Oxford Health NHS Foundation Trust

Inspection report

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

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

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

Ratings

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

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

Summary of findings

Background to the trust

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

In Oxfordshire, the trust is the main provider of the majority of non-GP based community health services for the population of Oxfordshire. It delivers these in a range of community and inpatient settings, and in people's homes. The trust has eight community hospital sites with ten wards across these. It also runs a GP surgery and GP out of hours services. Mental health teams provide a range of specialist healthcare services in community and inpatient settings across the geographic areas of Milton Keynes, Buckinghamshire, Oxfordshire, Wiltshire and BaNES. Additionally, the trust provides forensic mental health and eating disorder services across a wider geographical area including patients in Berkshire, the wider Thames Valley and Wales. The trust took over community and inpatient services for people with a learning disability in Oxfordshire, which had previously been run by Southern Health NHS FT, this includes the Evenlode medium secure inpatient service.

The trust operates a total of 562 inpatient beds over 34 sites. Oxford Health NHS Foundation Trust currently has 16 registered locations. It employs a total of 6761 (4825 WTE) staff members. It had a total income for the 2018/19 year which equated to £347.6 million. As a foundation trust it is also regulated by NHSI.

There have been several changes in senior leadership at the trust. The current director of nursing came into post in June 2019 and the chair took up his post in April 2019.

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

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

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

Overall summary

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

What this trust does

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

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

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Forensic inpatient/secure wards

Summary of findings

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

The trust also provides

- GP Out of Hours
- Luther Street medical practice
- Community Dental Services.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

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

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

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

What we inspected and why

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

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

- Wards for people with a learning disability or autism
- Forensic inpatient/secure wards
- Child and adolescent mental health wards

Summary of findings

- Community-based mental health services for older people
- Specialist community mental health services for children and young people
- Urgent care services

This inspection covered the trust's community health and mental health services only. The trust's primary medical services are inspected separately and have a separate inspection report.

The aggregated ratings used in this inspection report are for the trust's community health and mental health services only. They do not include the separate ratings for the trust's out of hours doctor service rated good and the Luther Street which provides primary health care services for homeless people which is rated outstanding.

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

What we found

Overall trust

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

- Since the last inspection in 2018 the trust has continued to make improvements despite facing some challenging funding issues. An independent report on the level of funding for mental health services in Oxfordshire (commissioned by Oxfordshire CCG, NHSE/I and OHFT) determined that there was a significant funding shortfall in mental health services. A further review carried out by Oxfordshire CCG highlighted a £12m shortfall in mental health funding but also a £10m shortfall in funding for community services. The shortage of funding has required an additional level of dedication and capability from the trust leaders and all the staff to maintain the capacity and quality of the services whilst managing scarce resources.
- During this inspection we inspected six core services and carried out a well led review.
- In rating the trust, we have taken into account the previous ratings of the ten mental health and community health core services not inspected this time. Following this inspection 14 core services were rated as good overall, one was rated requires improvement and one was rated outstanding.
- We found that the trust was led by a highly skilled and experienced senior team, including the chair and non executive directors. There was a strong patient focussed, learning culture within the trust and staff showed caring, compassionate attitudes, were passionate and proud to work for the trust and were involved in the development and improvements within the trust.
- The trust had made the majority of the improvements we said that it should make following our last inspection.
- Across the trust the majority of the environments were safe, clean, well equipped, well maintained and fit for purpose.
- In community services waiting lists were managed well, the number of patients on the caseload was not too high to prevent staff from giving each patient the time they needed and anyone needing to be seen urgently was seen in a timely manner.
- In the wards for people with a learning disability staff had received training in positive behaviour support, patients had individualised behaviour support plans and staff were supporting patients who had challenging behaviours appropriately.

Summary of findings

- Generally, staff completed comprehensive risk assessments and managed risks well. Physical and mental health needs were assessed and monitored, and care plans were holistic and recovery orientated. Staff followed good practice with respect to safeguarding.
- Patient safety incidents were managed well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons with their teams and the wider organisation.
- Staff provided a range of care and treatment interventions suitable for the patient groups and these were consistent with national guidance on best practice.
- Staff across all the services we inspected were kind, compassionate, respectful and supportive respected the privacy and dignity of patients. Feedback from people using services and their relatives and carers was highly positive. People who used services were appropriately involved in making decisions about their care. Staff ensured that the emotional and spiritual needs of people who used services were addressed, along with their mental and physical healthcare needs.
- The majority of services had access to the full range of specialists required to meet the needs of patients under their care. There was enough staff with a range of skills needed to provide high quality care. Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff planned and managed discharge well. Inpatient services, including wards for people with a learning disability and forensic secure wards, liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, people who used services did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- The trust had strong governance systems supported by good quality performance information. This meant that at all levels of the organisation staff and members of the board had access to useful information that enabled them to gain assurance and make improvements where needed. This enabled the trust to achieve a balance between assurance and improvement work.
- The trust had positive and collaborative relationships with external partners and was actively engaged with the local health economy in shaping services to meet the needs of the local population.
- The trust continued to build on their innovation as a Global Digital Exemplar, sharing learning and supporting other trusts to make improvements in technology. There was good practice and innovation around IT that was patient focussed such as access to records and 'I want great care' and the Blue Ice app.
- The trust had a strong focus on research and had strategic research links both to the University of Oxford and Oxford Brookes University. The trust ran one of only two mental health biomedical research centres in England.

However:

- The seclusion rooms at both Evenlode ward (wards for people with learning disability and autism) and Watling ward (forensic inpatients) did not always offer privacy for patients. Staff on Evenlode were not secluding patients for the shortest possible amount of time. Records showed that patients who were settled were not removed from seclusion promptly so not protecting their human rights. Documentation was not always completed at the correct time.
- Patients on Evenlode did not have access to a speech and language therapist; there had been no provision for 18 months.
- In forensic services the quality of physical healthcare provided to patients was inconsistent between wards and the quality of pre-prepared meals on wards at the Oxford clinic was poor.

Summary of findings

- In forensic services there was a lack of parity of access to entertainment between wards. Patients on male wards had access to satellite television and a range of activities, whereas patients on the two female wards had been made to choose between having satellite TV and some activities that incurred a cost (for example, baking).
- Ligature risk assessments were carried out but not always acted upon in Marlborough House inpatient ward.
- In specialist community mental health services for children and young people the increase in demand and capacity issues had created increased wait times for non-urgent referrals.
- Some staff said they found it hard to access supervision.
- The was a lack of robust board level oversight of the Mental Health Act.

Are services safe?

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

- Four of the sixteen mental health and community health core services operated by the trust were rated requires improvement for safe and one was rated inadequate. This takes into account the previous ratings of the ten services not inspected this time.
- On Evenlode ward (wards for people with learning disability and autism) we found that staff were not secluding patients for the shortest possible amount of time. Records showed that patients who were settled were not removed from seclusion promptly so not protecting their human rights. Documentation was not always completed at the correct time.

However

- The trust had made the required improvements in urgent care and specialist community mental health services for children and young people. We have changed the rating for safe from requires improvement to good.
- In urgent care services staff now understood how to protect patients from abuse and worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. The service checked staff at recruitment to make sure they were safe and suitable for their roles. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- In specialist child and adolescent community mental health services the number of young people on the caseload of the teams, and of individual members of staff were now manageable and staff could give each young person the time they needed.
- The majority of the environments were safe, clean, well equipped, well maintained and fit for purpose.
- In community services waiting lists were managed well, the number of patients on the caseload was not too high to prevent staff from giving each patient the time they needed and anyone needing to be seen urgently was seen in a timely manner
- Generally, staff completed comprehensive risk assessments and managed risks well. In the wards for people with a learning disability staff had received training in positive behaviour support, patients had individualised behaviour support plans and staff were supporting patients who had challenging behaviours appropriately.
- Patient safety incidents were managed well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons with their teams and the wider organisation.

Summary of findings

- Staff followed good practice with respect to safeguarding Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Are services effective?

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

- Thirteen of the sixteen core services were rated as good for effective and one was rated outstanding. This takes into account the previous ratings of the ten services not inspected this time.
- In the majority of services inspected teams included or had access to the full range of specialists required to meet the needs of patients under their care. Staff had a range of skills needed to provide high quality care. Staff had regular appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff provided a range of treatment and care for patients based on national guidance. Physical and mental health needs were assessed and monitored, and care plans were holistic and recovery orientated.
- The trust had effective systems in place to protect the rights of people subject to the Mental Health Act. The Mental Health Act administration team had a depth of specialist knowledge and provided high quality support to local teams.

