointments.
- We found evidence of inter-agency working taking place, with care-coordinators and representatives from NHS England attending ward meetings as part of patients' admission and discharge planning

Is the service caring?

Good

We rated caring as good because:

- We spoke to six patients who told us that they found staff to be kind, polite and treated them with respect. We spoke with families and carers of the patients and they felt their relatives were safe and well cared for.

Wards for people with a learning disability or autism

- When we discussed care plans with the patients, we found they were all aware and had been involved in the development of their care plans along with their primary nurse. There was evidence in the care plans that patients' personal choices had been taken into consideration.
- Staff had successfully and sensitively formed therapeutic relationships with the patients in their care

However

- Whilst carers were positive about the care received for their loved ones there was no formal arrangements for carers and family members to feedback to the service, such as a carers forum or a drop in clinic.

Is the service responsive?

Good

We rated responsive as good because:

- Patients were free to access their bedrooms at any time and had the ability to personalise their bedrooms and were encouraged to put up pictures of their family or things they liked.
- Leave arrangements were carefully and comprehensively arranged between the clinical team and the patient and recorded accurately on the patients' section 17 leave forms.
- There was occupational therapist input to the ward and daily schedules of activities for patients including art, cookery, music, gym sessions, games, mindfulness and a regular yoga session which patients felt was extremely valuable.
- Staff supported the patients to maintain contact with their families and had use of a portable phone which meant that people had privacy to make phone calls

However:

- Information was displayed on communal noticeboards on the ward. However, it was not always presented in an accessible and easy–to-read format.

Is the service well-led?

Requires improvement

We rated well led as requires improvement because:

- The staff were not aware of the trust's agenda for reducing restrictive practices which is in operation on other sites within Oxford Health.
- The organisation had no way of collecting data on whether supervision was taking place and so could not re-assure itself it was happening and intervene effectively where it was not occurring.

The consultant was due to retire shortly after the inspection. The role had been advertised but no-one had been appointed at the time of the inspection. The plans to cover the three month gap in consultant cover involved a plan to recruit a locum consultant supporting the locum junior doctor to manage the patients with the support of the lead consultant in the forensic directorate. The locum doctor had not appointed at the time of the inspection. There was also difficulty recruiting to the full time nursing posts, a newly appointed matron, and high use of non-contract agency staff. These issues could collectively lead to a lack of clinical leadership for the ward until the posts are recruited to.

Wards for people with a learning disability or autism

NHS trusts are able to participate in a number of accreditation schemes and quality networks whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. This service was not involved in any accreditation schemes for learning disability or forensic services.

However:

- Staff felt that since the ward had been taken over by Oxford Health, they were much more connected with their local clinical leadership teams than they had felt previously.
- Staff morale was high despite concerns with high use of agency staff. The core of nursing staff had worked on the wards for many years and were happy with the current management structure and the development of the ward.
- The service was in transition from Southern Health into the forensic directorate of Oxford Health NHS Foundation Trust. Oxford Health NHS Foundation Trust has made improvements since taking on the service and we recognise the ward was an improving service at the time of our inspection.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

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

Good 

Key facts and figures

Oxford Health NHS Foundation Trust provides inpatient and intensive care services for adults of working age with mental health conditions. Patient are admitted informally or detained under the Mental Health Act 1983. The trust provides 118 beds across three sites, two in Oxfordshire and one in Buckinghamshire. There is one psychiatric intensive care unit, in Oxford. The wards are outlined below:

Warneford Hospital, Oxford:

Allen ward is a 20-bed female adult mental health inpatient service.

Wintle ward is a 16-bed female adult mental health inpatient service.

Vaughan Thomas ward is an 18-bed male mental health inpatient service.

Buckingham Health and Wellbeing Campus , Aylesbury:

Ruby ward is a 20-bed female adult mental health inpatient service.

Sapphire ward is a 20-bed male adult mental health inpatient service.

Littlemore Mental Health Centre, Oxford:

Phoenix ward is an 18-bed male adult mental health inpatient service.

Ashurst ward is an 11-bed mixed gender psychiatric intensive care unit.

We inspected this core service as part of our next phase mental health inspection programme.

Our inspection took place between 13 and 15 March 2018. It was unannounced, which means that staff did not know we were coming, to enable us to observe routine activity. We were unable to complete our activities when we carried out our first visit to Ashurst ward on 15 March 2018, due to an incident on the ward. We conducted a second visit to Ashurst ward on 23 March 2018, which was announced to the trust on 15 March 2018.

Before the inspection, we reviewed information that we held and asked other organisations to share what they knew about the trust. These included NHS Improvement, local Health Watch organisations, local clinical commissioning groups and local authorities.

During the inspection visit, the team:

- visited all seven inpatient wards, looked at the quality of the environments and observed staff were caring for patients
- spoke with 37 patients who were using the service
- spoke with four carers
- spoke with 79 members of staff, including ward managers, matrons, medical staff (including consultant psychiatrists), senior managers, pharmacists, psychologists, physiotherapists, nurses, nursing assistants, cleaning staff, occupational therapists, activity coordinators and administrative staff

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

- attended and observed four patient community meetings, six staff handovers, four multidisciplinary team review meetings, one psychology group meeting, one supervision group meeting, one 'friends and family' meeting and three patient activity sessions
- hosted staff focus groups; one with nine members of staff and one with five patients
- reviewed 91 patient medicine administration charts
- carried out a specific check of the medicine management on the wards
- reviewed 45 care and treatment records including the Mental Health Act documentation of detained patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- Staff effectively managed risks for patients of acute mental health wards and the psychiatric intensive care unit. We observed shift handover sessions and multidisciplinary patient review meetings where staff discussed risk levels in light of recent events. Staff had worked to improve the clarity of the care pathway for patients diagnosed with emotionally unstable personality disorder, following two serious incidents in 2017.
- Staff actively sought to use verbal de-escalation techniques to resolve, and where possible pre-empt, situations where patients were becoming agitated or aggressive. Staff only used physical restraint as a last resort, when verbal de-escalation was unsuccessful. Every ward had a member of staff nominated to lead on work to reduce the use of restrictive interventions.
- Staff completed comprehensive mental and physical health assessments of each patient at the point of admission. Each ward had good access to physical healthcare. The trust operated a smoke-free environment and staff supported patients with smoking cessation groups and nicotine replacement therapy.
- Vaughan Thomas ward was participating in a three-year research project to study the benefits of a specially designed unit to monitor (installed at the junction between wall and ceiling) patient movement and bodily processes whilst in their bedroom. The aim was to develop a system that allowed staff to remotely monitor patient night-time safety without having to disturb the patient whilst asleep.
- All wards in this core service had gained national accreditation for demonstrating that they met a certain standard of best practice in their area. The six acute wards had gained accreditation for inpatient mental health services – working age units (AIMS – WA). Ashurst ward had gained accreditation for inpatient mental health services – psychiatric intensive care units (AIMS – PICU).
- Vaughan Thomas ward had been shortlisted for a national award in the Student Nursing Times Awards for 2018. The ward was one of several nominated for student placement of the year, and was the only mental health ward on the shortlist. The winner was due to be revealed at an upcoming awards ceremony.
- Staff were passionate about their work and motivated to deliver high quality care to patients. Staff told us they felt supported by their ward manager, modern (ward) matron and senior matron and able to raise concerns. We received a great deal of feedback from staff who told us that team morale had significantly improved in the last 12-18 months.

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

- Patients had access to local advocacy services who visited each ward on a weekly basis and multifaith spiritual support was available to patients who desired it. The provider's patient advice and liaison service (PALS) held a drop-in surgery on wards ward every week. Staff could access interpreters as needed and could provide information leaflets in over 60 languages, to cater for the needs of all patients and carers.
- Staff treated patients in a caring, respectful and responsive manner. Staff displayed a high level of understanding of the individual needs and abilities of patients. Patients and carers we spoke with told us they were happy with the care provided by staff.
- Staff actively involved patients and carers in aspects of care delivery. Staff sought the input of patients and carers when carrying out risk assessments and formulating care plans. Patients and carers were able to provide feedback on the service during regular meetings.

However:

- Staff vacancy levels within this core service were high. The number of qualified nursing vacancies amounted to 49% of the establishment total as of 30 November 2017. During the 12-month period November 2016 to October 2017, 19% of total hours were filled by bank staff and 25% were filled by agency staff. Staff we spoke with were concerned about the impact of high levels of staff vacancies on the team and the running of the service. They spoke of the extra stress placed on substantive staff when the ward was operating with a high proportion of agency workers.
- Compliance levels for some mandatory training courses were below 75% at the time of our inspection.
- There were several issues with seclusion rooms. The seclusion room on Ashurst ward was quite dirty, with visible blood stains on one of the walls. The intercom unit outside the seclusion rooms on Ruby and Sapphire wards were located too far from the door, which meant that patients inside the seclusion room would be unable to see the member of staff they were talking with. There was no clock visible from the seclusion room on Ruby ward. The patient control of the vision panel in the seclusion room door on Ruby ward was broken so that a secluded patient would be unable to see outside the room.
- Staff were potentially exposed to elevated risk when working on the health-based place of safety attached to some of the wards. During the course of our inspection, an incident occurred in which staff did not have a full, accurate, easily-accessible risk profile for the patient in the health based place of safety.
- At the time of our inspection visit, the overall appraisal rate for non-medical staff within this core service was 58%. The trust's target rate for appraisal compliance was 90%. The wards with the lowest appraisal rates were Ashurst with 29% and Phoenix with 31%.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- Staff vacancy levels within this core service were high. The number of qualified nursing vacancies amounted to 49% of the establishment total as of 30 November 2017. Staff turnover during the 12-month period to the same point was 14% (highest on Sapphire ward, with 27%). The trust used bank and agency staff to cover staff sickness, absences and vacancies. During the 12-month period November 2016 to October 2017, 19% of total hours were filled by bank staff and 25% were filled by agency staff. However, 11% of total hours were left unfilled by either bank or agency workers. The trust acknowledged that staff recruitment and retention were among their main challenges and this was reflected on their risk register.

