

Southern Health NHS Foundation Trust

Wards for people with learning disabilities or autism

Quality Report

Trust Headquarters, Tatchbury Mount, Calmore
Southampton, Hampshire, SO40 2RZ
Tel: 02380874036
Website: www.southernhealth.nhs.uk

Date of inspection visit: 19 and 20 January 2016
Date of publication: 29/04/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RW12N	Ridgeway Centre		HP12 4QF
RW13G	Evenlode		OX4 4XN

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

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

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

Summary of findings

Ratings

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

Overall rating for the service

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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

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

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

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	4
The five questions we ask about the service and what we found	6
Information about the service	11
Our inspection team	11
Why we carried out this inspection	11
How we carried out this inspection	12
What people who use the provider's services say	13
Good practice	13
Areas for improvement	13

Detailed findings from this inspection

Findings by our five questions	15
Action we have told the provider to take	29

Summary of findings

Overall summary

We found the following issues that need to improve:

- The trust had not taken appropriate steps to mitigate the risk from ligature points. Ligature points are places to which patients intent on self-harm might tie something to strangle themselves. At Evenlode, we identified multiple ligature points throughout the unit. A considerable amount of work had been carried out at the Ridgeway Centre to remove identified ligature points. However, we identified a number of outstanding and clear risks that needed further work to be more effectively reduced.
- We asked the trust at the time of our inspection to provide us with an assurance that steps would be taken to reduce the risk of ligatures until the completion of scheduled work. On a return visit to the service on 29 January 2016, we were informed that a number of steps had been taken to mitigate more effectively the risks from ligatures, including: new observation practice, use of safer beds, and electrical cables shortened and clearly identified on individual patient property lists. However, we were concerned that although the provider had taken action when we requested it, they had not engaged or consulted effectively with the patient group or explained the rationale behind the changes.
- We found the clinic room at Evenlode was unfit for purpose and did not contain appropriate essential resuscitation equipment. Further, the intercom that would allow patients who were placed in the seclusion room to talk to staff outside the room was not working. We asked the trust to put this right immediately. We also identified specific issues with the environment at both services that potentially compromised patients' privacy and dignity, including a lack of curtains on one patient's bedroom window at the Ridgeway Centre.
- The trust had developed an epilepsy map and toolkit, which had been rolled out across north learning disability services in 2013/14. However, a specific 'Protocol for the safe bathing and showering of people with epilepsy' was awaiting completion and final sign off by the board more than two and a half years after a much-publicised death by drowning of a young person at one of the trust's other learning disability services.

This patient had drowned while bathing, unobserved by staff, after having an epileptic seizure. Support workers were inconsistent in their explanations of how they would supervise patients when bathing. Staff's uncertainty and a lack of consistency meant that patients with epilepsy were still potentially being placed at unnecessary risk when bathing. We noted that the protocol was subsequently available from 1 February 2016 on the trust website.

- We identified a number of concerns about the processes and systems for learning from incidents. Following an incident in July 2015, when a member of staff at Evenlode suffered a serious assault, it was recorded in electronic care notes that staff were concerned about remembering physical intervention techniques. We found that more than six months later, there had been no subsequent investigation and no additional or revised specialist training provided for staff.
- Staff supervision at both services was poorly managed, inconsistent and infrequent. In addition to the lack of regular and consistent formal supervision, staff meetings had not taken place at Evenlode, which meant that staff had not had appropriate forums in which to raise concerns or to share best practice.
- None of the staff spoken with at Evenlode felt to be part of the wider trust, and staff at all levels expressed their sense of isolation from the trust. Staff told us there was an ongoing sense of uncertainty as to the future for the service, and that they felt the trust's senior management team had not effectively supported them.
- We identified a number of serious failings in relation to the trust's oversight and governance of Evenlode. Similarly, the trust's own most recent internal peer review of Evenlode catalogued a large number of concerns in relation to the safety, effectiveness, responsiveness and leadership of the service. The fact that the service had been left without appropriate senior support and oversight for so long, and allowed to deteriorate to such an extent, demonstrated both poor governance and ineffective oversight of the service by the trust's senior management team.

Summary of findings

However, we also found the following areas of good practice:

- We saw some evidence of positive leadership at a local level. We found there had been improvements, at the Ridgeway Centre, in staff's morale and sense of being part of the wider trust since our previous inspection. Staff were positive about the changes in the physical environment and the investment that had been made. They also told us that support from senior managers had also increased considerably. It was to the credit of the local level team at Evenlode that staff who had recently joined the service reported to us that they felt it was a strong and supportive team, who helped them and who were positive about patient care.
- We saw examples in care records to demonstrate appropriate assessments and monitoring of risks were carried out, specific to each individual patient. Staff completed comprehensive, timely assessments of patients' needs on admission. Care records showed that physical examinations were undertaken and that there was ongoing monitoring of patients' physical health problems. We saw evidence that staff at Evenlode managed complex patient needs with a therapeutic approach and very low use of psychotropic medication.

- We saw examples at the Ridgeway Centre of how patients were actively involved in decisions about their own care and treatment. For example, a ward service users group had been set up to look at key issues. At Evenlode, efforts were being made to involve patients more in decisions about their own care and treatment. Therapy sessions and one-to-one sessions with staff were good forums for people to raise concerns or to make suggestions for improvements. The ward community meetings were well attended by patients, and there was tangible evidence that patients felt relatively safe to raise concerns in this setting.

At the Ridgeway Centre, we found the female ward was welcoming and we saw staff engaged freely and positively with patients. When staff spoke with patients on the male ward, the interaction was appropriate and respectful, but was task-focused rather than person-centered. Patients at the Ridgeway Centre were positive about the care and treatment they received and told us they did not have anything about which to complain. However, they also confirmed they knew how to complain and were confident in complaining if they were unhappy about anything.

Summary of findings

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

Are services safe?

We found the following issues that need to improve:

- At Evenlode, we identified multiple ligature points throughout the unit. We asked the trust at the time of our inspection to provide us with an assurance that steps would be taken to reduce the risk of ligatures until the completion of scheduled work. On a return visit to the service, we were informed that a number of steps had been taken to mitigate more effectively the risks from ligatures. A considerable amount of work had been carried out at Ridgeway Centre to remove identified ligature points; however, we identified a number of outstanding and clear risks that needed further work to be more effectively reduced.
- The clinic room at Evenlode was not fit for purpose and did not contain appropriate essential resuscitation equipment. The intercom that would allow patients who were placed in the seclusion room to talk to staff outside the room was not working. We asked the trust to put this right immediately.

The trust had developed an epilepsy map and toolkit, which had been rolled out across north LD services in 2013/14. However, a specific 'Protocol for the safe bathing and showering of people with epilepsy' was awaiting completion and final sign off by the board more than two and a half years after a much-publicised death by drowning of a young person at one of the trust's other learning disability services. Support workers were inconsistent in their explanations of how they would supervise patients when bathing. Staff's uncertainty and a lack of consistency meant that patients with epilepsy were still potentially being placed at unnecessary risk when bathing.

- We identified a number of concerns about the processes and systems for learning from incidents.
- We found evidence that existing permanent staff at Evenlode were under pressure due to a problem recruiting and retaining qualified nursing staff. Feedback from patients that indicated there was a risk staffing pressures might also have affected the quality of service they received.

However, we also found the following areas of good practice:

- We saw examples in care records to demonstrate appropriate assessments and monitoring of risks were carried out, specific to each individual patient.

Summary of findings

Are services effective?

We found the following areas of good practice:

- Staff completed comprehensive, timely assessments of patients' needs on admission.
- Staff undertook physical examinations and ongoing monitoring of patients' physical health problems. Care records contained plans for meeting patients' specific physical needs.
- Staff at both services made care plans more personalised to individuals' different needs and we saw plans were available in different formats according to patients' personal wishes.
- Detailed internal peer reviews had been carried out on both services, and these had identified effectively key issues and ways in which the services could be improved. We saw evidence of additional ways the quality of service was assessed and assured by the trust at the Ridgeway Centre, including patient and staff satisfaction surveys and staff knowledge checks.
- The Ridgeway Centre was in the process of changing the ward culture, from one of staff watching patients to a focus on engagement.
- We saw evidence that Evenlode provided treatments in line with National Institute for Health and Care Excellence (NICE) guidance and other best practice. Staff managed these needs with a therapeutic approach and very low use of psychotropic medication. Psychotropic medication is medication capable of affecting a person's mind, emotions, and behaviour. The therapeutic approach included a focus on positive risk taking, and patients and their relatives we spoke with were keen to stress the progress they had made following their admission to the service. Patients told us they also very much appreciated the provision of dialectical behaviour therapy at the service.