However

- Two of the five community health core services operated by the trust were rated as requires improvement for effective. This related to community inpatients and end of life care. We did not inspect these services during the 2019 inspection.
- On Evenlode ward (wards for people with a learning disability or autism) staff did not follow best practice when using seclusion and patients were not always secluded them for the shortest possible amount of time. Records did not include the clinical discussions or clear rationales why patients need to remain in seclusion.
- Patients on Evenlode did not have access to a speech and language therapist; there had been no provision for 18 months.
- In the urgent care service some staff said they found it hard to access supervision.

Are services caring?

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

- Fifteen of the sixteen core services were rated as good for caring, one was rated outstanding. This takes into account the previous ratings of the ten services not inspected this time.
- The staff across all the community health and mental health services we inspected showed a caring attitude to those who used the trust services. Feedback from people using services and their relatives and carers was highly positive. Staff in all services were kind, compassionate, respectful and supportive. People who used services were appropriately involved in making decisions about their care.
- Staff supported people who used services to understand and manage their care, treatment or condition.
- The staff ensured that the emotional and spiritual needs of people who used services were addressed, along with their mental and physical healthcare needs.

Summary of findings

- Staff involved people who used services in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Are services responsive?

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

- Fifteen of the sixteen core services were rated as good for responsive, one was rated requires improvement. This takes into account the previous ratings of the ten services not inspected this time.
- Staff treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these within their teams and across the wider service.
- Staff planned and managed discharge well. Inpatient services, including wards for people with a learning disability and forensic secure wards, liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, people who used services did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- In specialist community mental health services for children and young people, staff ensured that young people, who would benefit from care from another agency, made a smooth transition. This included ensuring that transitions to adult mental health services took place without any disruption to the young people's care.
- Staff facilitated young people's access to high quality education throughout their time on the child and adolescent mental health wards. People who used inpatient services had access to a range of activities.

However:

- In forensic services the quality of physical healthcare provided to patients was inconsistent between wards. The location of the seclusion room on Watling ward meant that distressed patients could be heard in communal areas and the quality of pre-prepared meals on wards at the Oxford clinic was poor.
- In specialist community mental health services for children and young people the increase in referrals and capacity issues had created increased wait times for non-urgent referrals. The trust had a single point of access in Oxfordshire and Buckinghamshire which screened and triaged all referrals so that each could be passed to the most appropriate service or team to provide care and treatment. All children and young people referred to be seen urgently were seen within one week. All others received care and treatment within the national target of 18 weeks. However, the trust had set itself a target of seeing 75% of referrals within 12 weeks, some teams, for example, South East Oxfordshire and North Oxfordshire and Melksham were not meeting this target. The trust was well aware of the issues, had contracted with a private provider to outsource the assessment of children and young people deemed to be at lower risk and had a waiting time mitigation plan in place and was actively managing the waiting list.

Are services well-led?

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

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

- Fifteen of the sixteen core services were rated as good for well led, one was rated as requires improvement. This takes into account the previous ratings of the ten services not inspected this time.

Summary of findings

- The trust had positive and collaborative relationships with external partners and was actively engaged with the local health economy in shaping services to meet the needs of the local population.
- The trust continued to build on their innovation as a Global Digital Exemplar, sharing learning and supporting other trusts to make improvements in technology. There was good practice and innovation around IT that was patient focussed such as access to records and 'I want great care' and the Blue Ice app.
- The trust had a strong focus on research and had strategic research links both to the University of Oxford and Oxford Brookes University. The trust also had a collaborative relationship with the Oxford Academic Health Science Network (Oxford AHSN) and hosted the Oxford AHSN Anxiety and Depression Network, working to improve patient outcomes.
- The Chief Executive actively promoted research in the trust to improve the care and treatment of patients. The trust ran one of only two mental health biomedical research centres in England.
- The board was visible and supportive to the wider health and social care system. Reports from external sources including NHS England/Improvement and commissioners were consistently positive.
- The trust had a highly skilled and experienced senior team, including the chair and NEDs. There was evidence of some positive thoughts around succession planning at senior level and developing talent for the future.
- There was a strong learning culture within the trust and staff showed caring, compassionate attitudes, were proud to work for the trust and were involved in the development and improvements within the trust.
- The trust was working to further nurse and allied health professional leadership development within the organisation.
- Most staff felt respected, supported and valued. They had opportunities for career progression, and they felt able to raise concerns without fear of retribution.
- Of the 12 Clinical and Service Directors who lead the trust's five clinical service directorates (Community, Oxford and SWBaNES, Buckinghamshire, Forensic and LD) three, (25%) were from a BAME background.
- There were systems of accountability for medicines via the Trusts Drug and Therapeutics Group. The Medical Director had board level responsibility for medicines optimisation.
- Positive work was being done to address the recruitment and retention of staff and manage the demand pressures. This included the implementation of the nursing associate programme.
- Since the last CQC report in 2018, an independent report on the level of funding for mental health services in Oxfordshire was jointly commissioned by Oxfordshire CCG, NHSE/I and OHFT. The review determined that there was a significant funding shortfall in mental health services, Oxfordshire CCG accepted this and carried out their own evaluation, the funding report, whilst highlighting a £12m shortfall in mental health funding, also specifies a £10m shortfall in funding for community services. The shortage of funding has required an additional level of dedication and capability from staff, and particularly managers, to maintain the capacity and quality of the services whilst managing scarce resources. Negotiations with the CCG are ongoing.

Ratings tables

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

Summary of findings

Outstanding practice

We found examples of outstanding practice in child and adolescent inpatient wards, specialist community mental health services for children and young people, community based mental health services for older people.

For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including one breach of legal requirements that the trust must put right. We found 26 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

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

Action we have taken

We issued a requirement notice to the trust. Our action related to breaches of the legal requirements of Regulation 13: Safeguarding service users from abuse and improper treatment. in one core service at one location.

What happens next

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

Outstanding practice

Child and adolescent inpatient wards

In Marlborough House there was a physical health clinic called the 'wellbeing Wednesday' supported by two children's nurses, the specialist doctor and two support workers. The clinic monitored young people's medication, side-effects and was a place for young people to just drop in and have an informal conversation regarding any aspect of their medication or physical health in general.

In Highfield Unit young people had access to a music studio and a music therapist who assisted them to make and perform music.

Young people were very positive and described the activities available at the Highfield Unit as 'exceptional'. Activities included games, sports, art and craft related activities, musical activities and skills groups which enabled young people to learn how to cope with their feelings more successfully using mindfulness and other techniques.

The young people at the Highfield Unit were highly involved in the running of the Unit. The young people were involved with the recruitment of staff in all teams and they formed part of the recruitment process for new clinical staff in 2018.

The Highfield Unit employed dedicated patient engagement workers whose focus was to interact with and support the patients. For example, they responded to young people who were distressed by the sound of alarms and supported them to manage their feelings when alarms sounded.

The Highfield Unit had a dedicated family therapy suite and used technology to improve communication with families and carers. For example, they used video conferencing technology to work with family members overseas.

Specialist community mental health services for children and young people

Summary of findings

The Bath, North East Somerset, Swindon and Wiltshire CAMHS team won the Innovation in Digital Mental Health category for the Blue ICE app at the Positive Practice in Mental Health Awards 2019. This app was designed in co-production with young people. It aims to help young people manage negative emotions. The app has now been included in the national NHS library.

The Oxfordshire Outreach Service for OSCA won the CAMHS category at the 2019 National Mental Health Awards.

Community based mental health services for older people

Patients under the care of North Oxford team had an opportunity to receive support from an assistant practitioner who specialised in music. This intervention was used as an alternative to medication, and is research based on the human voices' ability to slow the heart rate and therefore help reduce anxiety.

Urgent Care

The service had successfully implemented a volunteer programme to improve patient experience and staff satisfaction across the urgent and ambulatory care service. The service worked with a local college to offer students experience in the clinical environment. There were over 21 volunteers in post and the trust provided a quarterly training and networking event, enabling volunteers to benefit from peer support, group learning and learning from outside speakers including service users.