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

- Compliance levels for some mandatory training courses were below 75% at the time of our inspection. When considered across all seven wards, the compliance level was below 75% in a total of 41 out of 209 training modules.
- There were several issues with seclusion rooms. The seclusion room on Ashurst ward was quite dirty, with visible blood stains on one of the walls. The intercom unit outside the seclusion rooms on Ruby and Sapphire wards were located too far from the door, which meant that patients inside the seclusion room would be unable to see the member of staff they were talking with. There was no clock visible from the seclusion room on Ruby ward. The patient control of the vision panel in seclusion room door on Ruby ward was broken, so that a secluded patient would be unable to see outside the room.
- Staff were potentially exposed to elevated risk when working on the health based place of safety attached to some wards. During the course of our inspection, an incident occurred in which staff did not have a full, accurate, easily-accessible risk profile for them to refer to.
- There were some gaps in the recording of controlled drugs stock checks on both Sapphire and Ruby wards.
- We noted blind spots on Vaughan Thomas and Allen wards, where there was no convex mirror or other form of mitigation present.
- The storage of the minutes of ward "learning from incidents" meetings was inconsistent. The minutes of approximately half of the meetings were missing from computerised records on some wards.

However:

- We observed shift handover sessions and multidisciplinary patient review meetings where staff discussed risk levels in light of recent events. Staff worked with colleagues from community teams to best ensure that risks were effectively managed when each patient was ready to leave the ward.
- Staff on Sapphire ward had developed a patient safety plan which sought to assist patients to stay safe whilst on the ward and following discharge. The plan was jointly formulated by a member of staff and the patient, with the aim of identifying risks associated with their own behaviour and highlighting sources of support available to them.
- Staff actively sought to use verbal de-escalation techniques to resolve, and where possible pre-empt, situations where one or more patients were becoming agitated or aggressive. Staff only used physical restraint as a last resort, when verbal de-escalation was unsuccessful. Staff on Sapphire ward were engaged in a project to attempt to reduce the amount of time patients spent on enhanced observation levels.
- Medicines management was good. Staff stored, dispensed, administered and recorded patient medicine appropriately. Staff received a high level of input from pharmacists and pharmacy technicians, who visited each ward regularly. Pharmacy staff were available when nursing staff needed to seek their advice; they regularly attended ward meetings; and, conducted regular audits of medicines management systems.
- Staff had worked to improve the clarity of the care pathway for patients diagnosed with emotionally unstable personality disorder, following two serious incidents in 2017. Staff identified the rationale for hospital admissions and communicated them clearly to the patient from the outset, to best ensure their safety. Admissions were typically only a few days in length, to safeguard against patients becoming emotionally dependent upon being in the ward environment.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- Staff completed comprehensive mental and physical health assessments of each patient at the point of admission. Each ward had good access to physical healthcare. The trust had recently employed a senior nurse to co-ordinate and provide input and advice on healthy living and physical healthcare to patients on the site where Ruby and Sapphire wards were located. The trust operated a smoke-free environment and staff supported patients with smoking cessation groups and nicotine replacement therapy.
- Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group. The ward teams had access to a range of specialists to meet the needs of patients. As well as doctors, matrons and nurses, each ward team included an occupational therapist and activity co-ordinator. Pharmacists and social workers visited each ward regularly and other health professionals were available upon demand.
- Staff on each ward met regularly for reflective practice sessions, to discuss things that had gone well and learning points for the future.
- Doctors we spoke with told us felt they benefitted from effective peer supervision and an appraisal from a consultant within another service.
- Staff held regular multidisciplinary meetings to review the care and treatment for each patient. Staff attended a handover when commencing their shift. The handover sessions we observed were focussed on recent events; the current wellbeing of each patient; current risks and observation levels; updates relating to patient care and treatment; and, plans for the forthcoming shift. Staff on Ruby and Sapphire wards met three times a week for a 'rapid review meeting'. This meeting bridged the gap between shift handovers and weekly multidisciplinary meetings, to focus on the most important aspects of care for each time at that time. The meetings linked closely with colleagues in community mental health teams, to discuss patients who were nearing the point of discharge.
- The staff team on each ward had effective working relationships with other teams within the organisation, such as community-based adult mental health teams. Staff from the wards were in regular contact with colleagues from community teams when planning discharges and ongoing care needs. The ward teams also had effective working relationships with external teams such as social services, advocacy services and GPs.
- Patients had access to independent mental health advocates and independent mental capacity advocates as required.
- Staff we spoke with had a good general understanding of the Mental Health Act, the Code of Practice and the guiding principles. Staff had access to trust policies and appropriate administrative support and legal advice in relation to the Mental Health Act. Staff requested the input of a second opinion doctor when necessary. We saw evidence that staff explained patients' rights to them at the point of admission and at regular intervals thereafter. Staff carried out regular audits of Mental Health Act documentation.
- Staff had a good understanding of the Mental Capacity Act, in particular the five statutory principles. The trust had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff assessed patient capacity to consent to treatment during multidisciplinary meetings. Staff had recorded capacity and consent appropriately in the majority of care records we looked at.

However:

- Compliance rates for staff completion of combined training on the Mental Health Act and Mental Capacity Act were below 75% on all seven wards. The trust submitted training figures correct at the time of our inspection visit. The figure was lowest on Sapphire ward with 36%.

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

- At the time of our inspection visit, the overall appraisal rate for non-medical staff within this core service was 58%. The trust's target rate for appraisal compliance was 90%. The wards with the lowest appraisal rates were Ashurst ward with 29% and Phoenix ward with 31%. The wards with the highest appraisal rates were Allen ward with 88% and Wintle ward with 86%.
- Retention of minutes from staff meetings was inconsistent. Staff held regular team meetings, including those to discuss learning from incidents. However, the minutes from a significant proportion of meetings were absent from ward records. For example on Ashurst ward, the minutes for approximately half of the scheduled meetings were not present.
- Psychologists did not provide input to every ward. There was no psychologist on Vaughan Thomas ward. Phoenix ward did not have a psychologist, but did have a cognitive behavioural therapy specialist nurse who came to the ward, albeit for just one day per week.
- We spoke with one informal patient who staff had refused to allow to leave the ward when the patient had wanted to leave. We raised this issue with the ward manager of the ward who said they would reinforce knowledge of the rights of informal patients with their staff as a matter of urgency.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients in a caring, respectful and responsive manner. Staff displayed a high level of understanding of the individual needs and abilities of patients. Patients and carers we spoke with told us they were happy with the care provided by staff.
- Staff used the admission process to inform and orient patients to the ward and to the service. For example, on Sapphire ward staff used the admission process to familiarise new patients with the different levels of patient observation employed by staff, in relation to varying levels of individually assessed risks.
- Staff on Sapphire and Phoenix wards had used their identity board as an opportunity to encourage positive interactions and build relationships with patients. The name and photograph of each member of staff was accompanied by a few pieces of biographical information (such as their likes, dislikes, hobbies and previous employment). Patients told us that it was good to get to know something of the people caring for them.
- Staff involved patients in care planning and risk assessment. Staff offered patients a copy of their individual care plan and risk assessment and recorded whether or not the patient accepted a copy.
- Staff enabled patients to state their night-time preferences, with a notice on the outside of their bedroom door. They could state their choice for how staff engaged with them during the night; whether or not they preferred to have their bedroom door's vision panel left open; and, their preference for night-time lighting. Patients we spoke with liked the notices and thought they had a beneficial effect on their night-time experience, such as quality of sleep.
- Patients were able to provide feedback on the service during daily planning meetings and weekly community meetings. In addition, the main points from weekly "Have your say" meetings on each ward were shared with the staff team, in their weekly team meeting.
- Patients could access advocacy services that visited each ward on a weekly basis.

- As part of a project on Sapphire ward to reduce the amount of time patients spent on enhanced levels of observations, staff proactively sought the preferences of each patient in advance, for how they liked staff to interact with them when they had enhanced observation levels imposed upon them. Some patients preferred staff to adopt a passive role, for example near their bedroom door, whilst others said they preferred staff to interact with them, for instance by playing a board game together.
- Staff involved carers in patient care. Carers attended weekly multidisciplinary team review meetings (staff arranged an interpreter for carers when needed); staff sought input from carers when formulating individual risk assessments and care plans; carers could attend peer support meetings; and, staff provided carers with information about how to access a carer's assessment.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- A bed was normally available for patients living in the catchment area. Staff worked with colleagues in community mental health teams to review when each patient was ready for discharge, to make beds available. If patients were admitted out of area due to lack of beds, wards worked to ensure they were admitted to their local ward as soon as a bed was available for them.
- Patients were not moved to a different ward unless it was for a clinical reason, for example requiring more or less intensive nursing care. A bed was normally available in Ashurst ward, the trust's psychiatric intensive care unit (PICU), if a patient required more intensive care.
- Staff planned with patients for discharge following admission. Staff supported patients during transfer to acute hospitals and to more intensive nursing wards.
- Patients told us they were happy with the quality and choices of food on offer. Patients had access to food from different cultures and selections that adhered to specific dietary requirements. For one week each month, staff on Ashurst ward held a cultural awareness event, focussing on a different country each month. Staff helped patients to prepare well known dishes from that country and talked to them about different aspects of the culture of the place.
- Patients had access to multifaith spiritual support. Local advocacy services visited each ward on a weekly basis. The provider's patient advice and liaison service (PALS) held a drop-in surgery on wards ward every week.
- Staff could access interpreters as needed and could provide information leaflets in over 60 languages, to cater for the needs of all patients and carers.

However:

- All wards within this core service reported average bed occupancies above the provider benchmark of 85%. The average bed occupancy across the seven wards was 93%. The highest average occupancy level reported was 95%, on both Phoenix and Vaughan Thomas wards. The lowest average occupancy level reported was 91%, on Ashurst, Allen and Ruby wards.
- Some members of staff we spoke with did not feel they received sufficient feedback on the outcome of patient complaints.