However, we also found areas that the service provider could improve:

- Staff supervision at both services was poorly managed, inconsistent and infrequent, and the supporting supervision records were chaotic.

In addition to the lack of regular and consistent formal supervision, staff meetings had not taken place at Evenlode, which meant that staff had not had appropriate forums in which to raise concerns or to share best practice. Further, we found that although staff were largely up-to-date with their mandatory training, there were gaps in specialist training. The need for specialist training in physical intervention had been identified by the trust following a serious

Summary of findings

assault on a member of staff in mid 2015. This training had not been provided at the time of this inspection. Staff also told us during the inspection that they felt they did not receive sufficient specialist training.

Are services caring?

We found the following areas of good practice:

- We saw examples at the Ridgeway Centre of how patients were actively involved in decisions about their own care and treatment.
- We observed that staff interacted effectively and positively with patients at both services during our inspection visits.
- At Evenlode, efforts were being made to involve patients more in decisions about their own care and treatment. Therapy sessions and one-to-one sessions with staff were good forums for people to raise concerns or to make suggestions for improvements. The ward community meetings were well attended by patients, and there was tangible evidence that patients felt relatively safe to raise concerns in this setting.

However, we also found areas that the service provider could improve:

- We were concerned about an apparent lack of interaction and meaningful engagement by staff with some of the male patients at the Ridgeway Centre.
- At Evenlode, patients spoke positively about named staff members, who were described as excellent and as giving more than was expected of them. However, feedback from patients was not unanimous and patients raised a number of specific concerns with us about the conduct of other members of staff. These concerns are covered in detail in the main body of the report.
- The trust showed a lack of consideration for the views and dignity of patients in its response to our request for them to address the ligature risks at Evenlode. We were concerned that although the provider had taken action when we requested it, they had not engaged or consulted effectively with the patient group or explained the rationale behind the changes.

Are services responsive to people's needs?

We found the following issues that need to improve:

- One patient's bedroom at the Ridgeway Centre did not have curtains. Staff had put a request for new curtains into the trust

Summary of findings

estates department in September 2015, but these had not arrived by the time of our inspection. This meant that the patient had no privacy at night when the lights were on in his room, and the staff on the unit had been unaware of this until we brought it to their attention.

-
- At the Ridgeway Centre, we found there was a different atmosphere in the male and female parts of the service. When staff spoke with patients on the male ward, the interaction was appropriate and respectful, but was task-focused rather than person-centred.
- The bedroom doors at Evenlode potentially compromised patients' privacy and dignity. The observation glass in the doors allowed people outside in the corridor, including other patients, to look into a person's bedroom.
- Several patients at Evenlode told us they did not feel confident in complaining to staff about the service they received.

However, we also found the following areas of good practice:

- Patients at the Ridgeway Centre were positive about the care and treatment they received and told us they did not have anything about which to complain. They also confirmed they knew how to complain and were confident in complaining if they were unhappy about anything.

The female ward at the Ridgeway Centre was a welcoming environment and we saw that staff engaged freely and positively with patients.

Are services well-led?

We found the following issues that need to improve:

- None of the staff that we spoke with at Evenlode felt part of the wider trust. Staff at all levels expressed their sense of isolation from the trust. Staff told us there was an ongoing sense of uncertainty as to the future for the service, and that they felt the trust's senior management team had not properly supported them. These issues had been highlighted at the previous inspection in October 2014.
- We identified a number of serious failings in relation to the trust's oversight of Evenlode that demonstrated poor governance of the service by the trust's senior management and executive team. Despite the trust having identified ligature risks and poor staff supervision at least 16 months earlier, we found unresolved and ongoing problems with both of these

Summary of findings

issues at this inspection. The trust's own internal peer review of Evenlode, carried out in December 2015, catalogued a large number of concerns in relation to the safety, effectiveness, responsiveness and leadership of the service, and judged the performance inadequate in those areas.

- Although the governance of the Ridgeway Centre had improved, we did identify a number of significant problems and areas of poor performance. Staff supervision was inconsistent, infrequent and poorly managed. In addition, a number of outstanding but important issues, such as significant remaining ligature points, had not been identified through the trust's own checks and audits.
- Despite the best efforts of many of the ward's staff at Evenlode, there was a risk that low staff morale was impacting on the care and support that patients received

However, we also found the following areas of good practice:

- We saw some evidence of positive leadership at a local level. At the Ridgeway Centre, the inspectors were particularly impressed with the behavior and professionalism of a senior charge nurse during the inspection. They demonstrated good engagement with and knowledge of patients, alongside good leadership skills in coordinating staff to meet patient needs
- At the Ridgeway Centre, there had been improvements in staff's morale and sense of being part of the wider trust since our previous inspection. Staff told us that management were now more visible on the unit. Staff were positive about the changes in the physical environment and the investment that had been made. They told us that support from senior managers had also increased considerably.

It was to the credit of the local level team at Evenlode that staff who had recently joined the service reported to us that they felt it was a strong and supportive team, who helped them and who were positive about patient care.

Summary of findings

Information about the service

The Ridgeway Centre and Evenlode are part of Southern Health NHS Foundation Trust's inpatient service for adults with learning disabilities and autism. The Ridgeway Centre is in High Wycombe in Buckinghamshire. It offers assessment and treatment services; mostly for adults who have learning disabilities and associated challenging behaviour. It consists of a

14-bed mixed gender unit. At the time of our inspection, the 14 beds were in use, seven on each of the male and female sides. All bedrooms are single and ensuite. Locked doors separate male and female ward areas.

Evenlode is in Oxfordshire, has 10 beds and is a medium secure unit for male patients. There were nine patients at the time of inspection.

Our inspection team

The inspection team was led by:

Team Leader: Karen Bennett-Wilson, head of inspection for mental health, learning disabilities and substance misuse, Care Quality Commission

The team that inspected this core service comprised an inspection manager, an inspector and an expert by experience. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them – for example, as a carer.

Why we carried out this inspection

In January 2016, the Care Quality Commission carried out a short notice, focussed inspection of Southern health NHS Foundation Trust.

Following the publication of the Mazars report in December 2015 CQC announced that it would undertake an inspection of the Southern Health NHS Foundation Trust early in 2016.

The Mazars report, commissioned by NHS England, details the findings of an independent review of the deaths of people with learning disability and mental health problems in contact with the trust between April 2011 and March 2015. The report described a number of serious concerns about the way the trust reported and investigated deaths, particularly of patients in older person's mental health and learning disabilities services. It also identified that the trust had failed consistently and properly to engage families in investigations into death of their loved ones.

In response to the publication of the Mazars report the Secretary of State requested that we:

- review the trust's governance arrangements and approach to identifying, reporting, monitoring, investigating and learning from incidents; with a particular focus on deaths, including ward to board assurance and
- review how the trust was implementing the action plan required by Monitor.

In addition, we wanted to check whether the trust had made the improvements that we had told it to make following the comprehensive inspection in October 2014 and the focussed inspection of the learning disability services at the Ridgeway Centre, High Wycombe and the forensic services, which we had carried out in August 2015. We had also received a number of complaints about some of the trust services, had contact from a number of whistle-blowers (people who expose activity or information of alleged wrong doing in a private or public organisation) and had identified a high suicide rate in the Southampton area.

As such, this inspection focussed on mental health and learning disability services delivered by the trust, in particular;

Summary of findings

- mental health acute inpatient wards (all 4 units)
- learning disability services in Oxfordshire and Buckinghamshire
- crisis/community mental health teams for adults of working age in Southampton
- child and adolescent mental health in-patient and forensic services

We also reviewed how the trust managed and responded to complaints and how the trust complied with the Duty of Candour regulation. The Duty of Candour regulation requires organisations registered with CQC to be open and transparent and apologise when things go wrong.