The trust had developed the minor injury units and first aid units to provide care locally for people with minor injuries. The service had improved fracture treatment, to reduce the need for patients to attend acute hospitals.At the time of the inspection there were nine pathways in place and the numbers of patients who were seen, treated and discharged regularly audited. This had led to a significant reduction in the numbers of patients who are required to attend follow up clinics in acute settings and is in response to the service strategy of delivering care closer to home.

An advanced nurse practitioner (ANP) outreach role had been developed in response to both the NHS Long term plan and the service strategy of 'right care, right time, right place'. This had enabled patients to remain in their own home whilst receiving treatment they may have had to travel to the EMUs or acute trust to receive. The ANP outreach role also supported frail patients within nursing and residential care to help support decision making to reduce admissions to acute trusts where appropriate. Although this role was set up to initially to support winter pressures the service had continued with this in response to patient's needs.

Areas for improvement

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

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with one legal requirement. This action related to one service.

Wards for people with a learning disability or autism

The provider must ensure that staff follow good practice guidance when secluding patients and include a rationale in records for the clinical decision to seclude a patient. Patients must also be secluded for the shortest time possible. Patients in seclusion must be offered an appropriate level of privacy.

Action the trust SHOULD take to improve:

Summary of findings

Wards for people with a learning disability or autism

The trust should ensure that all agency staff understand and follow all patients care plans.

The trust should ensure that all staff respect patients' wishes to have their doors closed quietly at night

The trust should ensure patients have access to speech and language services as required

The trust should provide a comfortably furnished garden to encourage patients to use the area.

Forensic inpatient/secure wards

The trust should ensure that patient care plans address all the individual needs of each patient.

The trust should ensure that physical healthcare provided to patients is of appropriate quality within every ward.

The trust should ensure that all seclusion facilities safeguard patient privacy and dignity.

The trust should ensure that all leave authorisations comply with Ministry of Justice conditions.

The trust should ensure that there is parity of access to activities, including satellite television channels, across the wards.

Child and adolescent inpatient ward

In Marlborough House the ligature risk assessment should include actions staff should take to ensure area with ligature risks were safe. The assessment should be updated to include work that had already been completed.

In Marlborough House staff members should ensure any changes to young people's care plans were updated quickly to ensure staff members worked consistently with the young people.

Specialist community mental health services for children and young people

The trust should record staff supervision in line with the trust`s policy.

The trust should ensure that care are plans are written in a consistent style including patient`s involvement for all patients in line with trust`s policy.

The trust should ensure the risk assessments are written in a consistent way to capture the severity of risk of patient to self, to others and from others.

The trust should continue the work to manage and reduce waiting times.

Community based mental health services for older people

The trust should ensure staff consistently record risk assessments.

The trust should ensure that staff assess and record mental capacity for patients who might have impaired mental capacity.

Urgent Care

The trust should complete the planned building work to enable staff at Henley minor injuries unit to see and assess patients attending the unit. Including ensuring patients with disabilities can access the building and toilets.

The trust should continue to recruit to the permanent staff vacancies.

The trust should ensure all staff are aware of who the 'freedom to speak up guardian' is, to encourage and support staff to speak up safely.

Trust wide

Summary of findings

The trust should review the board level oversight of the Mental Health Act.

The trust should review the monitoring of trends in the use of the Mental Health Act, particularly for those patients with protected characteristics under the Equality Act 2010.

Is this organisation well-led?

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

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

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

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

- Fifteen of the sixteen core services were rated as good for well led, one was rated as requires improvement. This takes into account the previous ratings of the ten services not inspected this time.
- The trust had positive and collaborative relationships with external partners and was actively engaged with the local health economy in shaping services to meet the needs of the local population.
- The trust continued to build on their innovation as a Global Digital Exemplar, sharing learning and supporting other trusts to make improvements in technology. There was good practice and innovation around IT that was patient focussed such as access to records and 'I want great care' and the Blue Ice app.
- The trust had a strong focus on research and had strategic research links both to the University of Oxford and Oxford Brookes University. The trust also had a collaborative relationship with the Oxford Academic Health Science Network (Oxford AHSN) and hosted the Oxford AHSN Anxiety and Depression Network, working to improve patient outcomes.
- The Chief Executive actively promoted research in the trust to improve the care and treatment of patients. The trust ran one of only two mental health biomedical research centres in England.
- The board was visible and supportive to the wider health and social care system. Reports from external sources including NHS England/Improvement and commissioners were consistently positive.
- The trust had a highly skilled and experienced senior team, including the chair and NEDs. There was evidence of some positive thoughts around succession planning at senior level and developing talent for the future.
- There was a strong learning culture within the trust and staff showed caring, compassionate attitudes, were proud to work for the trust and were involved in the development and improvements within the trust.
- The trust was working to further nurse and allied health professional leadership development within the organisation.
- Most staff felt respected, supported and valued. They had opportunities for career progression, and they felt able to raise concerns without fear of retribution.

Summary of findings

- Of the 12 Clinical and Service Directors who lead the trust's five clinical service directorates (Community, Oxford and SWBaNES, Buckinghamshire, Forensic and LD) three, (25%) were from a BAME background.
- There were systems of accountability for medicines via the Trusts Drug and Therapeutics Group. The Medical Director had board level responsibility for medicines optimisation.
- Positive work was being done to address the recruitment and retention of staff and manage the demand pressures.
- Since the last CQC report in 2018, an independent report on the level of funding for mental health services in Oxfordshire was jointly commissioned by Oxfordshire CCG, NHSE/I and OHFT. The review determined that there was a significant funding shortfall in mental health services, Oxfordshire CCG accepted this and carried out their own evaluation, the funding report, whilst highlighting a £12m shortfall in mental health funding, also specifies a £10m shortfall in funding for community services. The shortage of funding has required an additional level of dedication and capability from staff, and particularly managers, to maintain the capacity and quality of the services whilst managing scarce resources. Negotiations with the CCG are ongoing.

Ratings tables

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

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ➔➔ Sept 2019	Good ➔➔ Sept 2019	Good ➔➔ Sept 2019	Good ➔➔ Sept 2019	Good ➔➔ Sept 2019	Good ➔➔ Sept 2019

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Requires improvement ➔➔ Sept 2019	Requires improvement ➔➔ Sept 2019	Good ➔➔ Sept 2019	Good ➔➔ Sept 2019	Good ➔➔ Sept 2019	Requires improvement ➔➔ Sept 2019
Mental health	Requires improvement ➔➔ Sept 2019	Good ➔➔ Sept 2019	Good ➔➔ Sept 2019	Good ➔➔ Sept 2019	Good ➔➔ Sept 2019	Good ➔➔ Sept 2019
Overall trust	Requires improvement ➔➔ Sept 2019	Good ➔➔ Sept 2019	Good ➔➔ Sept 2019	Good ➔➔ Sept 2019	Good ➔➔ Sept 2019	Good ➔➔ Sept 2019

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

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Community health services for children and young people	Good Oct 2015	Outstanding Oct 2015	Outstanding Oct 2015	Good Oct 2015	Good Oct 2015	Outstanding Oct 2015
Community health inpatient services	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018
Community end of life care	Good Oct 2015	Requires improvement Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Community urgent care service	Good ↑ Jul 2019	Good ➔➔ Jul 2019	Good ➔➔ Jul 2019	Good ➔➔ Jul 2019	Good ↑ Jul 2019	Good ↑ Jul 2019
Overall*	Requires improvement ➔➔ Jul 2019	Requires improvement ➔➔ Jul 2019	Good ➔➔ Jul 2019	Good ➔➔ Jul 2019	Good ➔➔ Jul 2019	Requires improvement ➔➔ Jul 2019

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

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ↓ Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018
Long-stay or rehabilitation mental health wards for working age adults	Requires improvement →← Aug 2016	Good ↑ Aug 2016	Good →← Aug 2016	Good ↑ Aug 2016	Good ↑ Aug 2016	Good ↑ Aug 2016
Forensic inpatient or secure wards	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Requires improvement ↓↓ Jul 2019	Good →← Jul 2019	Good →← Jul 2019
Child and adolescent mental health wards	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019
Wards for older people with mental health problems	Good ↑ Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018
Wards for people with a learning disability or autism	Inadequate ↓ Jul 2019	Good ↑ Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good ↑ Jul 2019	Good ↑ Jul 2019
Community-based mental health services for adults of working age	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018
Mental health crisis services and health-based places of safety	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good →← Mar 2018
Specialist community mental health services for children and young people	Good ↑ Jul 2019	Good →← Jul 2019	Good ↓ Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019
Community-based mental health services for older people	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019
Community mental health services for people with a learning disability or autism	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Overall	Requires improvement →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019

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

Community health services

Background to community health services

Oxford Health NHS Foundation Trust is a large NHS trust that provides a range of services across a wide geographical area. In Oxfordshire, the trust is the main provider of the majority of non-GP based community health services for the population of Oxfordshire. It delivers these in a range of community and inpatient settings, and in people's homes. The trust provides five community health core services. We last inspected community health services in April 2018.