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

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good because:

- Ward managers and modern matrons had the skills, knowledge and experience to perform their roles. They were visible in their wards and were approachable for patients and staff alike.
- Staff we spoke with were passionate about their work and motivated to deliver high quality care to patients. Staff told us they felt supported by their ward manager, modern (ward) matron and senior matron. We received a great deal of feedback from staff who told us that team morale had significantly improved in the last 12-18 months. We saw evidence of strong partnership working between the ward manager and modern matron on each ward, to effectively drive forward the service provided to patients. Staff on most wards, directly attributed the improvements in team working and morale to the establishment of the current manager and matron partnership.
- Staff we spoke with said they felt able to raise concerns and propose suggestions to improve the service without fear of being victimised. Staff were familiar with the trust's whistleblowing policy and the role of the freedom to speak up guardian. They told us that each of the ward managers and modern matrons were approachable and open to feedback.
- Vaughan Thomas ward was participating in a research project to study the benefits of a specially designed unit to monitor (installed at the junction between wall and ceiling) patient movement and bodily processes whilst in their bedroom. The project was scheduled to last to three years in Vaughan Thomas ward and one ward in a high secure hospital. The aim was to develop a workable system that allowed staff to remotely monitor patient night-time safety without having to disturb the patient whilst asleep. The monitoring unit was able to detect the patient's heartbeat and respiration rate, plus their movements within the bedroom. The phases of the project were to be implemented out with the full agreement of the patients who occupied the six bedrooms being used.
- All wards in this core service had gained national accreditation for demonstrating that they met a certain standard of best practice in their area. The six acute wards had gained accreditation for inpatient mental health services – working age units (AIMS – WA). Ashurst ward had gained accreditation for inpatient mental health services – psychiatric intensive care units (AIMS – PICU).
- Vaughan Thomas ward had been shortlisted for a national award in the Student Nursing Times Awards for 2018. The ward was one of several nominated for student placement of the year, and was the only mental health ward on the shortlist. The winner was due to be revealed at an upcoming awards ceremony.

However:

- Staff were concerned about the impact of high levels of staff vacancies on the team and the running of the service. They spoke of the extra stress placed on substantive staff when the ward was operating with a high proportion of agency workers. This was particularly marked for qualified nurses, given their clinical and managerial responsibilities on each shift and that it was their role that had the most significant level of vacancies.
- Staff sickness within this core service was 6% during the 12-month period October 2016 to September 2017. This was higher than the trust average of 4%, during the same period.

Outstanding practice

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

- Staff on Sapphire and Phoenix wards had used their identity board as an opportunity to encourage positive interactions and build relationships with patients. The name and photograph of each member of staff was accompanied by a few pieces of biographical information (such as their likes, dislikes, hobbies and previous employment). Patients told us that it was good to get to know something of the people caring for them.
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- Staff on Sapphire ward were carrying out a project to reduce the amount of time patients spent on enhanced levels of observations. Staff proactively sought the preferences of each patient following admission, for how they liked staff to interact with them when they had enhanced observation levels imposed upon them. For instance, some patients said they preferred staff to adopt a passive role, whilst others said they preferred staff to interact with them, for instance by playing a board game together.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of services.

Action the trust MUST take to improve

- The trust must ensure that all staff receive the mandatory training necessary to perform their roles.

Action the trust SHOULD take to improve

- The trust should ensure that staff are given feedback on the outcome of patient complaints.
- The trust should ensure that the use of bank and agency nursing staff is minimised.
- The trust should ensure that all staff receive an annual appraisal.
- The trust should ensure that they protect the confidentiality of each patient.
- The trust should ensure that a clock is visible from all seclusion rooms.
- The trust should ensure that patients in all seclusion rooms have a clear view of staff outside the room, including when they are communicating on the intercom system.
- The trust should ensure that staff are given feedback on incidents on different wards and at other trust locations.

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

- The trust should ensure that all necessary checks of controlled drugs take place and that those checks are properly recorded.
- The trust should ensure that all necessary physical observations are carried out after a patient is given rapid tranquilisation and that those observations are appropriately recorded.
- The trust should ensure that all necessary monitoring checks of patients in seclusion rooms take place and that those observations are appropriately recorded.
- The trust should ensure that patients from all wards have access to psychological therapies.
- The trust should ensure that the legal rights of informal patients are upheld.
- The trust should ensure that all ward areas are kept clean and free from unpleasant odours.
- The trust should ensure that patient controls of all bedroom door vision panels are in working order.
- The trust should ensure that all patients' care plans are up to date, personalised, holistic and recovery oriented, incorporating patients' strengths and goals.
- The trust should ensure that staff are provided with detailed, up to date risk assessments of patients when providing care to patients in health-based places of safety.

Regulatory action

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements. For more information on things the provider must improve, see the Areas for improvement section above. Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	**Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 - safe care and treatment** Staff had not completed all mandatory training. Compliance levels for a significant number of mandatory training courses were below 75% at the time of our inspection. This is a breach of Regulation 12(1) and (2)(c)

Community-based mental health services of adults of working age

Good 

Key facts and figures

Oxford Health NHS Foundation Trust provides community based mental health services for adults of working age who require a mental health service, but do not need to be admitted to hospital for treatment. Some adults may be subject to conditions under the Mental Health Act 1983.

This core service was previously inspected in June 2016. At that inspection the service rated as good for safe, effective, caring, responsive and well led domains. This gave the core service an overall rating of good.

The trust provides assessment and treatment services based at five locations across Oxford and Buckingham. These are:

Aylesbury Vale adult mental health team based in Aylesbury, Buckinghamshire.

Chiltern adult mental health based in High Wycombe, Buckinghamshire.

Oxford City and North-East Oxford locality adult mental health team based in Headington, Oxford.

North and West Oxon adult mental health team based in Banbury, Oxfordshire.

South Oxon adult mental health team based in Wallingford, Oxon.

As part of this inspection we visited the Chiltern team, the Oxford City and North-East Oxford and the North and West Oxon teams. As well as providing the assessment service, all three teams were working to a flexible assertive community team model which meant that patients needing increased support and contact would be identified by staff and receive more frequent and intensive contact from the team. When patients needed this enhanced support, they would be placed in the 'step up' category, which meant that they received additional sessions with staff and could utilise the on-site day hospital services. Each team maintained a 'step up' board which listed patients in this category, so all staff knew who was receiving this additional support.

We inspected this core service as part of our next phase mental health inspection programme.

Our inspection between 20 and 22 March 2018 was announced at short notice, which means that staff did not know we were coming until two days prior, to enable us to observe routine activity.

Before the inspection, we reviewed information that we held and asked other organisations to share what they knew about the trust. These included NHS Improvement, local Healthwatch organisations, local clinical commissioning groups and local authorities.

During the inspection visit, the team:

- visited three of the community sites, looked at the quality of the environment and observed how staff were caring for patients
- spoke with team leaders or managers at each site
- spoke with 40 other members of staff including nurses, social workers, psychologists, occupational therapists, consultant psychiatrists, junior doctors, healthcare support workers, student nurses and social workers and administrative staff
- spoke with 21 patients and five carers

Community-based mental health services of adults of working age

- reviewed 22 care records of patients
- reviewed Mental Health Act paperwork for five patients subject to a community treatment order
- attended two groups for patients
- observed six multidisciplinary staff meetings
- looked at a range of policies, procedures and other documents relating to the running of the service

Summary of this service

Oxford Health NHS Foundation Trust provides community based mental health services for adults of working age who require a service, but do not need to be admitted to hospital for treatment. Some adults may be subject to conditions under the Mental Health Act 1983.

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs and well led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against registered service providers and registered managers who fail to comply with legal requirements, and help them to improve their services.

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

At the last comprehensive inspection of this core service in June 2016 we rated the community based mental health services for adults of working age as good for the safe, effective, caring, responsive and well-led key questions which resulted in an overall rating of good. We re-inspected all five domains as part of this inspection.

Our rating of these services stayed the same. We rated them as good because:

- The provider had determined safe staffing levels and the number, profession and grades of staff in post matched the overarching staffing plan. Across all teams well trained and supported agency staff were used to cover any staff vacancies.
- Team managers had regular caseload supervision with practitioners to ensure that caseloads were manageable and shared equally between the team. Part time staff and social workers with responsibility for safeguarding had reduced caseloads to enable them to manage their time effectively.
- We reviewed 22 care records of patients across the three teams. Staff had completed a risk assessment for each at the point of initial assessment. Staff updated risk assessments regularly and after any reported incidents. Staff shared risk appropriately with colleagues and discussed high or particular risks with senior team members in supervision, reflective practice sessions and in multidisciplinary clinical meetings. This ensured risk was clearly communicated between all staff. Crisis management plans were in place and groups were available in the day hospitals which looked specifically at planning to manage safely in a crisis.