We gave the trust several days' notice of the date of the inspection as we could not conduct a meaningful inspection of the issues that were the focus of this inspection without gathering information from the trust in advance of the site visit and we needed to ensure that members of the senior team were available to meet with us.

We did not provide a rating for any of the core services we inspected or an overall rating for the trust.

Ridgeway Centre and Evenlode

We inspected the Ridgeway Centre and Evenlode as part of our comprehensive inspection in October 2014. We

subsequently published a report specifically relating to the core service of 'wards for people with learning disabilities and autism'. The report detailed findings for four locations: two in Hampshire, Evenlode in Oxfordshire and the Ridgeway Centre in Buckinghamshire. The report identified breaches of five separate regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found breaches of four of those regulations at both the Ridgeway Centre and Evenlode. Those regulations were: Regulation 10, Assessing and monitoring the quality of service provision; Regulation 15, Safety and suitability of premises; Regulation 23, Supporting staff; and Regulation 13, Management of medicines. CQC set compliance actions in relation to these regulations.

On 5 August 2015, we carried out an unannounced, focused inspection at the Ridgeway Centre to check whether the trust had met the requirements of the regulations. We had also received additional information of concern about the service. At that inspection, we found steps had not been taken to address risks with the environment identified by the trust and highlighted in our comprehensive inspection in October 2014. We requested immediate actions be undertaken by the trust to address the concerns identified.

How we carried out this inspection

On this inspection, we focused on actions we had required the trust make in our previous inspection undertaken in October 2014, and in a follow up inspection at Ridgeway Centre August 2015. However, we reported on some issues that were outside of these areas when we saw them on inspection. Before the inspection visit, we reviewed information that we held about these services, and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the separate male, female and communal parts of the services and looked at the quality of the environments
- spoke with 16 patients and three relatives of people who used the service
- spoke with the ward managers, service manager and head of service for the locations
- spoke with 17 other staff members including nurses and healthcare assistants
- looked in detail at care plans for seven patients, physical monitoring charts for seven patients and medication charts for nine patients who were using the services at the time of the inspection
- met with seven staff members in a focus group at the Ridgeway Centre
- attended a newly formed governance meeting at Evenlode
- looked at a range of policies, procedures and other documents relating to the running of the services.

Summary of findings

What people who use the provider's services say

Most of the patients we spoke with at both services were satisfied with the care and treatment they received from staff, and described some staff as being excellent and as giving more than was expected of them.

However, feedback from patients at Evenlode in particular was mixed. One person told us they were very unhappy on the ward, and alleged poor behaviour of a

specific staff member. Another person told us that some staff were very good, but that others were not so good. Of the seven patients we spoke with during the day at Evenlode, two told us that there were 'good' and 'not-so-good' staff and two other patients raised substantial issues in relation to trusting staff.

Good practice

Patients in Evenlode had complex needs with elevated risks necessitating the need for admission to the medium security setting. Staff managed these needs with a therapeutic approach and very low use of psychotropic

medication. At the time of inspection, only four of the nine patients were prescribed it, and two of those were for rarely used pro re nata (PRN, or as and when) medication.

Areas for improvement

Action the provider MUST take to improve

- The provider must address the environmental risks at Evenlode. Until the necessary changes are made to make the environment as safe as possible, appropriate measures must be implemented immediately to mitigate effectively the risks to people using the service.
- The provider must also address the remaining environmental risks at the Ridgeway Centre.
- The clinic room at Evenlode must be made fit for purpose and contain all appropriate essential equipment for resuscitation.
- The provider must ensure that staff at Evenlode receive appropriate and up to date specialist training to be able to carry out their jobs as safely and effectively as possible.
- The provider must ensure that its 'protocol for the safe bathing and showering of people with epilepsy' is embedded as swiftly as possible and that staff receive appropriate training to ensure understanding and consistency of practice.
- The provider must ensure that all possible learning takes place and is acted promptly upon following serious incidents.

- The provider must ensure that staff at both services receive consistent and regular supervision and senior management oversight.
- The provider must make the necessary improvements to the environment at both services in order to protect people's dignity and privacy at all times.

Action the provider SHOULD take to improve

The provider should make every effort to ensure there are sufficient qualified nursing staff recruited to staff both services.

- The provider should ensure it engages and consults effectively with patients whenever significant changes are to be made which will affect them or the service they receive.
- The provider should consult with patients and review the activities provided for them at both services, to make sure that the activities provided meet people's needs and are in line with their wishes.
- The provider should consult openly with Evenlode's staff team, as to the long-term future of the service. The provider should take steps to improve staff morale, to ensure all staff at the service feel fully supported and are able to share in the trust's vision and values.

Southern Health NHS Foundation Trust

Wards for people with learning disabilities or autism

Detailed findings

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

Name of CQC registered location

Are services safe?

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

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

Our findings

Ridgeway Centre

Safe and clean ward environment

- Following our comprehensive inspection in October 2014, we visited the Ridgeway Centre again in August 2015 to view progress against the actions we had asked the provider to take. At that time, we found that the trust had not carried out work to address concerns identified by both CQC and the trust's own staff about the safety of the environment. This was despite staff on the unit putting in requests for the work to be completed. At the January 2016 inspection, we found that the provider had carried out a significant amount of work to make the environment safer for patients and staff. Mirrors had been installed in appropriate places to mitigate blind spots on the wards. New doors with observation windows had been installed in the majority of bedrooms. These were anti-barricade doors, which could be opened outwards in the instance of a patient blocking the inside of the door. One patient bedroom had not had the new door fitted. It was explained to us that this was following a clinical decision that the work would be too distressing for the patient currently using that room. Staff assured us that once the patient was discharged the room would no longer be used as a bedroom.

- A number of bedrooms at the Ridgeway Centre had not been fitted with the anti-barricade doors, but had been converted into store rooms or meeting rooms where staff could carry out 1:1 work with patients. Risk assessments had not been carried out for those rooms that were used for meetings with patients, which meant there was still a potential risk to patients and staff in relation to those rooms. The service had not considered the lack of observation window in the doors or the fact that moveable furniture in the rooms could be used to barricade the doors from inside.

- Work had been carried out at Ridgeway Centre to remove identified ligature points. A ligature point is an environmental feature or structure that is load bearing and

can be used to secure a cord, sheet or other tether that can then be used as a means of hanging. Mirrors in the bedrooms had been removed and curtain rails had been replaced with ones that would not allow a ligature.

- A new and comprehensive environmental risk assessment for ligature points was in place, and this covered the garden areas as well as the inside of the unit. However, a significant ligature point, that had been identified by our inspectors in the August 2015 inspection and raised with staff on the unit at that time, had still not been addressed. In both the male and female gardens, there were blind spots in the corners next to internal gates. The gates had hinges just above head height that were weight bearing. Access to the garden was available to patients at all times and not supervised. Although estates work was planned by an external contractor to address the handles on the gates, the hinges were not part of that work. Following raising this with the trust during our inspection the unit raised it with the estates department. The external contractor was asked to complete work on the hinges in addition to the planned work. An internal Southern Health review had 'identified gaps in assurance regarding the anti-ligature work' at Ridgeway Centre. New management structures had been put in place in the trust to oversee ligature work, but these had not identified fully the work needed in the garden. We also identified that there was a potential ligature risk with cables at the Ridgeway Centre. Long electrical cables were accessible in the communal lounges, including a five-metre cable in the female lounge.

- The Ridgeway Centre complied fully with guidance on same sex accommodation, as it had separate male and female wards. There were personal alarms for staff and nurse call systems available for patients. We found the unit well maintained and clean throughout at the time of inspection.

Safe staffing

- There were enough staff at the Ridgeway Centre to meet the needs of patients. The ward manager informed us that they generally worked to 0.7 members of staff to each patient, that staffing was based on acuity and that they

Are services safe?

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

were able to staff the ward as necessary to meet people's needs. They raised with us that recruitment and retention of qualified nursing staff was their greatest staffing challenge.