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

- Urgent care services

Summary of community health services

Requires improvement

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

- We rated safe and effective as requires improvement. Our rating for community health services took into account the previous ratings of services not inspected this time.

However

- The community health core service inspected on this inspection was rated good overall. This was an improvement in rating for Urgent care services.
- In urgent care services staff now understood how to protect patients from abuse and worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The services provided care and treatment planned around the needs of patients and ensured they could easily access the most appropriate service.
- The services had been planned to respond to the needs of the local population. Effective pathways were in place to ensure that patients could be referred to other services, such as out of hours doctors and orthopaedics.
-

Community urgent care service

Good ↑

Key facts and figures

Oxford Health NHS Foundation Trust provides urgent care services to the population of Oxfordshire from three minor injuries units (MIU) and two first aid units (FAU). It also has two emergency multidisciplinary units (EMU) and a rapid access care unit (RACU). These services are within the trust's urgent and ambulatory care service. This service also includes out of hours, GP led services and hospital at home outreach services, however we did not inspect these services.

The minor injury units are at the hospitals in Abingdon, Witney and Henley (Townlands Memorial Hospital). The first aid units are in Bicester and Wallingford. Minor injuries units and first aid units treat patients for a range of minor injuries such as sprains and strains, broken bones, traumatic wound infections, minor burns and scalds, minor head injuries, insect and animal bites, minor eye injuries and injuries to the back, shoulder and chest. They see and treat children and adults. They do not treat people for minor illness. The first aid units offer similar but more limited services as they do not have X-ray facilities.

The minor injury units in Abingdon and Witney are open 10am to 10.30pm every day and the unit in Townlands, Henley from 9am to 8pm. Their X-ray facilities are available at varying times. In Abingdon, they are available 9am to 7pm Monday to Saturday, and 11am to 5.30pm on Sundays. At Witney, X-ray is open 10am to 7.30pm weekdays and 10am to 5.30pm at weekends and at Henley 9am to 12.30pm and 1.30pm to 4pm, weekdays only.

The first aid unit in Bicester is open 6pm to 11pm weekday evenings and 8am to 11pm at weekends and bank holidays. The Wallingford first aid unit is open Monday to Friday (excluding bank holidays) 8.30am to 6.30pm.

The trust has two emergency multidisciplinary units (EMUs) at Abingdon and Witney. These are ambulatory care units, developed to provide community-based assessment and treatment services. They treat adults with sub-acute care needs following a referral from a GP or other healthcare professional. They offer a multi-disciplinary service from a team of medical, nursing and therapy staff, with access to social workers.

The unit in Abingdon is open for referrals from 8am to 8pm Monday to Friday and 10am to 4pm on weekends/bank holidays. The Witney EMU is open 10am to 8pm Monday to Friday and 8am to 4pm at the weekends. Both units can admit patients for short stay observations (up to 72 hours), with the Abingdon unit having six impatient beds and Witney four inpatient beds.

The rapid access care unit (RACU) in Henley offers multidisciplinary care from a team of doctors, nurses and therapists, to patients referred to the service by their GP or other healthcare professionals. It is based on the EMU model, serving patients in the south east of the county. It is open Monday to Friday, with medical services available from 9am to 5pm and therapy or nursing services from 9am to 8pm. The service has commissioned seven overnight beds from a nearby nursing home.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

We visited the three minor injuries units, two first aid units, the rapid access care unit and the two emergency multidisciplinary units for this inspection

We spoke with 41 staff in various roles and 18 patients/carers

Community urgent care service

To gain a range of patient feedback, we asked the trust to place CQC boxed comment cards in the units and we received 31 completed feedback cards. We reviewed eight patient notes whilst we were on site and a range of documents provided by the trust electronically.

Oxford Health Foundation Trust's urgent care service was last inspected in March 2018 where it was rated as requires improvement overall, having previously been rated good in September 2015. For the five key domains it was rated requires improvement for safe and well led, and good for effective, caring and responsive.

In 2018, we rated it as requires improvement because:

- Governance processes were not systematic some improvements that told the trust it must make in the 2015 report had not been made. Key areas of risk were not always identified and managed appropriately, and the service did not have a vision or strategy to develop the service.
- Staff did not always understand or comply with essential policies and processes such as safeguarding referrals, medicines storage and staffing escalation. The environment in some areas did not meet the needs of patients and presented an infection control risk.
- Although staff respected their line managers, they did not always know senior managers. Staff did not always receive appraisals and supervision and there was no evidence of succession planning for the service. Senior staff did not have assurance that all staff had completed the appropriate competency assessment. There was no competency assessment in place for adult trained staff who were caring for children.

During our most recent inspection we found the trust had made the required improvements.

Summary of this service

Our rating of this service **improved**. We rated it as good because:

- Staff treated patients with compassion, kindness and respect. They understood patients' specific needs and helped them make decisions about their care and treatment.
- Services were delivered to meet the needs of local people, and staff worked well with others in the wider health and care system to plan patients' individual care.
- There was effective leadership and senior managers developed the service vision and strategy, with engagement with partners in health and social care. The governance arrangements supported improvements in service quality. Leaders and staff understood the key risks and risks were managed and escalated appropriately.
- The services were delivered based on national guidance and evidence-based practice. Staff carried out audits to ensure they followed best practice.
- Staff reported and learnt from incidents.
- Services were delivered in accessible premises and planned to provide convenient care, close to people's homes. Equipment was safety checked and was in good condition. Medicines were well-organised, stored safely and at the right temperature, and staff protected people from infections by keeping the environment and equipment clean.
- Staff completed and updated risk assessments for each patient and kept clear records.
- The services sought patient feedback and had systems to manage and respond to complaints.

Community urgent care service

- Safeguarding training targets had been met. All staff had received an appraisal within the last year. The majority of staff had completed mandatory training required by the trust although a small number of staff had not completed training in key clinical skills.
- There was a positive and caring working culture. Staff respected the patients, their colleagues and managers. They responded kindly if patients were afraid or distressed. Staff understood the need for some patients to have privacy or a quiet space.
- Clinical leaders were respected by staff. They were knowledgeable about quality issues and priorities, understood what the challenges were and took action to address them.

However

- The service had a number of permanent staff vacancies. Leaders had identified this as a key risk and were continuing to recruit additional staff and offered in-house training to attract new staff from a range of clinical backgrounds.
- At Henley and Witney staff had difficulty observing patients due to the layout of the waiting areas. There was a risk that staff might not observe patients who deteriorated and needed prioritised care.
- Staff told us they found it difficult to access supervision.

Is the service safe?

Good 

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

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service checked staff at recruitment to make sure they were safe and suitable for their roles. There was always enough staff on each shift. The service used agency staff, including an advanced nurse practitioner and staff worked additional hours to cover shifts and to minimise patient risk.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The service understood there were issues with aspects of the premises and had included them on their risk register. Equipment was maintained and staff were trained to use them.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- Staff completed and updated risk assessments for each patient and removed or minimised risks.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- Staff collected safety information and shared it with staff, however this was not consistently shared with patients and visitors.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Community urgent care service

However

- The service had a number of permanent staff vacancies. Leaders had identified this as a key risk and were continuing to recruit additional staff.
- At Henley and Witney staff had difficulty observing patients due to the layout of the waiting areas. There was a risk that staff might not observe patients who deteriorated and needed prioritised care.

Is the service effective?

Good 

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

- The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.
- Staff gave patients enough food and drink to meet their needs and improve their health. They regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

However

- Some staff told us that they found it difficult to access supervision.

Is the service caring?

Good 

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

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Community urgent care service

Is the service responsive?