Community-based mental health services of adults of working age

- Care plans clearly reflected the individual persons' needs that staff had identified during the initial assessment. Care plans were personalised, holistic and recovery focused. Staff used a nationally recognised good practice care planning tool called the, 'recovery star' to ensure the full involvement of patients. Patients told us they had received a copy of their care plan and had participated in their risk assessment.
- All teams had embedded posts, employed by a community mental health organisation, which specialised in housing and employment. These staff had strong links with local colleges, housing organisations, local employers and enabled patients to acquire living skills to support patients find employment, vocational placements or work based training. These staff could also support patients with their benefits claims to ensure they were claiming appropriate benefits.
- All teams visited had a physical health clinic to ensure those using services had access to physical health screening and regular health checks. Teams were actively promoting healthy lifestyles and provided information on smoking cessation and healthy living. We saw that patients were referred and supported to attend their GP surgery.
- Staff provided a range of care and treatment interventions including psychological therapy, medication and social support. Interventions such as family intervention therapy for those with psychosis were in line with National Institute for Health and Care Excellence guidelines. Treatment offered at the day hospitals included groups on mindfulness, health and wellbeing, anxiety management, mood management and wellness recovery action planning.
- Whilst on inspection we saw that staff participated in wide range of clinical audits to monitor the effectiveness of the services provided. Areas covered included, ensuring good physical healthcare, ensuring adherence to the care programme approach, monitoring the quality of care plans, implementing the 'true colours' mood monitoring tool and developing educational, mental health information booklets. Action plans were developed to address any areas identified for improvement. Each team had a dedicated research assistant post.
- Each team had a duty system to respond to any sudden deterioration in the mental health of a person using the service. Staff would be on the daily rota and would know in advance if they had any assessments to complete on that day. The team leaders and duty worker would have a daily morning meeting to discuss any planned assessments or contacts needed that day.
- All three teams were working to a flexible assertive community team model which meant that patients needing increased support and contact would be identified by staff and receive more frequent and intensive contact from the team. When patients needed this enhanced support, they would be placed in the 'step up' category, which meant that they received additional sessions with staff and could utilise the on-site day hospital services. Each team maintained a 'step up' board which listed patients in this category, so all staff knew who was receiving this additional support.
- Skilled staff were available to assess patients in a timely manner. Each day both the assessment and treatment teams looked at all new referrals. Urgent referrals would be prioritised and processed by the teams, if required on a twice daily basis across all community teams. No team had a waiting list for either assessment or allocation to a treatment team. Each team had daily zoning meetings at which staff reviewed the risk of patients using the service to ensure they were receiving the appropriate amount of contact from the team.
- The community teams were well-led and had clinical lead managers in position. The managers were visible within the service during the day-to-day provision of care and treatment, they were accessible to staff and they were proactive in providing support and leadership. All staff we spoke with, without exception commented positively on this. The leaders of these teams had the skills, knowledge and experience to perform their role to a high standard. They had a very detailed and comprehensive understanding of the services they managed.
- Team leaders had access to their teams' performance dash boards so could monitor their team's key performance indicators and key risk issues. Team leaders used the boards daily in handover and clinical meetings.

However:

Community-based mental health services of adults of working age

- There was some confusion with one staff member at both the Elms Centre and the Valley Centre about what emergency equipment was stored on site.
- Two staff at both the Elm centre and the Valley Centre said they were not consistently ringing in at the end of each working day as per the trust lone working policy.
- In four cases, across all teams, the physical health section of the electronic care records system did not always make reference to why a physical health assessment was not carried out.
- The capacity section of the electronic care records did not have entries in 10 out of 22 cases to confirm that capacity was considered. However, this form had been recently introduced and capacity assessments had been recorded in a different section of the care records.

Is the service safe?

Good 

Our rating of safe stayed the same. We rated it as good because:

- Access to the mental health centres for appointments and clinics were through staffed reception areas with comfortable waiting areas. Staff carried out audits and risk assessments on all of the team premises to ensure the environments were safe, clean and tidy and that fixtures and fittings were provided to a good standard and were well maintained. Clinic rooms were clean and had the necessary equipment to carry out physical health examinations. Staff completed monthly audits of the clinic rooms to ensure all equipment was tested regularly and fridge temperatures checked.
- Interview rooms were available at each of the sites and with the exception of one room at the Valley Centre; they were soundproofed well for confidentiality. Staff at the Valley Centre were aware of this issue and had requested additional sound proof work to be carried out. When staff were interviewing patients, they took alarms into the meeting rooms with them and each team had an alarm procedure in place for a swift response.
- The provider had determined safe staffing levels and the number, profession and grades of staff in post matched the overarching staffing plan. Across all teams well trained and supported agency staff were used to cover any staff vacancies.
- Team managers had regular caseload supervision with practitioners to ensure that caseloads were manageable and shared equally between the team. Part time staff and social workers with responsibility for safeguarding had reduced caseloads to enable them to manage their time effectively.
- Each team had access to medical cover. There was at least one consultant psychiatrist available to each team. Staff could arrange out-patient appointments for patients using the service or sooner appointments if they needed to see a psychiatrist urgently. Each team doctor kept at least one appointment free each day for emergencies.
- The trust provided us with up to date training figures for the period up to March 2018. This showed that for the core service there was 84% compliance with mandatory training. The trust also provided details to show when staff could take protected time to complete mandatory training or had booked training in advance.
- We reviewed 22 care records of patients across the three teams. Staff had completed a risk assessment for each at the point of initial assessment. Staff updated risk assessments regularly and after any reported incidents. Staff shared

risk appropriately with colleagues and discussed high or particular risks with senior team members in supervision, reflective practice sessions and in multidisciplinary clinical meetings. This ensured risk was clearly communicated between all staff. Crisis management plans were in place and groups were available in the day hospitals which looked specifically at planning to manage safely in a crisis.

- Each team had a duty system to respond to any sudden deterioration in the mental health of a person using the service. Staff would be on the daily rota and would know in advance if they had any assessments to complete on that day. The team leaders and duty worker would have a daily morning meeting to discuss any planned assessments or contacts needed that day.
- There were no waiting lists in any of the teams, for either assessment or commencement of treatment at the time of our inspection. Staff said they would maintain contact with patients on waiting lists if they had one to ensure they could respond to any increase in risk or individual need. Staff could prioritise and bring forward assessments if the need had changed, or risk increased.
- All three teams were working to a flexible assertive community team model which meant that patients needing increased support and contact would be identified by staff and receive more frequent and intensive contact from the team. When patients needed this enhanced support, they would be placed in the 'step up' category, which meant that they received additional sessions with staff and could utilise the on-site day hospital services. Each team maintained a 'step up' board which listed patients in this category, so all staff knew who was receiving this additional support.
- Each team had daily zoning meetings at which staff reviewed the risk of patients using the service to ensure they were receiving the appropriate amount of contact from the team.
- The trust had a lone working policy and staff out on community visits at the end of the day should contact the designated duty worker for the day. If the staff member had not made contact by a specified time, the duty worker would contact them. This ensured someone always had oversight of where staff were and a main point of contact for all staff. Should contact not be made this would then be escalated to the team manager to arrange further action, for example a home visit. However, this procedure was not consistently followed at the valley and the Elm centres.
- The trust had a detailed safeguarding policy which made reference to both adults' and children's safeguarding, which all staff could refer to inform decision making. During our inspection all the teams had strong safeguarding links with the local authority and knew how to make a referral and if required undertake investigations. Staff demonstrated good knowledge and understanding of safeguarding issues and when to raise concerns. Multi agency safeguarding hubs were available to all staff in the localities. Social workers were fully integrated in the teams and often took the lead role in any safeguarding enquiry. Each team also had an appointed safeguarding champion who could advise and signpost staff. Training rates for safeguarding across the service was at the trust target of 92%.
- The electronic recording system had an alert which showed whether a person was subject to either safeguarding or multi-agency risk assessment conference procedures. This enabled practitioners to see quickly the safeguarding status of patients on their caseload, and helped them track progress.
- Staff stored all information relating to patients and their care records on an electronic system. All staff had access to this and also had access to the local authority electronic record keeping system. This ensured that staff could access relevant information in a timely manner, without having to request it from the local authority. However, it did also mean that staff had two systems to keep updated which took more time.
- Staff scanned and uploaded any paper documents so these were always available and accessible to all. Mobile devices were available to all staff so they could update care records remotely and in a timely manner.
- Staff from teams across the mental health pathway used the same system so staff from both inpatient services and community teams all had access to the same information. This helped to maintain effective communication between the various teams.

Community-based mental health services of adults of working age

- Staff followed the trust's policy for the safe management of medicine in the community which included good practice on the storage, transport, dispensing, administration, recording and disposal of medicine. All staff transporting medicine in the community had an appropriate licence to do so, in line with national institute for health and care excellence guidance.
- Staff monitored the effects of medicine on the physical health of patients and reviewed this regularly in physical health clinics. This was in line with guidance from the national institute for health and care excellence.
- We saw evidence of good pharmacy and medicines reconciliation at all the teams. Each team had contact with the team pharmacy technicians several times every week.
- All staff we spoke with knew how to report incidents and which incidents should be reported. All staff had access to the on-line incident reporting system. Staff sent all reported incidents to the team managers to review and sign off. If further review was needed, the team manager would send it on to the service managers for scrutiny.
- In addition to the trust holding twice yearly learning events, staff received feedback and learning from any incidents at monthly team business meetings and via email communications including the trust's learning bulletins. Staff had the opportunity to de-brief after an incident and were offered reflective feedback sessions.
- The trust had a duty of candour policy to which staff adhered. This ensured that staff were open and transparent with those using services and their families and carers and kept them informed of any incidents that might have affected them. The duty of candour policy clearly set out the steps staff must take when informing others following an incident.
- Staff told us of changes in practice following incidents. At the Elm Centre, for example, staff learnt that next of kin details need to be regularly checked and refreshed to ensure the details are correct.

However:

- There was some confusion with one staff member at the Elms Centre and the Valley Centre about what emergency equipment was stored on site.
- Two staff at both the Elm centre and the Valley Centre said they were not consistently ringing in at the end of each working day as per the trust lone working policy.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- We reviewed 22 individual care records. Each record showed staff had completed a comprehensive assessment including, where appropriate, the physical health needs of patients.
- Care plans clearly reflected the individual persons' needs that staff had identified during the initial assessment. Care plans were personalised, holistic and recovery focused. Staff used a nationally recognised good practice care planning tool called the, 'recovery star' to ensure the full involvement of patients.
- Staff reviewed their caseload with the multi- disciplinary team every four weeks to ensure care plans of those using services were relevant and up-to-date. This ensured that both the individual and practitioner knew the current goal and any discharge plans that may be in place.
- Staff followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medicines, in relation to options available for patients' care, their treatment and wellbeing, and in assuring the highest standards

of physical health care delivery. Staff also used NICE guidance in the delivery of the therapeutic programme that included nationally recognised treatments for patients such as psychology. Staff provided a range of care and treatment interventions including psychological therapy, medication and social support. Interventions such as family intervention therapy for those with psychosis were in line with National Institute for Health and Care Excellence guidelines. Treatment offered at the day hospitals included groups on mindfulness, health and wellbeing, anxiety management, mood management and wellness recovery action planning.