- According to information supplied to us by the provider following the inspection, the service had an overall staff vacancy rate of 21% as of January 2016. This was largely due to a high staff turnover in the preceding 12 months. At the time of inspection, the ward had a full complement of charge nurses, with four in post. Other nurse qualified and non-qualified vacancies were filled by bank and agency staff, which meant those non-permanent staff were essential to supporting safe staffing on the majority of shifts worked. The ward manager gave an assurance that bank and agency fill mitigated the staffing risk on both day and night shifts and ensured the unit was safely staffed. They assured us that agency staff, when employed, were familiar with the ward and paired with permanent ward staff.

- The ward manager was aware of the staffing issues at the Ridgeway Centre and had taken steps to recruit to the vacancies. The unit had recently introduced therapeutic support, whereby when a person received one-to-one support and it had been risk assessed, staff would only record their observations once an hour instead of every five minutes. This move away from overly onerous recording of observations had freed staff up to work more effectively and in a more therapeutic way with patients. We observed patients involved in one to one time with staff during the course of our visit.

Assessing and managing risk to patients and staff

- We saw examples in care records to demonstrate that staff carried out appropriate assessments and monitoring of risks, specific to each individual patient. For example, one patient's care plan for maintaining their safety had specific risks clearly identified and the steps that staff should take to mitigate the risks, including de-escalation and calming. We saw also how risk assessments tied in with a care plan for a risk of self-harming. We saw how staff monitored risk on an ongoing basis, for example, one person had an initial assessment that identified self-harming behaviour, and detailed body maps showed how staff then monitored this. Other patients had detailed risk assessments for ligature mitigation. For example, for one

patient identified as being at risk, their care plan contained detail as to how staff should reduce risks associated with personal care risks by the provision of a cordless electric razor.

- The ward manager explained to us how senior staff had taken on a more positive role, leading other staff by example when responding to incidents on the ward. They explained how they and the senior charge nurse would respond in person to alarms and incidents partly so they could act as role models for other staff, using non-physical intervention and de-escalation techniques whenever possible (i.e. discourage physical intervention). When the use of restraint was unavoidable, staff were encouraged to do short time periods to minimise the risk of harm to the patient, which meant there might be three or four short restraints during the course of an incident.

- Following a high profile death of a patient at another of the trust's learning disability inpatient service in July 2013, the coroner for the subsequent inquest to the death asked a number of questions of the trust's senior management team. The young man who died had drowned following an epileptic seizure that occurred while he was in the bath, unmonitored by staff. In a response, the trust sent a letter to the coroner in January 2016. This stated that the trust was working on a specific protocol for bathing called the 'protocol for the safe bathing and showering of people with epilepsy'. The letter to the coroner stated, "In the meantime, the draft document has been circulated to staff in the trust's learning disability inpatient units as it is already fit for purpose for use in these areas". It was not evident from speaking to staff who were involved in the bathing of patients that they were aware of or worked to this protocol. Whilst some staff did tell us that patients with epilepsy would be encouraged to shower or would be supervised at all times, some support workers were unclear who, if anyone, on the units had epilepsy. Some staff said all patients would be observed at all times if using a bath whether they had epilepsy or not. Others said that they would stand outside the door whilst another member of staff told us they would check every 10-15 minutes. We were concerned that the protocol was still awaiting completion and executive sign-off more than two and a half years after the death by drowning of a young person at one of the trust's other services. Furthermore, staff at both Ridgeway Centre and Evenlode were not consistent in their

Are services safe?

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

explanations of how they would supervise patients when bathing. This uncertainty and lack of consistency meant that, potentially, patients with epilepsy were still being placed at unnecessary risk when bathing.

Reporting incidents and learning from when things go wrong

- The ward manager explained to us that staff were encouraged to record all incidents on the trust's electronic incident log, no matter how minor or insignificant they might consider them to be. This was to encourage openness and to give a true picture of the ward. The ward manager, acting as gatekeeper, was then able to choose whether to deal directly with any incidents logged, if appropriate, or refer back to staff for further clarification. The ward manager could also refer on to other parties for action, such as the Estates department if they had identified that maintenance was required. The ward manager would escalate any incident logged on the system as amber or above to a more senior manager. The ward manager stated that analysis of incidents, for example whether incidents happened more frequently at specific times of the day, had led them to change meal times. They told us this had subsequently led to a drop in the number of incidents after meal times.

- We checked the trust's incident figures for the 12 months prior to our inspection and confirmed that the majority of the 600 or so incidents recorded as taking place on the ward had resulted in little or no actual harm to staff or patients, and that a quarter of the incidents recorded were under the lowest category of near miss. The manager told us they had encouraged staff to record all near misses, as this would allow them to demonstrate the good work being done by staff to avoid incidents.

Evenlode

Safe and clean ward environment

- We previously carried out an inspection of Evenlode in October 2014 as part of our comprehensive inspection of the trust. At that inspection, we identified a number of issues in relation to the safety of the environment, including an unsecure perimeter fence and multiple internal ligature points. At this inspection, we identified significant ongoing and unmitigated risks in relation to the safety of the environment at the service.

- We identified multiple ligature points throughout the unit. We had previously raised this in our comprehensive inspection in October 2014. We had given the trust a compliance action under regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises. This required the trust to complete the removal of ligature risks. The trust's own 'ligature environmental risk assessment form', completed for Evenlode in August 2015, had identified eight or nine ligature risks that were rated as red/high in all patient bedrooms. All of these were marked as 'remove and replace'. At this inspection, we found that a metal hook on the shower curtain had been removed following the audit, but the remaining eight ligature risks were still present in patients' bedrooms at the time of our inspection. These included taps in en suite bathrooms, notice boards and doorknobs. Of significant concern were the three weight-bearing ligature points at head height or above – wardrobe hinges, door closures and the beds - none of which had been replaced. The ligature risks were not being effectively mitigated by staff observation, as those carrying out observation were sited in a communal area that did not allow them to observe patient rooms due to the layout of the ward. The ward's layout made it difficult for staff to observe patients at all times. The main corridor where patients' bedrooms were situated had recessed alcoves that were not visible from the main communal ward area where staff were placed to observe the corridor. The risk from ligatures was further compounded by the fact that patients had unsupervised access to a large number of electrical cables. For example, a patient had a several meter long microphone lead on top of his wardrobe. Patients had electrical equipment including televisions, games consoles and music systems with numerous electrical cables. Appropriate risk assessments were not in place for these cables.

- Despite ligature risks in bedrooms being on risk assessments, staff had not considered fully or understood the nature of all environmental risks. These included risks such as the hinges on the wardrobe doors and door closures that were not in line with staff sight. Staff had also not identified a risk with the beds, in that they had metal frames that were not fixed and could be stood on end. We brought this to the attention of senior managers who had been unaware the beds were not fixed. Staff showed us a schedule for ligature works for the bedrooms and en suite bathrooms, dated 6th January, that had the schedule date

Are services safe?

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

for works to be completed in May 2016. Clinical staff and managers on the unit were unable to provide us with details as to exactly what work was going to be done, because they had not been effectively consulted with about the planned works. We asked the trust at the time of our inspection to provide us with an assurance that steps would be taken to mitigate the risk of ligatures pending completion of the scheduled works, including making changes to patient observation. On a return visit to the service on the 29 January 2016, we were informed that staff observing the bedrooms at night no longer sat in the main communal ward area where they were unable to carry out effective observation. We saw that new beds had been delivered from other units for three of the rooms and were given an assurance that more had been ordered for the remaining bedrooms. Electrical cables had been shortened and were clearly identified on individual patient property lists.

- The clinic room at Evenlode was not fit for purpose and did not contain appropriate essential resuscitation equipment. There was no portable suction unit in the clinic room and one of the required airway devices was loose and unpackaged, which made it non-sterile. There were no records to demonstrate regular checking of the emergency equipment prior to 10 December 2015. On the record for that date, the missing items were noted. The service had ordered replacements on 15 December 2015, but they were still not present more than a month later at the time of our inspection. Further, although the trust had a detailed checklist in the 'Resuscitation Equipment Information and Automated External Defibrillator Checklists' dated August 2014, the emergency bags were not standardised and we found different equipment was available at the Ridgeway Centre. Staff told us that there had been longstanding plans to standardise emergency equipment across all wards in the trust. The clinic room at Evenlode had only a dining room chair instead of an examination couch. The room also contained the staff lockers. All staff had access to the lockers and it was reported that staff sometimes accessed their lockers whilst patients were receiving treatment such as dressings. We discussed with senior trust representatives at the time of inspection that the lockers in the clinic room affected the privacy and dignity of patients and presented a potential infection control risk. When we revisited the unit on 29 January 2016, the trust had removed the lockers from the clinic room.