Good 

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

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made some adjustments to help patients access services, and they coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- Leaders were aware that morale was low in some areas and had taken steps to support staff and improve the culture. Staff felt respected and trusted in their work, but were less positive about communication and involvement. Those in urgent care services, in particular, felt there had been a culture of poor managerial support. They recognised this was beginning to change.
- The service had a vision for what it wanted to achieve and had a strategy for ambulatory care. The trust was in consultation with the clinical commissioning groups to update the urgent care strategy for the county. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

- All staff were committed to continually learning and improving services. They used quality improvement methods and leaders encouraged innovation.

However

- Not all staff were aware of who the 'freedom to speak up guardian' was or how to access the person to ensure and support staff to speak up safely.

Outstanding practice

The service had successfully implemented a volunteer programme to improve patient experience and staff satisfaction across the urgent and ambulatory care service. The service worked with a local college to offer students experience in the clinical environment. There were over 21 volunteers in post and the trust provided a quarterly training and networking event, enabling volunteers to benefit from peer support, group learning and learning from outside speakers including service users.

The trust had developed the minor injury units and first aid units to provide care locally for people with minor injuries. The service had improved fracture treatment, to reduce the need for patients to attend acute hospitals. At the time of the inspection there were nine pathways in place and the numbers of patients who were seen, treated and discharged regularly audited. This had led to a significant reduction in the numbers of patients who are required to attend follow up clinics in acute settings and is in response to the service strategy of delivering care closer to home.

An advanced nurse practitioner (ANP) outreach role had been developed in response to both the NHS Long term plan and the service strategy of 'right care, right time, right place'. This had enabled patients to remain in their own home whilst receiving treatment they may have had to travel to the EMUs or acute trust to receive. The ANP outreach role also supported frail patients within nursing and residential care to help support decision making to reduce admissions to acute trusts where appropriate. Although this role was set up to initially to support winter pressures the service had continued with this in response to patient's needs.

Areas for improvement

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

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

- The trust should complete the planned building work to enable staff at Henley minor injuries unit to see and assess patients attending the unit. Including ensuring patients with disabilities can access the building and toilets.
- The trust should continue to recruit to the permanent staff vacancies.
- The trust should ensure all staff are aware of who the 'freedom to speak up guardian' is to encourage and support staff to speak up safely.

Mental health services

Background to mental health services

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

The trust provides eleven core mental health services across eight registered locations We last inspected the trust in April 2018. In this inspection, we completed the trust's annual well led review and inspected the following core services:

- Forensic inpatient/secure wards
- Child and adolescent mental health wards
- Wards for people with a learning disability or autism
- Specialist community mental health services for children and young people
- Community-based mental health services for older people

Summary of mental health services

Good ➔➔

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

- We rated effective, caring, responsive and well-led as good. Our rating for mental health services took into account the previous ratings of services not inspected this time.
- Following this inspection all eleven mental health core services were rated as good.
- Leadership at directorate level was very strong. The directorates had clear plans and strategies to improve patient care and treatment. Trust governance systems supported and encouraged the development of strong, local leadership teams.
- The staff showed a caring attitude to those who used the trust services. Feedback from people using services and their relatives and carers was highly positive. Staff in all services were kind, compassionate, respectful and supportive. People who used services were appropriately involved in making decisions about their care.

However

- Following this inspection, we have rated one key questions – safe – as requires improvement.
- On the ward for people with learning disabilities or autism, staff did not always complete a seclusion care plan at the correct time and seclusion records did not demonstrate that patients had been only been secluded for the shortest possible amount of time. The seclusion room did not always offer the patient privacy.
- The trust continued to have challenges regarding recruitment and retention, but there was positive progress with the implementation of the nursing associate programme and other initiatives to address this.

Specialist community mental health services for children and young people

Good ➔➔

Key facts and figures

Oxford Health NHS Foundation Trust is commissioned by five different clinical commissioning groups to deliver child and adolescent mental health services (CAMHS) across a wide geographical area and 13 locations. The trust provides services to Oxfordshire, Buckinghamshire, Swindon, Wiltshire and Bath and North East Somerset. These included services from Aylesbury to Salisbury. The service used The THRIVE Framework in service provision. The framework provides a set of principles for creating coherent and resource-efficient communities of mental health and wellbeing support for children, young people and families. It aims to talk about mental health and mental health support in a common language that everyone understands. The framework is needs-led. This means that mental health needs are defined by children, young people and families alongside professionals through shared decision making. Needs are not based on severity, diagnosis or health care pathways.

The services are commissioned differently in each area. For example, some services have integrated learning disability services whilst others have separate learning disability teams. Some areas have specialist commissioned services such as regional forensic CAMHS where the trust provides two services one across Oxfordshire, Buckinghamshire, Berkshire, Hampshire, the Isle of Wight and Dorset and the second across the South West in Bath & North East Somerset, Swindon & Wiltshire, Bristol, South Gloucester and Gloucestershire and the child and adolescent harmful behaviour service across Oxfordshire and Buckinghamshire.

However, all the areas provided tier three child and adolescent mental health services and are delivered using the same out of hours model coupled with an assertive outreach service known as outreach service for children and adolescents (OSCA). The trust also provided tier two (or primary) CAMHS across the counties with the exception of Swindon where tier two provision was provided by the local authority.

During our last inspection in 29 September – 1 October and12 October 2015 we told the provider it must take the following actions to improve:

- The provider must address the variable quality of risk assessments to ensure that all risks to young people are properly recorded and managed.
- The provider must review the caseloads in the CAMHS teams and the impact on safe patient care.

Before the inspection visit, we reviewed information that we held about these services and information requested from the Trust.

During the inspection visit, the inspection team:

- visited five hubs where the service was delivered.
- spoke with nine children and young people, and nine carers.
- interviewed nine managers across the services.
- spoke with seventy-six other staff including nurses, social workers, psychologists and occupational therapists, assistant psychologist, cognitive behavioural therapist (CBT), family therapist and senior leads for CAMHS for the trust.
- interviewed three doctors, including one locum doctor.
- reviewed care records for thirty-eight children and young people.

Specialist community mental health services for children and young people

- •reviewed thirty-five comment cards from young people and family of young people who use or used the service in the past.

We also observed:

- the initial assessment of one young person and one complex case discussion.
- one family-based therapy session and one dialectical behaviour therapy (DBT) session.
- an appointment with a young person and their carer.

Our inspection between 30 July and 1 August 2019 was announced (staff knew we were coming).

Summary of this service

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

- The service provided safe care. Clinical premises where young people were seen were safe and clean. The provider made improvement following the requirement from the last inspection in 2015 to address the number of young people on the caseload of the teams, and of individual members of staff. At this inspection, staff said their caseload was not too high to prevent staff from giving each patient the time they needed. Staff managed waiting lists well to ensure that young people who required urgent care were seen promptly. Staff followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the young people. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of the young people. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood the principles underpinning capacity, competence and consent as they apply to children and young people and managed and recorded decisions relating to these well.
- Staff treated young people with compassion and kindness, respected their privacy and dignity, and understood the individual needs of young people. They actively involved young people and families and carers in care decisions.
- The service was easy to access. Staff assessed and treated young people who required urgent care promptly and those who did not require urgent care did not wait too long to start treatment. The criteria for referral to the service did not exclude children and young people who would have benefitted from care.
- The service was well led, and the governance processes ensured that procedures relating to the work of the service ran smoothly.

However:

- Although the service made significant improvements following our last inspection in 2015 to address the variable quality of risk assessments. In the care records we reviewed we found there were still a small number of risk assessment that had not been regularly reviewed and staff were not always using any rating scale to ascertain the severity of these risk to young people.
- The increase in referrals and capacity issues had created increased wait times for non-urgent referrals. The trust had a single point of access in Oxfordshire and Buckinghamshire which screened and triaged all referrals so that each could

be passed to the most appropriate service or team to provide care and treatment. All children and young people referred to be seen urgently were seen within one week. All others received care and treatment within the national target of 18 weeks. However, commissioners of the service had set a target of seeing 75% of referrals within 12 weeks, some teams, for example, South East Oxfordshire and North Oxfordshire and Melksham were not meeting this target. The trust was well aware of the issues, had contracted with a private provider to outsource the assessment of children and young people deemed to be at lower risk and had a waiting time mitigation plan in place and was actively managing the waiting list.

- Documentation of children and young people`s views in care plans were variable across the hubs and appeared dependent on the practitioner who wrote the care plan.
- Supervision were not always recorded in line with the trust`s policy.

Is the service safe?