- All teams had embedded posts, employed by a community mental health organisation, which specialised in housing and employment. These staff had strong links with local colleges, housing organisations, local employers and enabled patients to acquire living skills to support patients find employment, vocational placements or work based training. These staff could also support patients with their benefits claims to ensure they were claiming appropriate benefits.
- All teams visited had a physical health clinic to ensure those using services had access to physical health screening and regular health checks. Teams were actively promoting healthy lifestyles and provided information on smoking cessation and healthy living. We saw that patients were referred and supported to attend their GP surgery.
- Staff used health of the nation outcome scales to monitor the impact of mental health problems on patients and measure outcomes at the end of an episode of care.
- Patients had access to a recovery college which provided courses on mental health and recovery. The courses were designed for those using services to gain knowledge of their condition to enable them to take control of their own recovery. The recovery college courses and workshops were co-produced and co-delivered by tutors with both personal and professional experience of mental health problems. The college followed an adult education model and aimed to deliver a responsive, peer led education and training curriculum.
- Whilst on inspection we saw that staff participated in wide range of clinical audits to monitor the effectiveness of the services provided. Areas covered included, ensuring good physical healthcare, ensuring adherence to the care programme approach, monitoring the quality of care plans, implementing the 'true colours' mood monitoring tool and developing educational, mental health information booklets. Action plans were developed to address any areas identified for improvement. Each team had a dedicated research assistant post.
- All staff participated, at least weekly, in reflective practice sessions to also evaluate the effectiveness of their interventions.
- Each team had access to a full range of mental health specialists, including psychiatrists, psychologists, social workers, nurses, health care assistants, occupational therapists, research assistants, pharmacists and support, time and recovery workers. Staff could refer to additional specialists, for example, dieticians, physiotherapists and speech and language therapists as required.
- Whilst on inspection the trust refreshed the compliance figure and appraisal compliance increased to 75%. Staff who had had an appraisal reported that they were meaningful and included opportunities to discuss learning, future career development as well as challenges and successes
- Staff received a variety of supervision including managerial, clinical, reflective practice and peer support. Social workers and psychologists received professional supervision from outside the team to ensure their practice was current and up to date. We received refreshed data from the trust that showed that in January 2018 the core service had met the trust target of 90% for staff receiving supervision. Psychology staff offered patient specific supervision and reflective practice sessions for staff in each team.

Community-based mental health services of adults of working age

- Each team had regular meetings to ensure staff were kept informed of any trust news, learning from complaints and incidents and any service developments. Staff were able to access specialist training for their role and we heard of staff attending family therapy training, psychological interventions training, suicide prevention and medicines management training, alongside their mandatory training.
- Newly qualified nurses and social workers were offered a preceptorship year which included being offered a mentor and additional training and supervision. The trust had developed the role of the nurse associate which offered a clear career development opportunity for support workers.
- A new initiative had been agreed and 20 volunteer peer support workers had been recruited to take up work placements across inpatient and community teams. These were people who had lived experience of using mental health services. It was hoped these volunteer staff would go on to be recruited into paid and substantive posts in the teams.
- Staff attended daily multidisciplinary clinical meetings to discuss new referrals and assessments as well as on going cases for additional support. Teams also held zoning meetings to discuss the risks of those using the service and monthly business meetings to discuss service developments and any trust issues.
- The teams had good links with other services within the mental health pathway. Twice daily staff conference calls were held with the teams, day hospitals and inpatient wards where all potential admissions, discharges and high clinical risks were collectively discussed.
- The teams had strong links with other organisations for example, 'One Recovery' a substance misuse service in Buckinghamshire, 'community mental health groups, primary care and the local authority. In Oxfordshire, six mental health organisations from the NHS and charity had signed up to work closely with each other, called, 'the Oxfordshire mental health partnership'.
- As of March 2018, 95% of the community team staff had received training in the Mental Health Act. Staff we spoke with had a good understanding of the Mental Health Act Code of Practice and the guiding principles. Staff had access to administrative support and advice on the implementation of the Mental Health Act.
- We reviewed community treatment orders across the teams. These were all up to date and we saw evidence that staff were routinely reading individuals their rights under this legislation and gave those subject to the treatment order timescales for lodging an appeal against this. All of these orders were updated on the 'step up boards' so staff could see that timescales were adhered to correctly.
- The trust had a Mental Health Act policy and all staff had access to the Mental Health Act Code of Practice.
- The trust employed approved mental health professionals and many of these were based within the community teams. The approved mental health professionals carried out their statutory duties on a rota system so everyone knew when they would be available for case work and when they were performing Mental Health Act duties.
- As of March 2018, 88% of staff had undertaken Mental Capacity Act (MCA) training. There was a MCA policy in place and staff told us about the principles of the Act and how they applied to their service users.
- Notice boards in the team bases contained information about the MCA, with contact numbers to call for further advice.
- Staff were familiar with obtaining a person's consent, although they commented that patients using community services had a high degree of autonomy to determine many aspects of their daily lives, including contributing to their risk assessments and care plans. Where appropriate patients had a mental capacity, assessment relating to care and treatment. Documentation was available around best interest decisions in patients' notes and staff told us confidently what this meant.

Community-based mental health services of adults of working age

However:

- In four cases, across all teams, the physical health section of the electronic care records system did not always make reference to why a physical health assessment was not carried out.
- The capacity section of the electronic care records did not have entries in 10 out of 22 cases to confirm that capacity was considered. However, this form had been recently introduced and capacity assessments had been recorded in a different section of the care records.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- In all three community teams we observed the staff to be kind, caring and compassionate. This was demonstrated by all the staff we shadowed. When we spoke with patients they were very positive about the support they had been receiving. The majority of patients we spoke with and their carers reported that they were treated with respect and found staff to be supportive and helpful. All feedback given commended individual staff highly and gave examples of how they had been cared for and assisted towards their recovery. Administrative staff were also praised highly by the patients we spoke with, particularly in regard to their helpfulness, professionalism and approachability.
- Staff supported patients to understand and manage their care and treatment. This included directing them to other services when appropriate. The staff had strong links with other services and community groups.
- Staff were confident they could and would raise any concerns about inappropriate or disrespectful behaviour towards patients.
- Patients' confidentiality was maintained by all the community teams. When we accompanied staff in meetings with patients, the staff members asked if the person was content for a Care Quality Commission team member to be present prior to the meeting or group. All staff spoken with were aware of the need to ensure a person's confidential information was kept securely. Staff access to electronic case notes was protected.
- Patients told us they had received a copy of their care plan and had participated in their risk assessment. We discussed recovery goals which had been set and the involvement that patients had in their care planning. They had a good deal of involvement, for example one person told us they were asked on each visit whether their needs had changed and whether they were happy with the recovery goals set.
- Patients were offered a variety of therapies both individually and on a group basis which actively included their involvement. For example, we spoke to patients who had participated in groups to help with mood stabilisation, others who had joined groups to learn about recovery principles, health and wellbeing and to help build self-esteem and confidence.
- In the care review meetings, we attended, we saw that these involved the person receiving care. Records showed that patients had received at least a six-monthly review of their care under the care programme approach protocols.
- The trust had appointed a patient care involvement lead who had held a series of focus groups with service users to get their feedback on how best to involve patients in both their care and also service developments. A number of initiatives were introduced and included, the 'I want great care' feedback survey. The most recent survey showed 85% of patients and 75% of carers would recommend the service to another person. In addition, a service user co-produced monthly newsletter was published and a mental health multi agency partnership event was planned with service users and held to raise awareness of mental health and reduce stigma in the community.

Community-based mental health services of adults of working age

- Suggestion and comment boxes seeking feedback were available in all community bases.
- Patients using services had access to a wide and relevant range of information which included information on; employment support services, support following a bereavement, alcohol and drugs advisory service, support for people suffering from domestic abuse, signs and support if elder abuse is suspected, support for people with anxiety and depression and the care programme approach explained. There was access to leaflets in different languages if needed. Interpreting services and advocacy services were available if required and contact numbers were advertised.
- Patients were encouraged to participate with staff recruitment processes.
- Carers we spoke with said they had been involved in discussions about their relatives' care and treatment, once consent had been given. Carers said they had been offered and received a carers' assessment to establish what support they may need. A carers' handbook had been co-produced by service users, carers and staff. Carers were also encouraged to feedback via the 'I want great care' survey.
- In 2017, the trust had reviewed the family, friends and carers strategy, called, 'I care, you care'. The strategy set out how the trust planned to work with the Carers Trust with the aim of acquiring a level three accreditation having already successfully applied for and met the key standards of the, 'triangle of care'. This involved, for example, dedicated funded posts to co-ordinate family and carer involvement and developing a culture of the organisation to better value the importance of carers' roles and to deliver services which support carers in their caring role.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- Referrals into the trust came from a variety of sources which included; mental health inpatient wards, GPs, social care, the non-statutory sector, accident and emergency departments, the police and the criminal justice system. Each team averaged 200-250 referrals every month.
- Targets set by commissioners for patients to be seen were 4 hours for an emergency referral, 72 hours for an urgent referral and 28 days for a routine referral. There were no breaches of the crisis or urgent targets across any team. There were a minority of breaches for routine referrals however this was generally patients requesting a change of appointment over the 28-day period.
- The teams operated a single point of access and assessment function and all patients referred to the community teams were triaged through this team function. The assessment team could go on to offer patients some brief intervention work which included, medication monitoring and review, support with physical health needs and ongoing monitoring, support with returning to work, a range of psychological therapy, advice on coping with symptoms of illness and support with accessing community facilities and resources. In addition, both the assessment teams and treatment teams could 'step up' support by utilising the services on offer in the day hospitals.
- Skilled staff were available to assess patients in a timely manner. On average 20-30% of patients seen by the assessment team went on to receive a service from the treatment teams. This meant these patients would have already received a detailed assessment of their emotional, psychological and social needs before being seen by the treatment teams.
- Each day both the assessment and treatment teams looked at all new referrals. Urgent referrals would be prioritised and processed by the teams, if required on a twice daily basis across all community teams. No team had a waiting list for either assessment or allocation to a treatment team.