- The seclusion room at Evenlode allowed for clear observation of patients through both windows and with CCTV. The shower and toilet area had been refurbished and was safe and comfortable. Water could be isolated from outside the room if required. A clock was visible from the seclusion room. Specialist bedding had been sourced which was tear resistant, but also comfortable and soft. In our previous inspection, we had been concerned about the privacy and dignity of the patients in the seclusion room as there was a window on to the garden, by which people outside could see in to the room. This had been rectified with the use of privacy film that allowed patients in seclusion to look out, but prevented patients in the garden from looking in. However, we found that the intercom that would allow patients in seclusion to talk to staff outside the room was not working. Staff were unaware of this until the intercom was tested during our inspection. We asked the trust to rectify this immediately.

- As a male only ward, Evenlode complied fully with guidance on same sex accommodation. There were appropriate personal alarms for staff and nurse call systems available for patients. We found the unit to be clean throughout at the time of inspection.

Safe staffing

- There were enough staff to meet the needs of patients at Evenlode at the time of inspection. There were usually five or six staff on each daytime shift, consisting of one or two qualified nurses and four band 3 support workers. At night time, there was generally one nurse and three support workers. The ward manager told us that recruitment and retention of qualified nursing staff, as was the case with the Ridgeway Centre, was their greatest staffing challenge. Core staff told us that they made up some of the deficit in staff by covering additional shifts. Figures supplied by the provider confirmed that showed bank and agency staff covered a much smaller number of shifts than at the Ridgeway Centre. Permanent nursing staff generally supported daytime shifts, and an agency nurse worked the night shift. The manager told us they were able to bring in more staff as and when required according to the needs of people at the service.

- We did find some evidence that existing permanent staff were under pressure due to staffing problems, specifically resulting from the problem of recruiting and retaining qualified nursing staff. Staff showed flexibility in how they covered gaps in the rota with multiple changes each week

Are services safe?

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

and by working more than their contracted hours. The provider had identified this through its internal peer review carried out in September 2014. In the review report, it was noted: 'Although the staff we spoke to were clearly very skilled and knowledgeable they were also clearly working many additional hours and were clearly very tired, this gave the impression that with any additional pressures the team could be very fragile.' Staff that we spoke with during the January 2016 inspection told us that staffing could be a challenge. It was evident from feedback we received that repeated long shifts continued to have a negative effect on some of them.

- We also gathered feedback from patients that staffing pressures might also be having an impact on the quality of service they received. Although we were unable to validate it for ourselves, one patient told us they thought they did not always get the treatment they needed due to staff being too busy. Similarly, other patients told us they believed that leave was sometimes cancelled due to there being insufficient staff available to escort them.

Assessing and managing risk to patients and staff

- We saw examples in care records of good practice in relation to assessments and monitoring of risks. For example, staff had identified one patient as being at clear risk to themselves and others following previous and recent incidents. Their risk assessment was detailed and gave clear steps staff were to take to mitigate the risks. This included placing the patient in a high dependency bedroom, keeping them under an increased level of observation, and regularly monitoring their mood. We also saw evidence of positive risk taking in the care plan for a patient who had a physical health problem. The assessment explained the steps to be taken and a full rationale.
- Staff had undertaken detailed assessments of the risks posed to individual patients by ligature points. These took into account the patient's past risks, and were clinically appropriate in assessing the patient's risk of suicide. However, the assessments did not take into account any of the environmental ligature risks detailed in the ward's most recent ligature assessment, including the large numbers of cables and the weight bearing ligature points above head height in patients' bedrooms. We asked the trust to address this at the time of our inspection. At our return visit, ligature risk assessments had been updated to include patient-centred statements about managing the risks. For example,

one risk assessment stated the importance of headphones to a patient with autism, and described how he used them to manage his sensory needs. Staff were arranging cordless headphones to lessen that risk further. Clinical staff on the ward acknowledged positively that this had been a useful point of learning for them, as a team, and that they would link the risk assessments in future.

- Staff were required to watch a ligature training video as part of now mandatory ligature training for all staff. It was stated in this training that, "A ligature risk assessment in isolation is likely to fail. The service user's risk assessment and specific self-harm care plan will reflect any identified ligature points from the ligature risk assessment." The training contained no explanation of how staff were to link the assessments in practice.

- We saw evidence of effective systems and processes for medicines management practice. Medicines cabinets were well organised and an appropriate amount of stock was present. It was positive that the unit had moved away from the use of rapid tranquilisation to respond to unrest or patients' unrest, and that there was a very low level of medication overall on the ward. Similarly, staff told us there was minimal use of restraint, other than when patients had to be placed in seclusion, which was confirmed by patients with whom we spoke.

Reporting incidents and learning from when things go wrong

- We saw some changes had been made following learning from a recent incident. For example, following a number of incidents involving a patient, the level of observation they were under had been increased and staff had been made more aware of how to support them. Following on from recent safeguarding concerns about patient well-being at night time, the ward manager had made appropriate changes to processes and staffing. They were also in the process of moving their office down on to the ward, so they could oversee more directly what took place on the ward, and had started to attend all patients' community meetings in person.
- The trust carried out internal quality assurance audits of individual services. The latest of these internal peer reviews, from December 2015, had identified a number of issues in relation to the processes and systems for learning from incidents. It was recorded in the peer review report that, 'There is no process currently for learning from

Are services safe?

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

incidents; there is no regular team meeting or opportunity to discuss with all staff. Information is currently shared via email or in the communication book but does not provide assurance with regard to learning and embedding learning from incidents.' We also identified similar concerns during our inspection of the service. For example, although reflective practice sessions had been held with staff as part of a follow up to safety concerns raised by patients, we were not assured that all necessary steps had been taken to demonstrate that essential learning had taken place. A number of patients told us that they still had concerns regarding the conduct of some staff on specific shifts. Further, although the ward manager had made some changes to staffing and processes, we were not convinced they had taken sufficient steps to effectively check and monitor staff performance across all shifts.

- We also identified a lack of learning following a specific serious incident at the service in July 2015. Following an

assault on a member of staff, several members of staff had been required to restrain the patient involved. It had been recorded in the electronic daily care notes that staff had been concerned about remembering physical intervention techniques, highlighting a lack of up to date specialist training, and it was stated that these concerns had been raised to management. The ward manager confirmed that this incident had been entered on to the trust's electronic incident log, but that there had been no subsequent investigation and no additional or revised specialist training provided for staff. We subsequently looked in detail at the recording and response to this incident, as part of a broader investigation of the trust's response to incidents, and identified a number of critical gaps and errors in the recording and response to the incident. These concerns are covered in greater depth in the provider level report.

Are services effective?

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

Our findings

Ridgeway Centre

Assessment of needs and planning of care

- The care plans showed that staff completed comprehensive, timely assessments of patients' needs upon admission. One person's records, for example, contained an admission assessment with a lot of detail gathered at the point of admission to the service including the person's mental health history and information about their deterioration.
- Care records showed that physical examinations had been undertaken and that there was ongoing monitoring of patients' physical health problems. For example, we looked at charts that showed regular monitoring of patients' physical condition (temperature, pain, and neurology), circulation (systolic blood pressure, heart rate), airway and breathing, and weight. We reviewed charts for each of the seven male patients. Although each person's record stated the frequency of which checks were to take place, the checks were not always taking place according to stated frequency. However, there had been some confusion with staff duplicating charts, which made it difficult to ascertain exactly the frequency and accuracy of monitoring taking place. The confusion with duplicated records also meant it was more difficult for staff to monitor properly changes in patients over time. The ward manager was aware of the issue and taking steps to improve the process. We saw records of weekly GP visits to the ward as part of the ongoing monitoring of patients' physical health. Notes for these visits showed that ward staff raised concerns they had about their patients' health with the GPs in a proactive and appropriate way. Care records contained plans for patients' specific physical needs, including choking (intervention of speech and language therapist), pain management, physiotherapy, and occupational therapy involvement. Staff were making care plans better personalised to individuals' different needs, and we saw how plans were available in different formats and able to be modified according to a patient's personal wishes.
- We saw evidence of how the staff at the Ridgeway Centre assessed and assured the quality of service. Satisfaction surveys monitored the induction of students and ensured they were properly involved in the service. Regular patient satisfaction surveys were carried out, as were internal

checks of clinical aspects of service, such as controlled drugs audits. Staff knowledge checks were carried out to see if staff knew what to do in the event of different scenarios, such as patient falls, medication errors, and supporting a patient if they wanted to complain. We saw that these checks had been carried out over the past year. Initially, staff had given very basic yes or no responses, but the checks had been improved so that detail that is much more useful was now collated, in an effort to better gauge staff's skills and knowledge.