Good 

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

- All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough staff, who knew the young people and received basic training to keep patients safe from avoidable harm. The number of young people on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each young person the time they needed.
- Staff assessed and managed risks to young people and themselves. They responded promptly to sudden deterioration in a young person's health. Staff worked with young people and their families and carers to develop crisis plans. Staff monitored young people on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- Staff understood how to protect young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.
- Staff kept detailed records of young people`s care and treatment. Records were clear, up to date and easily available to all staff providing care.
- Staff regularly reviewed the effects of medications on each young people's physical and mental health. Staff followed a safe recording forms used for prescriptions.
- The teams had a good track record on safety. The service managed young people safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave young people honest information and suitable support.

However:

- Although the service made significant improvements following our last inspection in 2015 to address the variable quality of risk assessments. In the care records we reviewed we found there were still a small number of risk assessment that had not been regularly reviewed and staff were not always using any rating scale to ascertain the severity of these risk to young people.

Specialist community mental health services for children and young people

Is the service effective?

Good ➔➔

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

- Staff provided a range of treatment and care for the young people based on national guidance and best practice. They ensured that young people had good access to physical healthcare and supported young people to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes such baseline assessment tool for depression in children and young people. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of young people under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit young people. They supported each other to make sure young people had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported young people to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16. Staff assessed and recorded consent and capacity or competence clearly for young people who might have impaired mental capacity or competence.
- Staff assessed the mental health needs of all young people. They worked with young people and families and carers to develop individual individualised plans and updated them when needed. These were recorded in the care records.

However:

- Documentation of children and young people`s views in care plans were variable across the hubs and appeared dependent on the practitioner who wrote the care plan.
- Managers did not ensure the documentation of staff receiving supervision were recorded appropriately in line with the trust`s policy.

Is the service caring?

Good ➔

Our rating of caring went down. We rated it as good because:

- Staff treated young people with compassion and kindness. They understood the individual needs of young people and supported young people to understand and manage their care, treatment or condition.

Specialist community mental health services for children and young people

- Staff involved young people in their care and risk assessment and actively sought their feedback on the quality of care provided. They ensured that young people had easy access to advocates when needed.
- When appropriate, staff involved families and carers in assessment, treatment and care planning.
- Young people and parents and carers were involved in the design and delivery of the service. Staff informed and involved families and carers appropriately. The service had a lead for the triangle of care (a scheme promoting joint work between carers, young people and professionals).
- Young people's emotional and spiritual needs were addressed, along with their mental and physical healthcare needs.

Is the service responsive?

Good ➔➔

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

- The service was easy to access. Its referral criteria did not exclude young people who would have benefitted from care. Staff assessed and treated young people who required urgent care promptly. Staff followed up young people who missed appointments.
- The service ensured that young people, who would benefit from care from another agency, made a smooth transition. This included ensuring that transitions to adult mental health services took place without any disruption to the young people's care.
- The service met the needs of all young people including those with a protected characteristic. Staff helped young people with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However

- The increase in referrals and capacity issues had created increased wait times for non-urgent referrals. The trust had a single point of access in Oxfordshire and Buckinghamshire which screened and triaged all referrals so that each could be passed to the most appropriate service or team to provide care and treatment. All children and young people referred to be seen urgently were seen within one week. All others received care and treatment within the national target of 18 weeks. However, the commissioners of the service set a target of seeing 75% of referrals within 12 weeks, some teams, for example, South East Oxfordshire and North Oxfordshire and Melksham were not meeting this target. The trust was well aware of the issues, had contracted with a private provider to outsource the assessment of children and young people deemed to be at lower risk and had a waiting time mitigation plan in place and was actively managing the waiting list.

Is the service well-led?

Good ➔➔

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

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for young people and staff.

Specialist community mental health services for children and young people

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.
- The teams worked closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) to ensure that there was an integrated local system that met the needs of children and young people living in the area. There were local protocols for joint working between agencies involved in the care of children and young people.

Outstanding practice

The Bath and North East Somerset, Swindon, Wiltshire CAMHS team won the Innovation in Digital Mental Health category for the Blue ICE app at the Positive Practice in Mental Health Awards 2019.

The Oxfordshire Outreach Service for OSCA won the CAMHS category at the 2019 National Mental Health Awards.

Areas for improvement

Action the trust SHOULD take to improve:

- The trust should record staff supervision in line with the trust`s policy.
- The trust should ensure that all care are plans clearly document how young people have been involved in their care planning in line with trust`s policy.
- The trust should ensure the risk assessments are written in a consistent way to capture the severity of all risks for young people.
- The trust should continue the work to manage and reduce waiting times.

Forensic inpatient or secure wards

Good ➔➔

Key facts and figures

Oxford Health NHS Foundation Trust provides forensic/secure inpatient services for adults with mental health conditions. Patients are detained under the Mental Health Act 1983. The trust provides 141 beds across three sites, one in Oxford, one in Aylesbury and one in Milton Keynes.

Littlemore Mental Health Centre, Oxford:

- The Oxford Clinic comprises: Kennet ward, a 15-bed male medium secure admission and assessment unit; Glyme ward, a 17-bed male rehabilitation unit; Wenric ward, a 21-bed male low secure ward; and, Lambourn House, a 15-bed mixed gender, open pre-discharge unit.
- Thames House comprises: Kestrel ward, a 10-bed female low secure high dependency unit; and, Kingfisher ward, a 16-bed female low secure rehabilitation unit.

Buckingham Health & Wellbeing Campus, Aylesbury:

- Woodlands is a 20-bed mixed-gender low secure unit (following our inspection, Woodlands became a male-only ward).

Marlborough House, Milton Keynes:

- Watling ward is a 20-bed male medium secure admission and assessment unit
- Chaffron ward is an 8-bed male medium secure rehabilitation unit.

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

Our inspection took place on 30 July, 31 July and 01 August 2019. It was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

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

During the inspection visit, the team:

- visited six of the nine inpatient wards (Watling, Chaffron, Kennet, Lambourn, Kingfisher and Kestrel), looked at the quality of the environments and observed staff caring for patients
- spoke with 17 patients who were using the service
- spoke with 74 members of staff, including ward managers, medical staff (including consultant psychiatrists), psychologists, nurses, nursing assistants and occupational therapists
- attended and observed one multidisciplinary team care review meeting; one multidisciplinary team daily planning meeting; one ward daily planning meeting; one patient community meeting; and, one staff handover session
- reviewed 70 patient medicine administration charts
- carried out a specific check of the medicine management on the wards
- reviewed 31 care and treatment records including the Mental Health Act documentation of detained patients

Forensic inpatient or secure wards

- collected 37 comments cards from patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

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

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed individualised, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. In general, ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However:

- The quality of physical healthcare provided to patients was inconsistent between wards. Staff teams from different wards had developed local processes which were largely dependent on nursing staff to deliver.
- The location of the seclusion room on Watling ward was adjacent to the central communal area of the ward so other patients could potentially see into the room and could hear when the occupant was distressed. The CCTV screen for the Kestrel ward seclusion room was located in a high position and so was visible to other patients using the intensive care area of the ward at that time.
- Patients were not happy with the Halal options on the menu of pre-prepared meals offered on some wards, such as Kennet.

Is the service safe?

Good 

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

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

Forensic inpatient or secure wards

- All wards were safe, clean, well equipped, well furnished, well maintained and generally were fit for purpose.
- Staff assessed and managed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- Ligature risk assessments had failed to highlight all potential ligature risks within each ward, such as long, exposed telephone cords present in ward corridors.

Is the service effective?

Good 

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

- Our rating of effective stayed the same. We rated it as good because:
- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans were personalised and recovery-oriented.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward team(s) included or had access to the full range of specialists required to meet the needs of patients on the ward(s). Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation and engaged with them early on in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and in general, discharged these well. Managers made sure that staff could explain patients' rights to them.

Forensic inpatient or secure wards

However:

- Patient care plans did not always address every need of individual patients, for instance in relation to a protected characteristic or their communication needs. The quality of physical healthcare provided to patients was inconsistent between wards. Staff teams from different wards had developed local processes which were largely dependent on nursing staff to deliver. Leave arrangements in place for some patients contravened Ministry of Justice restrictions in place. This occurred where a doctor had authorised the patient to drink alcohol, when the Ministry of Justice had forbidden it. Neither the ward staff nor the ward governance system had detected the issue.

Is the service caring?

Good  

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

- Staff generally treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

Is the service responsive?