Community-based mental health services of adults of working age

- Staff managed their own electronic diaries and could be flexible in offering patient appointment times.
- There was out of hours (21.00 to 07.00) cover provided at each locality accident and emergency departments. These mental health rapid response teams could see urgent referrals, and also took on the role of out of hours support.
- Each team followed a protocol of making follow up contact with patients who did not attend appointments. Staff tried to contact them by telephone, and then wrote letters to the individual and referrer so that all relevant people were kept aware. If staff felt risks were sufficiently high they could attempt a cold call visit of anyone who did not attend their appointment.
- All team bases had a wide range of rooms to see patients, including clinic rooms and the day hospital facilities. With the exception of one room at the Valley Centre, these were all soundproofed to maintain confidentiality.
- Waiting areas were spacious and well furnished, offering a wide variety of information leaflets.
- Staff reported there were enough rooms for them to book to see patients at the service.
- Staff ensured patients had access to education and work opportunities, for example staff had strong links with local colleges, local employers and enabled patients to acquire living skills to support them maintain or finding employment, vocational placements or work based training.
- Staff at all teams encouraged patients to maintain healthy relationships with those people that mattered to them, be that family, friends or community groups.
- A wide selection of literature was available in all reception areas which included: how to raise a concern or complaint, access to advocacy services, mental health diagnosis defined, treatment options available, medication explained, access to self-help groups and voluntary sector mental health support organisations such as the Samaritans and MIND. Information could be sourced from the trusts website in different languages when required.
- Disability access was available in all of the team bases.
- Good signage, including pictures, symbols and hearing loops were apparent in all bases for those people who may have difficulty communicating.
- Patients' diverse needs such as ethnicity and religion were recorded in their care records. Managers ensured easy access to interpreters and/ or signers.
- Information about how to complain was on display in reception areas of all of the community sites and on the trust's website. Reception areas also had information available about the patient advice and liaison service which supported patients in raising concerns. A representative from this team visited the community bases every month to talk with patients and gain their feedback about the services. Patients were given information about how to make a complaint as part of their introductory information leaflets.
- Staff were able to describe the complaints process and how they would process any complaints. Staff knew how to respond to anyone wishing to complain and clinical lead managers demonstrated how both positive and negative feedback was used to improve the quality of services provided. For example, we heard that one team had received a complaint about how busy the reception area was and that at times patients would prefer to sit quietly. The reception staff listened to the complainant and set up a room booking system to enable patients to sit quietly in a smaller interview room whilst waiting for their allotted appointment time with a staff member.
- All of the patients we spoke with told us they were confident to raise any concerns or complaints and that they thought they would be listened to and their complaints taken seriously. Many patients said they would feel extremely confident to ring the team managers if they had any concerns at all.

Community-based mental health services of adults of working age

- We looked at eight complaints received and the related correspondence. We found complaints were taken seriously and responded to promptly in adherence to the trusts complaints policy and associated procedures. All complainants received an individual response to their complaint as well as contact details of other bodies they could approach if they were unhappy about the outcome. Local resolution of complaints in the teams was always attempted.
- We saw through staff team meeting minutes that complaints were discussed and actions were taken to ensure any lessons highlighted were learnt. We saw discussions took place in one team meeting to agree to ring patients prior to assessment to offer them the opportunity to choose a date and time following a complaint received about rigid appointment times.
- Patients were given the opportunity to participate in an annual satisfaction survey in addition to feeding back their experiences at care review and planning meetings.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good because:

- We found that the community teams were well-led and had clinical lead managers in position. The managers were visible within the service during the day-to-day provision of care and treatment, they were accessible to staff and they were proactive in providing support and leadership. All staff we spoke with, without exception commented positively on this.
- The leaders of these teams had the skills, knowledge and experience to perform their role to a high standard. They had a very detailed and comprehensive understanding of the services they managed. All of the managers we interviewed had been offered leadership development opportunities, such as coaching skills and managing a budget.
- Most staff knew who the senior managers and executive directors were. They had met the chief executive and executive and non-executive directors. Staff said they had raised issues with the chief executive and felt they had been heard and action had been taken. All staff said they could raise issues with their manager if required and action would be taken.
- The trusts vision and values were on display in all of the community sites. Staff understood the trust's vision and values and how these were applied in the work of their teams. The trust's senior leadership team had successfully communicated this to front line staff through regular updates, bulletins and clear communication processes.
- Staff contributed to the on-going development of services and implementations of new ways of working. Staff were confident in explaining how they delivered high quality care, support and treatment within a defined budget.
- Staff felt valued and listened to, which gave them more confidence to contribute new ideas. Staff told us they felt proud about working for the organisation and they were motivated and passionate about providing care and treatment for patients to a high standard.
- Staff told us they felt able to report incidents, raise concerns and make suggestions for improvements. They were confident they would be listened to by their line managers. Some staff gave us examples of when they had spoken out with concerns about the care of patients and said this had been received positively as a constructive challenge to practice. All of the community teams had a regular team meeting and each team had planned away days. All staff described morale as very good. Staff were aware of the whistleblowing process if they needed to use it. The trust had appointed 'fair treatment at work facilitators' who were trained to provide confidential and supportive listening and a signposting service to staff who felt they were being bullied, harassed or treated unfairly.

- Staff appraisals included conversations about career development, training opportunities and how these could be supported within the teams.
- The trust provided an occupational health service for staff to access support for their own needs, both physical and emotional, to maintain their wellbeing.
- The trust had set up an awards scheme to further incentivise staff to provide a high-quality service. These were awards which celebrated success and achievements within the trust. All of the teams inspected had been nominated for these awards. For example, the City and North-East team had been nominated as the trust's best placement for students.
- Staff in the teams had systems and procedures in place to ensure that the premises were safe and clean. There were enough staff available who were well trained and supervised by team leaders regularly. Patients were assessed and offered treatment in an effective and timely manner, there were no waiting lists and there were no breaches in emergency or urgent assessments. Any incidents were investigated promptly and lessons were learnt to prevent any re-occurrence. The 'step up safety board' was an effective risk management system.
- There was a clear framework of what should be discussed at both team and directorate level.
- Recommendations had been implemented following any lessons learnt from incident investigations, complaints and safeguarding alerts.
- Staff participated in clinical audits to ensure their practice was regularly evaluated and was effective.
- Staff had an excellent understanding of the working arrangements of other mental health teams within the trust and also external organisations to ensure patients' needs were met.
- Staff had access to systems and equipment needed to do their work effectively. Staff in teams with integrated social workers had access to both the trust and local authority information systems.
- Information with details of patients was secure and kept confidential at all times.
- Team leaders had access to their teams' performance dash boards so could monitor their team's key performance indicators and key risk issues. Team leaders used the boards daily in handover and clinical meetings.
- Information stored was accessible and accurate.
- Staff, patients and their carers had access to up to date information about the services offered by the trust. Regular and comprehensive communication was available. Feedback was sought and the trust had a dedicated patient care involvement lead. The lead visited the teams regularly to ensure feedback from patients was encouraged.

Each team had a research assistant and several research projects were underway. For example, research projects looking into causes of mental illness, effective medicine to treat mental illness and assessing the impact of mental illness for patients experiencing symptoms, such as hearing voices, depression and anxiety

Outstanding practice

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Wards for older people with mental health problems

Good 

Key facts and figures

Oxford Health NHS Foundation Trust provides assessment and treatment for older people with mental health problems across three wards. Amber ward is a 20-bedded mixed sex ward at the Buckingham Health & Wellbeing Campus, Aylesbury. Sandford ward is a 14-bedded male ward at the Fulbrook Centre, Oxford. Cherwell ward is a 17-bedded female ward at the Fulbrook Centre, Oxford. This core service is commissioned by two clinical commissioning groups, Buckinghamshire and Oxford.

When we visited the wards, there were 16 patients on Amber ward, 11 patients on Sandford ward and Cherwell ward was fully occupied. Some adults may be subject to conditions under the Mental Health Act (1983).

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs and well led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against registered service providers and registered managers who fail to comply with legal requirements, and help them to improve their services.

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

At the last comprehensive inspection of this core service in September and October 2015 we rated wards for older people with mental health problems as requires improvement for the safe domain, and good for effective, caring, responsive and well-led. This resulted in an overall rating of good. We re-inspected all five domains as part of this inspection.

We inspect and regulate healthcare service providers in England. We inspected this core service as part of our next phase mental health inspection programme.

Our inspection between 20 and 22 March 2018 was unannounced, which means that staff did not know we were coming, to enable us to observe routine activity.

Before the inspection, we reviewed information that we held and asked other organisations to share what they knew about the trust. These included NHS Improvement, local Healthwatch organisations, local clinical commissioning groups and local authorities.