Skilled staff to deliver care

- The manager explained to us that they were in the process of changing the ward culture, from one of staff just watching patients to focusing much more on engaging with them. Staff were actively encouraged to improve their own performance. One incentive was an increase to staff's job grade. However, in addition to positive encouragement we also saw first-hand how steps were taken to address quickly and effectively shortcomings in the performance of an agency worker during the inspection.
- Staff supervision was poorly managed, inconsistent and infrequent, and the supervision records were chaotic. The main folder, which recorded the frequency of supervision, contained records for a large number of staff members who no longer worked on the unit. According to what had been recorded in the frequency log, only two out of 17 staff were receiving regular supervision. Other staff showed large gaps in supervision, with five of the 17 records showing staff had only received two supervision sessions in the previous year. Minutes of supervision sessions in individual personnel files did not match the supervision frequency log. There were no written notes for the last three supervision meetings of one member of staff who had been recorded as receiving regular supervision. Individual staff files were disorganised and papers were loose and out of order in the filing cabinet.

Evenlode

Best practice in treatment and care

- We saw evidence that Evenlode provided treatments in line with National Institute for Health and Care Excellence (NICE) guidance and other best practice, including dialectical behaviour therapy and a treatment programme for sex offenders. Patients in Evenlode had complex needs with elevated risks necessitating the need for admission to the medium security setting. Staff managed these needs

Are services effective?

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

with a therapeutic approach and very low use of psychotropic medication. At the time of inspection only four of the nine patients were prescribed it, and two of those were only given antipsychotic medication on an occasional 'as required' basis. The unit was calm and we observed positive interactions between staff and patients throughout the inspection. Part of the therapeutic approach included a focus on positive risk taking, for example regular shared meals where patients and staff cooked meals together for the whole ward. Patients and their relatives that we spoke with were keen to stress the progress they had made following their admission to the service. One patient, for example, told us they had requested not to move to a low secure service and instead complete their transition to the community from Evenlode, due to the nature of the support he was getting and the progress he had made. Patients told us they also very much appreciated the provision of dialectical behaviour therapy (DBT) at the service. DBT is a talking therapy, used to treat problems associated with borderline personality disorder, including self-harm, attempting suicide, and eating problems.

Skilled staff to deliver care

- We found a similar situation to that at the Ridgeway Centre concerning staff supervision at Evenlode. The provider's own 2014 internal Peer Review, from September 2014, prompted management to make sure staff supervision records were up to date and available. More than a year later, in an internal peer review from December 2015, it had been found that: 'There is a supervision folder in the Office at Evenlode but is out of date, there are no supervision files for staff. There are slings in a filing cabinet in the administrator's room but there was poor evidence of supervision taking place on a regular basis for any staff and no evidence of appraisals.' That was very much what we

also found when we inspected the service the following month. We checked four personnel files. Two of the staff members had received supervision recently, one had supervision last recorded in September 2014 and one had no records to show they had ever received formal supervision. Regular and effective staff supervision is essential to ensuring the quality and safety of a service. It helps staff to manage the demands of their work, allows staff to reflect on and challenge their own practice in a safe and confidential environment, and helps to identify development needs. This in turn benefits patients, as effective supervision can help to ensure people who use services receive high quality care at all times from staff who are able to manage the personal and emotional impact of their practice.

- In addition to the lack of regular and consistent formal supervision, staff meetings had not been taking place, which meant that staff had not had appropriate forums in which to raise concerns or to share best practice. Further, we found that although staff were largely up to date with their mandatory training, there remained gaps in specialist training.. The need for essential specialist staff training had been identified some time previously, at our previous inspection in 2014. It had also been raised internally following a safeguarding incident in July 2015, when a member of staff had been seriously assaulted. It had been recorded on the electronic notes of the time that staff had been concerned about remembering physical intervention techniques, and that the need for staff to update specialist training had been raised with management. The specialist training staff had requested had not been provided more than six months later. Lack of appropriate support and training meant there was a risk that staff would not be able to respond effectively to such incidents in future.

Are services caring?

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

Our findings

Ridgeway Centre

Kindness, dignity, respect and support

- We saw examples of staff interacting effectively with patients during our inspection visit, particularly on the female ward. All the patients and carers we spoke with told us staff treated them well, and were polite and respectful.
- However, we found there was a different atmosphere in the male and female parts of the service. The female ward was more welcoming and we saw staff engaged freely and positively with patients. On the male ward the atmosphere was much more task-focused (for example, staff spoke with patients to find out whether they had showered that day or if they wanted a drink), and we didn't see any of the staff on duty sitting with or engaging with patients as happened on the female ward. We were concerned about the apparent lack of interaction and meaningful engagement with two patients on the male ward. We saw that staff left these patients alone through much of the day, asking only occasionally and in passing whether they were okay. We asked ward staff about activities those patients might engage in. They told us one of the patients was feeling unwell and the other preferred to be alone. We saw, however, that when the speech and language therapist (SALT) and occupational therapist (OT) arrived, both patients responded and, with encouragement, took part in activities. One of the patients had bare feet and flip-flops, and despite it being a cold day went out into the garden with a member of staff. In the afternoon his feet looked cold, and when the OT arrived we saw she gently encouraged him to go with her to his room to put on socks and trainers. The patient responded positively and became more talkative. Similarly, when the SALT went to the other patient and engaged with him by playing a hand game, which he clearly enjoyed, he interacted with the SALT and went with them to a relaxation class. When they returned, the patient told us they had really enjoyed it, and the SALT confirmed the patient had taken part.

The involvement of people in the care they receive

- We saw examples of how patients were being actively involved in decisions about their own care and treatment. Weekly feedback charts, filled in by patients, were used in the multidisciplinary team (MDT) meeting. This allowed patients to say what had worked well in their care and

treatment and what had not been so successful. Topics covered in the feedback included medicines and physical health, and moving on from the Ridgeway Centre. The care records we viewed contained evidence of patients attending their MDT meetings. Posters and leaflets advertising independent advocacy support were clearly visible, and some patients accessed this support. A ward service users group had been set up to look at key issues. One of the topics discussed at the group was food, and the involvement of patients had led to improved food choices being provided and a nutritionist had also been brought in to advise.

Evenlode

Kindness, dignity, respect and support

- At Evenlode, we saw positive interaction between staff and patients during our visit. Interaction between staff and patients was warm, appropriate and genuine. We felt that the majority of staff were doing their best to provide a good standard of care for their patients. Conversations and interaction with patients demonstrated a person-centred approach. Most of the patients we spoke with were very satisfied with the most of the staff, and described named staff as being excellent and as giving more than was expected of them.
- However, not all patients agreed. One person told us that they were very unhappy on the ward, and alleged that a member of staff had shared confidential information with them inappropriately. Another person told us that some staff were very good, but that others were not so good. They said that some staff were not always truthful and made patients do things they did not want to do. They alleged that 'privileges,' such as activities, were withheld or they were threatened with their removal if patients did not behave how staff wanted them to. Of the seven patients we spoke with during the day, two patients told us that there were 'good' and 'not-so-good' staff and two other patients raised substantial trust issues. The trust subsequently informed us that they were aware of the concerns raised by patients, and had taken steps to address them.
- We felt that the trust showed a lack of consideration for the views and dignity of patients in its response to our request for them to address the ligature risks at Evenlode. Following a request from patients, we made a return visit to the ward to speak with them a week after the initial inspection. Patients shared their concern that following our

Are services caring?