Requires improvement  

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

- The location of the seclusion room on Watling ward did not safeguard the privacy and dignity of the room's occupant. The seclusion room was adjacent to the central communal area of the ward. Other patients could potentially see into the room and could hear when the occupant was distressed.
- The location of the CCTV screen for the Kestrel ward seclusion room did not safeguard the privacy and dignity of the room's occupant. The screen was located in a high position and could be visible to other patients using the intensive care area of the ward at that time. Staff used the CCTV screen, to view a patient whilst they used the en suite facilities within the seclusion room.
- The outside space at Marlborough House was large, but mostly featureless.
- There was a lack of parity of access to entertainment between wards. Patients on male wards had access to satellite television and a range of activities, whereas patients on the two female wards had been made to choose between having satellite TV and some activities that incurred a cost (for example, baking).
- Patient access to activities was inconsistent. Some wards had employed a band 3 activities co-ordinator (whose job it was to facilitate diversional activities), but others had not.
- Patients were not happy with the Halal options on the menu of pre-prepared meals offered on some wards, such as Kennet.

However:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.
- The overall design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Is the service well-led?

Good ➔➔

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

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

However:

- A significant proportion of staff we spoke with were unfamiliar with senior leaders, above matron level.
- Some staff told us there was a culture of downplaying the effects of assaults on them by patients and of not welcoming negative feedback from them.
- Staff told us there was division between the ward team, therapy staff and medical team within the Oxford Clinic, which adversely affected the quality of team working (which included Kennet ward, Glyme ward and Lambourn House).

Areas for improvement

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

Action the trust SHOULD take to improve

- The trust should ensure that patient care plans address all the individual needs of each patient.
- The trust should ensure that physical healthcare provided to patients is of appropriate quality within every ward.

Forensic inpatient or secure wards

- The trust should ensure that all seclusion facilities safeguard patient privacy and dignity.
- The trust should ensure that the food offered to all patients is varied and of good quality, regardless of individual patient dietary requirements.
- The trust should ensure that all leave authorisations comply with Ministry of Justice conditions.
- The trust should ensure that there is parity of access to activities, including satellite television channels, across the wards.

Child and adolescent mental health wards

Good 

Key facts and figures

Oxford Health NHS Foundation Trust provides inpatient mental health services for children and young people in the Wiltshire, Swindon and Oxford area at Highfield Unit and Marlborough House

Highfield Oxford and Marlborough House Swindon, both provide mental health inpatient services for children and adolescent principally within Oxfordshire, Buckinghamshire, Bath & North East Somerset, Swindon and Wiltshire. In addition, the service is as part of the nationally commissioned Tier 4 CAMHS provision which can be accessed by any area across England.

Marlborough House is an inpatient mental health ward for children and young people in Swindon, Wiltshire. The service has 12 beds.

Both services are mixed sex and treat young people aged between 12 and 18 years. They provide 24 hour specialist psychiatric care and treatment for those with behavioural, emotional or mental health difficulties.

Both services have on-site schools which are separately registered with the Office for Standards in Education, Children's Services and Skills (Ofsted).

We inspected this service as part of a comprehensive inspection programme of mental health services. Our inspection took place between 30 July and 01 August 2019.

We last inspected the inpatient wards in September 2015 as part of a comprehensive inspection of Oxford NHS Foundation Trust. During that inspection we rated the service as good. The key questions safe, effective, caring, responsive and well-led were rated as good.

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

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

Before the inspection, we reviewed information that we held and asked other organisations to share what they knew about the trust.

During the inspection visit, the team:

- visited both wards
- interviewed seventeen members of staff including; consultants, junior doctors, nurses, support workers, occupational therapists and family therapists
- spoke with eleven young people both individually and in focus groups
- observed one handover

Child and adolescent mental health wards

- observed one multidisciplinary meeting
- observed an activity on the ward for the young people
- reviewed the medicines management at each ward and the clinic room.
- reviewed 10 care records, including risk assessments.
- reviewed supervision and training records.

Summary of this service

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

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the young people and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of young people on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They followed good practice with respect to young people's competency and capacity to consent to or refuse treatment.
- Staff treated young people with compassion and kindness, respected their privacy and dignity, and understood the individual needs of young people. They actively involved young people and families and carers in care decisions.
- Staff planned and managed discharge well and liaised well with services that could provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However;

- In Marlborough House the ligature risk assessment did not always include actions staff should take to ensure areas with ligature risks were safe. They were not updated to include work that had already been completed.
- In Marlborough House staff members did not always ensure that any changes to young people's care plans were updated quickly to ensure staff members work consistently with the young people.
- In Marlborough House young people's physical health assessments were kept in the clinical notes. They were not easily assessible to staff because they were not kept with the information in the young person's care plan.

Is the service safe?

Good 

Child and adolescent mental health wards

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

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the young people and received basic training to keep young people safe from avoidable harm
- Staff assessed and managed risks to young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.
- Staff had access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave young people honest information and suitable support.

However;

- In Marlborough House the ligature risk assessment did not consistently include actions staff should take to ensure area with ligature risks were safe. They were not updated to include work that had already been completed.
- In Marlborough House information about young people's physical health checks was not kept in the care plans. This meant that staff did not have easy access to all information about the young people.

Is the service effective?

Good 

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

- Staff assessed the physical and mental health of all young people on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that young people had good access to physical healthcare and supported young people to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Child and adolescent mental health wards

- The ward teams included or had access to the full range of specialists required to meet the needs of young people on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit young people. They supported each other to make sure young people had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain young people' rights to them.
- Staff supported young people to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to young people under 16. Staff assessed and recorded consent and capacity or competence clearly for young people who might have impaired mental capacity or competence.

However;

- In Marlborough House staff members did not always ensure any changes to young people's care plans were updated quickly. This meant that staff members did not always work consistently with the young people.
- In Marlborough House young people's physical health assessments were kept in the clinical notes. They were not easily assessible to staff because they were not kept with the information in the young person's care plan.

Is the service caring?

Good ➔➔

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

- Staff treated young people with compassion and kindness. They respected young people' privacy and dignity. They understood the individual needs of young people and supported young people to understand and manage their care, treatment or condition.
- Staff involved young people in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that young people had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

Is the service responsive?

Good ➔➔

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

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, young people did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

Child and adolescent mental health wards

- The design, layout, and furnishings of the ward/service supported young people's treatment, privacy and dignity. In Highfield unit young people had their own bedroom with an en-suite bathroom. All young people could keep their personal belongings safe. In both wards there were quiet areas for privacy.
- Staff facilitated young people's access to high quality education throughout their time on the ward.
- The food was of a good quality and young people could make hot drinks and snacks at any time.
- The wards met the needs of all young people who used the service – including those with a protected characteristic. Staff helped young people with communication, advocacy and cultural and spiritual support.
- In Highfield Unit young people had access to a music studio and a music therapist who assisted them to make and perform music.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Is the service well-led?

Good ➔➔

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

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for young people and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

Outstanding practice

- In Marlborough House there was a physical health clinic called the wellbeing Wednesday' supported by two children's nurses, the specialist doctor and two support workers. The clinic monitored young people's medication, side-effects and was a place for young people to just drop in and have an informal conversation regarding any aspect of their medication or physical health in general.
- In Highfield Unit young people had access to a music room and sound recording studio. The Unit had a music therapist who assisted young people to make and perform music.
- Young people were very positive and described the activities available at the Highfield Unit as 'exceptional'. Activities included games, sports, art and craft related activities, musical activities and skills groups which enabled young people to learn how to cope with their feelings more successfully using mindfulness and other techniques.

- The young people at the Highfield Unit were highly involved in the running of the Unit. The young people were involved with the recruitment of staff in all teams and they formed part of the recruitment process for new clinical staff in 2018.
- The Highfield Unit employed dedicated patient engagement workers whose focus was to interact with and support the patients. For example, they responded to young people who were distressed by the sound of alarms and supported them to manage their feelings when alarms sounded.
- The Highfield Unit had a dedicated family therapy suite and used technology to improve communication with families and carers. For example, they used video conferencing technology to work with family members overseas.

Areas for improvement

The trust should ensure:

- In Marlborough House the ligature risk assessment should include actions staff should take to ensure area with ligature risks were safe. The assessment should be updated to include work that had already been completed.
- In Marlborough House staff members should ensure any changes to young people's care plans were updated quickly to ensure staff members worked consistently with the young people.