During the inspection visit, the team:

- Visited all three wards, looked at the quality of the environment and observed how staff were caring for people using services
- Spoke with modern matrons, wards managers or deputy ward managers on each ward
- Spoke with 25 other members of staff including nurses, healthcare assistants, social workers, psychologists, occupational therapists, doctors and clinical leads
- Spoke with 12 patients and two carers
- Reviewed 18 patient care records

Wards for older people with mental health problems

- Reviewed 19 medicine charts
- Attended two groups for people using services
- Observed one ward round, three staff handovers and two discharge meetings
- Looked at a range of policies, procedures and other documents relating to the running of the service

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The wards, including the clinic rooms, were clean, had good furnishings and were well maintained. Staff ensured that equipment, including emergency equipment, was also well maintained, checked annually and was clearly monitored. Ward doctors prescribed medicine in a streamlined way and in line with the National Institute for Health and Care Excellence (NICE) guidance. The recording and maintaining of good medicines management was in place across all wards and there was good input from pharmacy colleagues.
- The management of risk both within the environment and to patients was well managed. Staff had completed a risk assessment for each patient at the point of initial assessment and managed patients' physical and mental health risks in line with trust policy and NICE guidance. Staff were aware of risks, documented and communicated this well. Staff followed good policies and procedures for the use of observation and adjusted observation levels according to individual patient need.
- Care planning was inclusive and included input from a range of disciplines as well as the patient and their carers. Patient welcome packs included a 'Knowing Me' questionnaire that asked patients and carers questions around personal likes, dislikes and preferences.
- There was a good skill mix of staff on the ward and mental health nurses had access to a physical health course. All staff received level one dementia training and level two dementia training was being piloted. Ward based psychologists offered therapy in line with NICE guidance that included weekly cognitive stimulation groups, cognitive behavioural therapy and provided formulation training for staff. There was a good range of occupational therapy and access to a full range of rooms and outdoor space.
- There was a good multi-disciplinary approach to care treatment and discharge. There were regular ward rounds on each of the wards that included a wide range of disciplines and had discharge planning as a key focus. The wards contributed to daily inter-county bed management teleconferences with community mental health teams. There was a trust social care lead in place who assisted with planning and discharge.
- Staff demonstrated good awareness of safeguarding issues, how to report an incident and learning from these was shared. However, safeguarding incidents and referrals were not collated on the wards for the purpose of data collection or review.
- Training compliance with the Mental Capacity Act 2005 was at 100% and above the trust target. Staff demonstrated a good understanding of the Act, in particular the five statutory principles, Deprivation of Liberty Safeguards (DoLS) and trust policy around best interest meetings.

Wards for older people with mental health problems

- Staff demonstrated respect, patience and compassion for patients and were very aware of any changes to a patient's presentation. There was a clear emphasis on promoting patient choice and independence and staff sought patient and carer views to inform the care plans. Patients felt safe and well cared for on the wards. There was access to a lesbian, gay, bisexual, and transgender lead for the wards and patients received support to access tools that translated key care information into their first language.
- The wards varied in how dementia friendly they were. Sandford and Cherwell wards were decorated to assist patients with dementia, with the use of colour zoning and good signage that included pictures accompanied by large words. All wards had plans in place, at various stages, to create a sensory garden. Amber ward had minimal signage and colour zoning that would have assisted patients with dementia.
- Ward managers had access to a development programme designed to link leaders, improve communication skills and help them understand trust priorities. Organisational changes were communicated effectively and staff felt supported by their line managers and described feeling valued. They felt positive and proud about working for the provider and their team.
- To address the high number of staff vacancies, senior staff worked with local universities to engage with nursing students at an early stage. We saw examples of other staff, such as housekeepers, that had been encouraged to undertake training as healthcare assistants.
- At the time of our inspection, all three wards had received Accreditation for Inpatient Mental Health Services (AIMS) – OP (Wards for older people). The Royal College of Psychiatrists 'Essential Standards' were assessed across the wards and in February 2018 the results were found to be 'good' overall.

However:

- Staff vacancies were high overall. Shifts were usually covered by bank or agency staff who knew the wards. The ward managers could adjust staffing levels daily to respond to the wards' changing needs.
- There were no nurse call buttons in the patient bedrooms on Amber ward except for the assisted bathrooms and two assisted bedrooms. The ward mitigated the risk and the trust planned to install an alarm system for patients on Amber ward in July 2018.
- Trust audits showed a high variance of compliance across the wards for timely assessments of malnutrition and incontinence and the inclusion of incontinence in care plans.
- Not all medicine charts contained patient photographs when the patient had consented. The lack of photographs on medicine charts was contrary to trust policy.
- Mandatory training for staff in this core service fell just below the trust's target of 90% and this included staff training compliance in the Mental Health Act (1983). However, staff had a good understanding of the Mental Health Act (1983), the Code of Practice (2015) and the guiding principles.
- Compliance with appraisals was below the trust's target rate of 90%. Staff told us they had had an annual appraisal.
- Despite patients presenting with this diagnosis, there was no specialist training in emotionally unstable personality disorder.
- Staff on Amber ward told us that morale was sometimes low and they attributed this to the ward staffing issues, particularly when they were required to work with agency staff that did not know the patients. Some staff on this ward also reported feeling isolated from the rest of the trust at times. However, the trust had appointed a modern matron to work across both Oxford and Buckinghamshire to ensure consistency and equity.

Wards for older people with mental health problems

Is the service safe?

Good 

Our rating of safe improved. We rated it as good because:

- The management of risk both within the environment and to patients was well managed. Staff were aware of risks and documented and communicated this well. Staff updated risk assessments regularly and after each reported incident. There was good communication between community mental health teams and the wards regarding handover of known patient risks.
- The wards were clean, had good furnishings and were well maintained. Clinic and treatment rooms were clean, tidy and well organised.
- Ward doctors prescribed medicine in a streamlined way and in line with the National Institute for Health and Care Excellence guidance. The recording and maintaining of good medicines management was in place across all wards and there was good input from pharmacy colleagues.
- There had been a higher number of patient restraints since the last time we inspected. However, we were reassured that these incidents of restraint were proportionate and that restraints were carefully care planned with full multi-disciplinary team input. The majority of staff on the ward had received de-escalation training and used restraint only after de-escalation techniques had failed.
- Safeguarding was well understood as was incident reporting. Staff knew how to raise concerns and learning from incidents was shared.

However:

- Staff vacancies were high overall. The ward managers could adjust staffing levels daily to respond to the wards' changing needs and staff told us it was rare not to have the full complement of staff. There was adequate medical cover across the wards and staff were able to access an on-call doctor when necessary.
- There were no nurse call buttons in the patient bedrooms on Amber ward except for the assisted bathrooms and two assisted bedrooms. The ward planned to install an alarm system for patients on Amber ward in July 2018. If patients were considered to be at risk, the ward placed staff in the bedroom corridor to mitigate the risk.
- Not all medicine charts contained patient photographs when the patient had consented. The lack of photographs on medicine charts was contrary to trust policy. This presented a potential risk of medicine errors caused by patients being wrongly identified.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- Staff completed a comprehensive mental health and physical health assessment of patients within 72 hours of admission. Patients' physical healthcare was assessed and monitored in line with the trust's 'Operational Protocol for

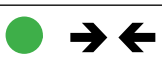
Older Peoples' Mental Health Inpatient Services'. Staff carried out falls risk assessment, prevention and intervention care plans on admission and sought additional information from family. A range of disciplines contributed to care plans and these were up to date, personalised, holistic and recovery oriented. Staff carried out interventions in line with guidance from the National Institute for Health and Care Excellence.

- There was a good skill mix and staff were fully skilled to deal with the complexity and acuity of patients admitted to the ward. All staff received level one dementia training and level two dementia training was being piloted. The wards had access to physical specialists including dieticians, podiatrists and diabetic nurses. The ward teams had effective working relationships with teams outside the organisation. There were regular ward rounds on each of the wards that included a wide range of disciplines.
- All wards had regular access to psychologists and psychology assistants who offered therapy in line with guidance from the National Institute for Health and Care Excellence and provided formulation training for ward staff. Following the high level of restraints on one ward, the psychology team completed an audit that enabled staff to see whether any patterns emerged. The wards provided a good range of weekly occupational therapy and activities input that was well-received by patients and staff.
- Staff told us that frequency of supervision had improved recently and they had access to a reflective practice group once a month, facilitated by psychology staff. Doctors had weekly supervision.
- Training compliance with the Mental Capacity Act (2005) was above the trust target and staff demonstrated a good understanding of the Act. Staff assessed patient capacity frequently and the ward round template contained a reminder section to discuss capacity and what might have changed. The wards made applications for Deprivation of Liberty Safeguards as soon as possible.

However:

- Trust audits showed a high variance of compliance across the wards for timely assessments of malnutrition and incontinence and the inclusion of incontinence in care plans.
- Some care records lacked evidence that staff had had discussions with patients about their care and treatment and lacked a reason for patients not being given a copy.
- Despite patients presenting with this diagnosis, there was no specialist training in emotionally unstable personality disorder.
- Compliance with appraisals were below the trust's target rate of 90%. Staff told us they had had an annual appraisal.
- Staff training compliance in the Mental Health Act (1983) fell below the trust's target of 90%. However, staff had received training and had a good understanding of the Mental Health Act (1983), the Code of Practice (2015) and the guiding principles. However, we did not see any care planning or risk assessment references to capacity concerns for patients who were subject to Deprivation of Liberty Safeguards.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

Wards for older people with mental health problems

- Staff demonstrated respect, patience and compassion for patients and were very aware any changes to a patient's presentation. There was a clear emphasis on promoting patient choice and independence and staff sought patient and carer input and staff arranged for carers to receive carer assessments. The patient welcome packs included a 'Knowing Me' questionnaire that included questions like 'what I like/don't like to eat and drink, hobbies, previous occupation, what might worry upset me, how you can tell I'm in pain'.
- The wards varied in how dementia friendly they were. The two Oxford based wards were decorated to assist patients with dementia, with the use of colour zoning and good signage that included pictures accompanied by large words. All wards had plans in place, at various stages, to create a sensory garden. Amber ward had less evident signage and colour zoning that would have assisted patients with dementia.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- Discharge was a key focus and staff scheduled patients' discharge Care Programme Approach meetings to occur within 14 days of admission and community mental health teams were actively involved in discharge planning. The wards contributed to daily inter-county bed management teleconferences with community mental health teams and there was a trust social care lead in place who assisted with planning and discharge for patients' and their ongoing social care needs.
- Patients felt safe and well cared for on the wards. Patients had their own bedrooms, access to a full range of rooms and equipment to support their treatment and care and access to outdoor gardens. Patient mealtimes were protected from distracting ward activities and patients told us that the food was of a very good quality. Patients' individual needs were met, including dietary requirements, access to a lesbian, gay, bisexual, and transgender lead and access to translation tools.
- Staff knew how to support patients to complain and the trust's patient liaison and advice service visited the wards frequently to talk to patients and held a complaints clinic with staff on the wards.