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

visit staff had been located directly outside their bedrooms at night, which was disturbing their sleep. They told us they had been given no warning that the night routine was to change. They also told us that they had returned from therapy groups to find workers in their bedrooms shortening electrical cables on their personal electrical equipment. Again, they said this had not been discussed with them. Door alarms had been installed on bedroom doors without explanation and then removed following complaints, and new furniture had been brought in for some bedrooms. Patients told us that the only explanation given to them was that it was because of our inspection. Our inspectors explained that we had asked the trust to take action due to risks in the environment that may not be relevant to them individually, but which needed to be addressed. We also apologised for the disruption it had caused them. We were concerned that although the provider had taken action when we requested it, they had not engaged or consulted with the patient group or explained the rationale behind the changes.

The involvement of people in the care they receive

- At Evenlode, efforts were being made to involve patients more in decisions about their own care and treatment. Therapy sessions and one to one sessions with staff were good forums for people to raise any concerns or to make suggestions for improvements. The ward community meetings were well attended by patients, and there was tangible evidence that patients felt relatively safe to raise concerns in this setting as they had raised concerns about night time procedures and the conduct of some staff. This had resulted in managers taking appropriate action to address the concerns raised. The service was in the process of introducing 'easy-read' care plans. Although this was still in its infancy, staff were working on making the care plans more personalised to each individual's specific communication needs.

Are services responsive to people's needs?

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

Our findings

Ridgeway Centre

The ward optimises recovery, comfort and dignity

- The Ridgeway Centre was being redecorated at the time of inspection. Decorators from the trust's maintenance department worked around the unit's activities and were very sensitive to the complexity of patients' needs. This included announcing their arrival on the ward and explaining to patients what they would be doing, using staff to support engagement. They also stopped working and left when a patient became distressed, ensuring confidentiality and respecting the patient's dignity.
- One patient's bedroom in Ridgeway Centre did not have curtains. Staff had put in a request for new curtains into the trust estates department in September 2015, but these had still not arrived or been fitted by the time of our inspection. Staff were confident that the patient's dignity was protected due to a mirror film that had been applied to the windows. However, when it became dark and the lights were on in the bedroom it was possible to see the whole room, including the person's bed. The window was overlooked by a large nursing home, and people would have been able to see into the bedroom from the windows of the home. This meant that the patient had no privacy at night when the lights were on in his room, and neither he nor the staff on the unit had been aware of this until we brought it to their attention.

Listening to and learning from concerns and complaints

- Patients at the Ridgeway Centre were positive about the care and treatment they received and told us that they did not have anything about which to complain. However, they also confirmed they knew how to complain and were confident in complaining if they were unhappy about anything.

Evenlode

The ward optimises recovery, comfort and dignity

- The bedroom doors at Evenlode potentially compromised patients' privacy and dignity. The observation glass in the doors allowed people outside in the corridor, including other patients, to look into a person's bedroom simply by lifting a flap of cloth that hung over the glass.

- At our previous inspection of the service in October 2014, we found patients were unhappy about lunchtime arrangements. We looked at minutes of community meetings, and they confirmed that staff had discussed mealtime arrangements with patients, and that patients were happy with the provision. Patients that we spoke with confirmed they were satisfied with the quality of the food provided and mealtime arrangements, which consisted of finger food for lunch five days a week, 'spoon' food two days, and full sit-down meals at dinner time.

- Three of the seven patients we spoke with in detail told us that they felt there were insufficient activities provided at the service. We saw that audits of activities were taking place, and these indicated a fairly extensive selection of activities were offered, but this was somewhat at odds with patients who told us there were insufficient activities or that they spent most of their time watching television because there were no activities. Patients also told us that escorted leave from the ward was sometimes cancelled due to staffing shortages. We were unable to confirm whether there was a clear correlation between staffing and the stated lack of activities or if the activities provided were not suited or of interest to some patients.

Listening to and learning from concerns and complaints

- Feedback from patients at Evenlode was mixed. Two patients told us they had no complaints but were happy to speak to staff to raise complaints if necessary. However, one patient told us that they had complained about issues but that staff had not listened to them. Another alleged that patients were told not to complain about anything because the unit was already under close scrutiny. They stated that staff entered into a 'tit for tat' campaign if they did complain about anything, slowing down responses to requests and delaying paperwork for example. A third person told us they felt like the patients were made to feel like they were to blame if things didn't go right on the unit. The trust subsequently informed us that they were aware of the concerns raised by patients, and had taken steps to address them.

Are services well-led?

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

Our findings

Ridgeway Centre

Vision and values

- The provider's own internal peer review of the service, carried out in October 2015, found that there was a sense of uncertainty for the future amongst the staff team at the Ridgeway Centre, and a need leadership and direction from senior managers within the trust. We had raised a similar concern from our previous inspection of the service in August 2015. However, we found there had been improvements in staff's morale and sense of being part of the wider trust at the January 2016 inspection.

Good governance

- The ward manager told us that there had been improvements in sharing and learning from best practice in other parts of the division and the wider trust. They showed us the latest 'Learning Disabilities Learning From Experience and Sharing Information' bulletin, from January 2016. This covered topics such as reporting and investigating deaths, ligature training and epilepsy best practice. This newsletter was sent to the manager for onward communication to ward staff. However, we found that this process of communication had not yet been effectively embedded. Staff at both the Ridgeway Centre and Evenlode were not aware of any learning from other learning disability inpatient services within the trust, or from each other. Qualified staff were aware of a reflective practice group, but told us this was not held often.
- The ward manager spoke positively about the corporate risk register, which they said was now much more straightforward. They were able to add risks on to the system as and when necessary, and liked the fact that with open access to the register they were now able to see all the risks across the trust, not just the ones in their own service. They told us this gave them a better understanding of what was going on in the trust, and allowed for better shared learning between different services. They gave an example of a risk on the register related to the difficulties recruiting qualified nursing staff. This had resulted in their getting senior approval for increased national recruitment advertising in medical journals. They also said there had been improvements in the flow of information about the service. We saw examples of the information received by them in monthly reports, covering such areas as

department trends, impact trends, and analysis of incidents. Another recent improvement in governance raised by the manager was that there was now a shared quality assurance schedule, so there was a planned programme of checks and audits of the service's performance. Areas covered included quality of care, infection control, medicines management, and epilepsy. The manager assured us that the trust had become more responsive, and gave the example of improved responses to requests from the ward for maintenance to be carried out.

- Despite improvements to the ward's systems for governance, we also identified a number of significant problems and areas of poor performance that demonstrated that further improvements in the service's governance were needed. Staff supervision was inconsistent, infrequent and poorly managed. In addition, a number of outstanding but significant issues had not been identified through the trust's own checks and audits. For example, there were significant remaining ligature points, which had not been identified by staff until we brought them to their attention during the inspection.

Leadership, morale and staff engagement

- Staff at the Ridgeway Centre told us that there had been considerable improvements at the service since our last inspection in August 2015. They told us that senior management was now more visible on the unit. Staff were positive about the changes in the physical environment and the investment that had been made. The ward manager told us that support from senior managers had also increased considerably. They now received monthly supervision, and the clinical services director was now based on site and on-hand to give additional support. They felt that senior associate directors had been supportive. These changes had contributed to a noticeable improvement in staff's morale from our previous visit. However, despite the improvement in morale we found there was still some anxiety amongst staff over the uncertainty surrounding the future of the service.
- We saw evidence of positive leadership at a local level. The ward manager told us they had strengthened relationships with the community team, and now worked more closely with the local authority to better support patients' transition and discharge. The inspectors were particularly impressed with the behaviour and professionalism of a senior charge nurse during the

Are services well-led?

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

inspection. They demonstrated good engagement with and knowledge of patients, alongside good leadership skills in coordinating staff to meet patient needs, understanding issues facing both patients and staff and being sensitive to both. When talking about patients they spoke with sincerity and warmth, giving descriptions of them as people first before moving on to describe any clinical features.