Wards for people with a learning disability or autism

Good ↑

Key facts and figures

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

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

Wards for people with a learning disability were previously inspected in March 2018. We rated the service requires improvement overall with safe, effective and well-led domains being rated requires improvement. Caring and responsive were rated as good. Following the 2018 inspection we served requirement notices and told the trust it must ensure they make the following improvements:

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

We carried out an announced inspection on the ward for people with a learning disability, Evenlode. Before the inspection, we reviewed information that we held and asked other organisations to share what they knew about the trust.

During the inspection visit, the inspection team:

- interviewed 12 staff including nurses, a consultant psychiatrist, a psychologist, healthcare support workers and an occupational therapist
- Interviewed the ward manager
- spoke with five patients and one carer
- observed three clinical sessions
- visited the ward, toured the environment and reviewed the clinic room
- reviewed five sets of notes and other paper work relating to patient care
- reviewed five sets of medicines records.

Summary of this service

Our rating of this service **improved**. We rated it as good because:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well and managed medicines safely. Staff had the skills required to develop and implement good positive behaviour support plans to enable them to work with patients who displayed behaviour that staff found challenging.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of patients with a learning disability (and/or autism) and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.

Wards for people with a learning disability or autism

- Managers ensured that staff received training, regular supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward, who would have a role in providing aftercare.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed, other than for a clinical reason.
- The service worked to a recognised model of mental health rehabilitation. It was well-led and the governance processes ensured that ward procedures ran smoothly.

However:

- Staff did not follow good practice guidance when secluding patients. They did not complete a seclusion care plan at the correct time and seclusion records did not demonstrate that patients had been only been secluded for the shortest possible amount of time. The seclusion room did not always offer the patient privacy.
- There was no speech and language therapist for the ward and staff had not been able to access one for 18 months.
- The trust did not keep staff up to date with changes to the Mental Health Act and the Mental Capacity Act. Agency staff did not always follow care plans.
- Patients reported that staff disturbed them at night by not closing doors quietly.

Is the service safe?

Inadequate 

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

- Staff did not follow best practice when secluding patients. Staff did not always seclude patients for the shortest possible time. Records did not include the clinical discussions around why a patient needed to remain in seclusion and care notes did not always match other documentation such as nursing observations.
- The seclusion room did not offer patients the appropriate level of privacy. Patient using the in the high dependency unit could see into the seclusion room when accessing their bedrooms.

However:

- All wards were safe, clean, well equipped, and fit for purpose. The service had enough nursing and medical staff, by using agency staff, who knew the patients and received basic training to keep patients safe from avoidable harm
- Staff assessed and managed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

Wards for people with a learning disability or autism

Is the service effective?

Good 

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

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Managers made sure they had staff with a range of skills needed to provide high quality care. The ward had trained all staff in positive behaviour support so it would be central to the care they provided on a day to day basis. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early on in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Patients and their families reported that agency staff did not always understand the patients care plan and follow it.
- There had been no speech and language therapist for the ward for 18 months.

Is the service caring?

Good 

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

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

However:

- Not all staff had respected the patients request for them to be quiet at night.

Is the service responsive?

Good

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

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. Discharge was rarely delayed for other than a clinical reason.
- The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas on the ward for privacy.
- The food was good quality and patients could make hot drinks and snacks at any time.
- The wards met the needs of all patients who used the service, including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- Patients felt the ward garden was uninviting and garden furniture was uncomfortable, which discouraged them from spending more time outdoors.
- Patients wanted more opportunities to cook for themselves.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed, were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Most staff felt respected, supported and valued. They reported they were provided with opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local quality improvement activities.

Areas for improvement

The provider MUST ensure:

Wards for people with a learning disability or autism

- The provider must ensure that staff follow the Mental Health Act Code of Practice and the providers policies guidance when secluding patients. Patients must only be secluded for the shortest time possible. Patients in seclusion must be offered an appropriate level of privacy. Regulation 13: Safeguarding service users from abuse and improper treatment.

The provider SHOULD ensure:

- That agency staff understand and follow all patients care plans.
- That staff receive regular updates relating to the Mental Health act and Mental Capacity Act.
- Staff respect patients' wishes to have their doors closed quietly at night
- That the ward garden is comfortably furnished to encourage patients to use the area.

Community-based mental health services for older people

Good

Key facts and figures

Oxford Health NHS Foundation Trust community based mental health services for older people had five community mental health teams (CMHT's) across Buckinghamshire and Oxfordshire. The teams provided mental health services in the community to people over 65 years of age who were experiencing functional illness such as severe depression, schizophrenia and bi-polar disorder and organic mental health problems such as dementia. People under the age of 65 who had dementia were also seen by the service.

The teams provided assessment and diagnosis, psychological intervention, medication management, memory clinics for the diagnosis of dementia, and treatment and support for people newly diagnosed with dementia. Each team incorporated memory assessment services.

The service was provided on weekdays during the hours of 9am to 8pm and at weekends from 9am to 5pm. Crisis out of hours support was provided by the adult mental health team outside of these hours.

At the last inspection in 2015 we rated community based mental health services for older people as good in safe, effective, caring, responsive and well-led.

Our inspection was announced (staff knew we were coming) to ensure everyone we needed to talk to was available as well as allowing us access to home visits where appropriate. As part of our inspection of this core service we inspected the following locations:

- North Oxford based at Elms Centre in Banbury
- Central Oxford based at Manzil Resource Centre in Oxford
- South Oxford based at Abingdon Hospital in Abingdon

We inspected all five key questions.

During the inspection visit, the inspection team:

- visited each environment where patients attended the premises
- checked the clinic room and medicine charts where applicable
- interviewed the team managers (deputy team manager for Central Oxford)
- Spoke with 34 staff in one-to-one interviews and focus groups across Oxfordshire and Buckinghamshire services. Staff we spoke with included consultant psychiatrists, nurses, occupational therapists, social workers, support workers, assistant psychologists, students, assistant practitioners and administrative staff. In addition to this, 16 members of staff gave us written feedback in sealed envelopes.
- reviewed four 'Tell us about your care' cards completed by patients
- reviewed 24 care records
- spoke with three patients and two carers
- observed a teleconference call, home visit and handover meeting.
- we reviewed policies and procedures, meeting minutes, training and supervision records and audits.

Community-based mental health services for older people

Summary of this service

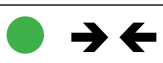
Our rating of this service **stayed the same**. We rated it as good because:

- The service provided safe care. Clinical premises where patients were seen were safe and clean. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. Staff managed waiting lists well to ensure that patients who required urgent care were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service was easy to access. Staff assessed and treated patients who required urgent care promptly and those who did not require urgent care did not wait too long to start treatment. The criteria for referral to the service did not exclude people who would have benefitted from care.
- The service was well led and the governance processes ensured that procedures relating to the work of the service ran smoothly.

However:

- Staff had not consistently assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Is the service safe?

Good 

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

- All clinical premises where patents received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough staff, who knew the patients and received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.
- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.

Community-based mental health services for older people

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- Staff had not consistently recorded detailed risk assessments for patients.

Is the service effective?

Good 

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

- Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions that were informed by best-practice guidance and suitable for the patient group. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

However:

- Staff had not consistently assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Community-based mental health services for older people

Is the service caring?

Good 

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

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers appropriately.

Is the service responsive?

Good 

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

- The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments.
- The teams met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Good 

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

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Community-based mental health services for older people

- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Outstanding practice

- Patients under the care of North Oxford team had an opportunity to receive support from an assistant practitioner who specialised in music. This intervention was used as an alternative to medication, and is research based on the human voices' ability to slow the heart rate and therefore help reduce anxiety. The assistant practitioner had developed CD's for patient use om breathing and voice techniques and visualisation to help with relaxation and depression.

Areas for improvement

We found areas for improvement in this service:

The trust should ensure:

- That staff consistently record risk assessments.
- That staff assess and record mental capacity for patients who might have impaired mental capacity.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Our inspection team

Serena Coleman, Inspection Manager led this inspection. A head of hospital inspection, Karen Bennett-Wilson and an executive reviewer, Aidan Thomas, retired chief executive, supported our inspection of well-led for the trust overall.

The team included two further inspection managers, eleven inspectors, two assistant inspectors, one mental health act reviewer, thirteen specialist advisers, and four experts by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.