However:

- All of the wards within this core service reported average bed occupancies ranging above the provider benchmark of 85%. However, during our inspection only one of the three wards was fully occupied.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good because:

- Ward managers had access to a development programme designed to link leaders, improve communication skills and help them understand trust priorities.
- Organisational changes were communicated effectively to staff. Staff felt able to speak up without fear of victimisation and received recognition for their work. Staff felt supported by their line managers and described feeling valued. They felt positive and proud about working for the provider and their team.

Wards for older people with mental health problems

- Staff concerns about staffing levels were reflected on the trust's risk register. The trust had taken action to recruit and retain staff. Senior staff worked with local universities to engage with nursing students at an early stage. We saw examples of other staff, such as housekeepers, that had been encouraged to undertake training as healthcare assistants.
- Staff had access to the equipment and information technology needed to do their work.

The team responsible for training staff in the prevention and management of violence had amalgamated related policies into one, such as reducing restrictive interventions and rapid tranquilisation and the new combined policy was well-received by staff.

- At the time of our inspection, all three wards had received Accreditation for Inpatient Mental Health Services (AIMS) – OP (Wards for older people). The Royal College of Psychiatrists 'Essential Standards' were assessed across the wards and in February 2018 the results were found to be 'good' overall. The trust carried out a range of audits specific to wards for older people with mental health problems.

However:

- The lack of nurse call alarms on Amber ward was not on the trust risk register but was on the Amber ward risk register. Staff had been updated and understood the delay for the alarms were due to complications in the procurement and tender process. Alarms were due to be installed on Amber ward in July 2018.
- Staff commented on the lack of specific personality disorder services for older people within the trust.
- Staff on Amber ward told us that morale was sometimes low and they attributed this to the ward staffing issues, particularly when they were required to work with agency staff that did not know the patients. Some staff on Amber ward also reported feeling isolated from the rest of the trust at times. However, the trust had appointed a modern matron to work across both Oxford and Buckinghamshire to ensure that there was consistency and equity in the support and oversight for all ward areas.
- Safeguarding incidents and referrals were not collated on the wards for the purpose of data collection or review.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Community mental health services for people with a learning disability or autism

Good

Key facts and figures

Oxfordshire Community Learning Disability team provides support to adults aged 18 and over with a diagnosed learning disability. The service is made up of three distinct local teams.

- The North team is based in Banbury and at the time of our inspection provided support to 249 people.
- The City team is based in central Oxford, supporting 260 people.
- The South team is based in Abingdon and was supporting 195 people.

The teams are supported by the Intensive Support Team, also based in central Oxford, which had an active caseload of 17 people.

A step-down service and an outreach service are also provided by the trust at a central Oxford site and were not included in this inspection.

This was the first inspection of the Community Learning Disability Team (CLDT) since it has been delivered by this provider. The service transferred to Oxford Health Foundation Trust in July 2017. This was a significant transition project that involved the transfer of all staff and patients, and a transition to new policies, procedures and systems, and was still in progress at the time of our inspection.

Summary of this service

We rated the service as good overall because:

- The service maintained safe staffing levels across all the teams we inspected and both staff turnover and sickness were low.
- Caseloads were manageable and both patients and carers commented positively on the availability of staff when they needed them.
- Incidents were well reported and monitored and routinely discussed in multidisciplinary team meetings, with learning shared with the rest of the team.
- The trust embraced the Transforming Care 2015 agenda.
- Staff were highly skilled, qualified and experienced.
- Care plans were well recorded and were available in accessible formats for people with different communication needs.
- Patients and carers were actively involved in the care provided and praised the staff for their understanding and supportive approach.
- Staff worked hard to ensure that patients gained access to the right care at the right time, through effective management of external waiting lists and tracking cases through the service.
- Staff ensured accessibility for the service by travelling to patients' homes and day services for appointments.
- Feedback from patients and carers had informed significant service developments.

Community mental health services for people with a learning disability or autism

- All staff and patients we spoke with described a positive experience of the transition of the service from the previous provider. Carers described the process as seamless and staff universally said they felt welcomed and supported and optimistic about the future of the service.
- The service promoted a culture in which people with a learning disability were respected and valued as individuals and in which learning disability was not treated as an illness. A clear vision for the future of the service was understood by staff and had been shared with patients and carers.

However:

- Whilst staff had a very good working knowledge of the Mental Capacity Act, teams were not recording capacity assessments consistently.
- Some patients experienced a lengthy wait for nursing assessments and speech and language therapy assessments despite caseloads being low.
- Outcome measures were not used to track patients' progress.
- Whilst referrals and discharges from the main teams were well managed, pathways between professionals were not always clear and could involve long wait times.
- Governance systems to manage pathways and care coordination responsibilities were not always clear and in some cases resulted in duplication of work between the intensive support and community teams.

Is the service safe?

Good

We rated safe as good because:

- The service maintained safe staffing levels across all the teams we inspected, and both staff turnover and sickness were low. To manage the risk of under staffing in nursing posts, the trust had agreed the service could over staff these posts where possible.
- Staff reported to us that their caseloads were manageable, and both patients and carers commented positively on the availability of staff when they needed them.
- Staff routinely completed risk assessments and updated them at the appropriate intervals.
- Staff were competent at raising safeguarding alerts and knew when and how to report.
- Incidents were well reported and monitored and routinely discussed in multidisciplinary team meetings, with learning shared with the rest of the team.

Is the service effective?

Good

We rated effective as good because:

- The trust embraced the Transforming Care 2015 agenda. This is a national agenda to improve services for people with learning disabilities and a mental health problem or behaviour that challenges.

Community mental health services for people with a learning disability or autism

- Staff were highly skilled, qualified and experienced. Staff accessed specialist training to improve their skills and received regular clinical and managerial supervision and attended regular team meetings. Managers and staff also shared best practice and research news via a trust wide social networking system called Yammer.
- Care plans were present and up to date in all records we reviewed. We saw very good examples of care plans in accessible formats for people with different communication needs.
- The provider ensured that its clinical areas of practice and their reference to up to date National Institute of Health and Care Excellence (NICE) Guidelines.
- Staff used positive behaviour support plans with patients who presented with behaviour that was challenging and were able to receive enhanced support for these patients via the intensive support team.

However:

- Whilst staff had a very good working knowledge of the Mental Capacity Act, teams were not recording capacity assessments consistently.
- Whilst waiting times to access the service were good, we found instances of patients experiencing a lengthy wait for nursing and speech and language therapy assessments despite caseloads being low. Managers were in the process of reviewing how best to address this through capacity building within teams.
- The service did not have clear pathways for patients once they were taken on to the caseload of the intensive support team, which sometimes led to duplication of work or a lack of clarity about which team was leading on a piece of work. It was not always clear what the criteria was for receiving support from this team. Managers were aware of this and a standard operating procedure to improve this was in draft form at the time of the inspection.
- Whilst patients, carers and staff described many examples of people making big improvements to their lives with the support of the service, staff in the community teams did not use outcome measures to track patients' progress. This was a missed opportunity to gather quantitative data to evidence the effectiveness of the interventions delivered.

Is the service caring?

Good

We rated caring as good because:

- All patients and carers we spoke to praised the staff from the service for their understanding and supportive approach.
- All staff we spoke with demonstrated respect and compassion for the patients, and the case files we reviewed showed that this underpinned the clinical work they did.
- Patients and carers were actively involved in the care provided by the service, both for individual support packages and strategic planning for the whole service.
- Staff from the service had won internal trust awards after being nominated by patients' families for exceptional levels of support. One member of staff had been nominated for their role in enabling a patient to communicate with her family and enjoy community activities. A second member of staff had been nominated for the relationship they had built with a patient and their family while delivering intensive support for behaviour that challenged.

Community mental health services for people with a learning disability or autism

Is the service responsive?

Good

We rated responsive as good because:

- Staff worked hard to ensure that patients gained access to the right care at the right time, through effective management of external waiting lists and tracking cases through the service.
- Staff ensured accessibility for the service by travelling to patients' homes and day services, overcoming restricted space to see patients at the community team locations.
- Managers had taken feedback from patients and carers which had informed significant service developments, including the expansion of the intensive support team to offer support to children and young people, and in developing step-down provision for individuals at high risk of long term hospital admissions

However:

- With the exception of the intensive support team, staff bases were in local authority buildings where reception areas and facilities were shared. It was therefore not possible to display service information about advocacy, complaints and opening times in the majority of services.
- Whilst referrals and discharges from the main teams were well managed, pathways between professionals were not always clear and could involve long wait times. Managers were addressing this through a standard operating procedure.

Is the service well-led?

Good

We rated well led as good because:

- All staff and patients we spoke with described a positive experience of the transition of the service from the previous provider. Carers described the process as seamless and staff universally said they felt welcomed and supported and optimistic about the future of the service.
- Senior managers were visible within teams and in patient engagement meetings, were approachable and accessible.
- The service promoted a culture in which people with a learning disability were respected and valued as individuals, and in which learning disability was not treated as an illness. A clear vision for the future of the service was understood by staff and had been shared with patients and carers.

However

- Governance systems to manage pathways and care coordination responsibilities were not always clear and in some cases resulted in duplication of work between the intensive support and community teams. Managers were aware of this and work was in progress to streamline processes for patients and maximise capacity.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

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 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) 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	Regulation 18 HSCA (RA) Regulations 2014 Staffing
Diagnostic and screening procedures	
Treatment of disease, disorder or injury	

Our inspection team

Geraldine Strathdee chaired this inspection and Natasha Sloman, Head of Hospital Inspection, led it.

The team included three inspection managers, 17 inspectors, two MHA reviewers and 14 specialist advisers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.