Evenlode

Vision and values

- We found a different situation at Evenlode, and identified a serious problem in that none of the staff spoken with felt to be part of the wider trust, and in fact staff at all levels expressed their sense of isolation from the trust. This clearly made it difficult for staff to share in the trust's vision and values. Staff raised with us that there was an ongoing sense of uncertainty as to the future for the service, and that they did not feel they had been supported effectively by the trust's senior management team. For example, staff told us they were unhappy that they had only received a visit from members of the trust's executive team the week prior to our inspection. Staff felt this was simply in anticipation of our carrying out an inspection visit at the service. This lack of support from and engagement with senior management had contributed directly to a staff team that "don't feel like part of the trust."
- The same issue was identified in our inspection in October 2014 and in the trust's own internal peer review, carried out in December 2015. It was stated in the report following that review that, 'Services in Oxfordshire are changing due to the Big Plan, whilst Evenlode is not part of this change it does impact. At this time, there is no clarity where the service will sit when the Community Services transfer from Southern Health to a new provider in 2016. Staff reported that they rarely see staff from other parts of the division or Senior staff and therefore do not feel part of the wider division. Due to this and lack of clarity re the future of the service staff do not feel clear about the direction.'
- Support workers did not know who the new service managers were despite them being in post for some time. Some staff were aware that members of the executive team had visited the week prior to our inspection but no staff were aware of any previous visits. In addition to staff, we spoke with most of the nine patients at Evenlode during the inspection and none of them knew who the trust's

senior managers or executives were, or if they had ever seen them at the service. We requested information from the trust about executive visits to the learning disabilities services in the Oxfordshire and Buckinghamshire learning disabilities services within the past 12 months. Information received showed there had been visits by members of the executive team to the Ridgeway Centre in March, July and August 2015. This included a visit by the chief executive in August 2015, following our previous inspection of the service. There had been one executive visit to Evenlode, by the chief operating officer and head of mental health, on 15 January 2016, the week before this inspection. Staff at Evenlode confirmed that this was the first time they had seen a member of the executive team. We noted that there was also a manager's review of the service on 12 January 2016.

Good governance

- We identified a number of serious failings in relation to the trust's oversight and governance of Evenlode. The trust's own internal peer review of the service, carried out in September 2014, raised a concern in the form of a question, 'Are your staff supervision records up to date and available?' In the next internal peer review, carried out in December 2015, the service had been rated as inadequate under the 'well led' domain. One of the findings of that peer review was that there was 'no evidence of supervision taking place as per trust policy on a 4-6 weekly basis.' Despite the issues in relation to staff supervision being known about internally for at least 16 months, we identified ongoing problems at our inspection. Supervision was found to be infrequent and inconsistent, and the system for managing, monitoring and recording supervision was still dysfunctional.

Similarly, in regard to ligature risks at the service, the 2014 internal peer review found that, 'There remains some ligature risks within the patients shower rooms and the patient bathroom, risks have been identified, assessed, placed on the risk register and plans are progressing to ensure the appropriate work is undertaken.' Yet despite being identified internally, 16 months later we found there were still multiple ligature risks throughout the unit. We discussed both the ward's ligature risks and the risk register with the ward manager during the course of the inspection. The ward manager confirmed to us that they were able to submit items to the corporate risk register, but had not had cause to. The ward manager had sent through a detailed

Are services well-led?

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

ligature assessment, highlighting many of the ligature points, through to senior managers more than 6 months previous but that nothing had been done in response. The trust stated that work should be completed by May 2016.

The trust's own internal peer review of Evenlode carried out in December 2015 was detailed and thorough. It catalogued a large number of concerns in relation to the safety, effectiveness, responsiveness and leadership of the service, and judged the performance inadequate in those areas. The peer review also highlighted that despite the large number of concerns and areas identified as being in need of improvement, there was no quality improvement plan for the service. A quality improvement plan had just been introduced at time of our inspection, and was being progressed at newly convened governance meetings. Qualified staff at Evenlode spoke to us about the recent peer review. Although they did not contest its findings, they were concerned about the way the action plan following the review was being implemented with what they considered unrealistic deadlines.

- The fact that the service had been left without appropriate senior support and oversight for so long, and allowed to deteriorate to such an extent, demonstrated both poor governance and ineffective oversight of the service by the trust's senior management team.

Leadership, morale and staff engagement

- We were concerned to find that staff morale was very low at Evenlode. A recent safeguarding investigation, lack of support and direction from senior managers, and ongoing uncertainty as to the future of the service had all had a noticeable impact on staff's morale. Investigations following on from safeguarding concerns raised by patients were still in progress at the time of our inspection, but it was clear that this process had affected the mood at the unit. The ward manager had been in post since November 2013, and there had been five heads of service in the time since 2013. Unsurprisingly, this had led to a lack of continuity and consistency in the support and guidance available to the ward manager during that time. There had also been no clinical service manager until September 2015. The negative effect of numerous management

changes and lack of consistent support for the ward manager were highlighted as issues in both the 2014 and 2015 internal peer reviews. However, at this inspection visit the manager spoke positively about it being a time of change, and told us they had received good support since the new senior team's arrival in September 2015.

- Other staff we spoke with were concerned about the direction of the service and expressed a feeling of isolation from other services. Some staff expressed concern that there was a negative view of all Oxfordshire learning disability services within the trust following adverse events in other services. The clinical team did not feel they had received appropriate recognition from the trust for positive clinical outcomes patients were achieving or the low use of medication at the unit. Some staff reported bullying behaviours, but felt unable to escalate concerns about this within the trust. Staff reported that the trust responded quickly to issues but not always in a measured way, which meant they felt under pressure to complete actions immediately. For example, following the first day of our inspection staff told us that senior managers wanted ligature risk assessments to be completed for all patients within two days of our visit. This had led to some staff, including ones who had started work at 8am, staying on until 5:30am the next day to complete the assessments. We were told that several staff had left and others were thinking of leaving because of the pressure under which they were being put.

- It was to the credit of the team at a local level that staff who had recently joined the service reported to us that they felt it was a strong and supportive team, who helped them and who were positive about patient care. Yet, despite the best efforts of many of the ward's staff, there was a risk that low staff morale was affecting the care and support that patients received. Patients we spoke with identified the issue of staff morale. One patient told us they felt that staff were negative about everything, including their own jobs. Two other patients told us they thought staff morale was very low, and a fourth patient told us they thought staff were under a great deal of pressure, and this was affecting morale.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The training, learning and development needs of staff had not been identified and actions taken to meet any gaps. Staff did not receive appropriate on-going supervision in their role. This is a breach of Regulation 18(2)(a)
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 17 HSCA (RA) Regulations 2014 Good governance The trust had not analysed and responded to information gathered from internal reviews to take action to address issues where they were raised, or used information to make improvements and demonstrated they have been made. The trust had not monitored progress against plans to improve quality and safety. This is a breach of Regulation 17(2)(a)
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 The provider had not ensured the safety of their premises and the equipment within it. The environmental risks at Evenlode must be addressed. Until the necessary changes are made to make the environment as safe as possible, appropriate measures must be implemented immediately to mitigate effectively the risks to people using the service.

This section is primarily information for the provider

Requirement notices

The clinic room at Evenlode must be made fit for purpose and contain all appropriate essential equipment for resuscitation.

The remaining environmental risks at the Ridgeway Centre must also be addressed.

The provider must make the necessary improvements to the environment at both services in order to protect people's dignity and privacy at all times.

This is a breach of Regulation 12(2)(d)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

The trust had not made the necessary improvements to the environment at both locations in order to protect people's dignity and privacy at all times.

This is a breach of Regulation 10(2)(a)

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance
Diagnostic and screening procedures	The trust did not have effective governance arrangements that identified, prioritised and mitigated risks to patient safety, for example, ligature risks, fall from heights and risks from patients absconding
Treatment of disease, disorder or injury	The trust did not have effective governance arrangements to deliver robust incident investigation or respond to concerns raised by patients and staff
	Key risks and actions to mitigate risks were not driving the senior management team or the board agenda
	See quality (provider) report for more detail