Requires Improvement

Southern Health NHS Foundation Trust

Wards for people with learning disabilities or autism

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Evenlode	RW13G	Evenlode	OX4 4XN
Moorgreen Hospital	RW154	Willow Ward	SO30 3JB
Ridgeway Centre	RW12N	Ridgeway Centre	HP12 4QF
Austen House	RW190	Westview and Ashford Units	SO40 2TA

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

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

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

Summary of findings

Ratings

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

Overall rating for services for people with a learning disability	Requires Improvement 
Are services for people with a learning disability safe?	**Requires Improvement** 
Are services for people with a learning disability effective?	**Requires Improvement** 
Are services for people with a learning disability caring?	**Good** 
Are services for people with a learning disability responsive?	**Good** 
Are services for people with a learning disability well-led?	**Requires Improvement** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We inspected four inpatient learning disability services, two in Hampshire, one in Oxfordshire and one in Buckinghamshire. Two of the inpatient services in Oxfordshire had stopped providing a service shortly before the inspection.The Short Term Assessment & Treatment unit (STATT) closed in December 2013 and John Sharich House (JSH) closed in early 2014.

We gave an overall rating for wards for people with learning disabilities or autism of **requires improvement** because:

- Whilst staff were working hard to identify and manage individual risks, the inpatient environments needed improvements to make them safer including reducing ligature risks and improving lines of view.
- Staff were reporting incidents but learning from incidents was not being shared consistently across the inpatient services. External stakeholders in Oxfordshire told us the trust did not have a well-developed safety culture and had previously not reported or investigated serious incidents well in this particular service. It was felt that this was improving but it was too early to be confident about the level of that improvement. Observations by the inspection team across the core services inspected demonstrated that Southern Heath did have a well-developed safety culture in place in respect to incident reporting and management in Hampshire but this was still being embedded into the Oxfordshire and Buckinghamshire services which it had acquired in November 2012.
- Staff working in the Hampshire services felt a stronger connection to the trust while the staff working in Oxfordshire and Buckinghamshire felt more removed. The trust had made an effort to address this especially through the use of training, executive and senior staff visits, roadshows, staff briefings and the people development programme. Senior staff acknowledged that there was the continued need to improve contact and communication across all the teams. The divisional director had been promoted from head of service from within the LD service three weeks before the inspection and although he was new to the post he had an extensive knowledge of the service.
- There was poor local leadership at Evenlode as the head of service had not been working for three months and interim management arrangements had not provided the ward manager and staff team with sufficient support.
- At the time of the inspection Verita were undertaking an independent review into the commissioning, assurance and governance of learning disability services in the Oxfordshire area. This was in response to a tragic death on the Short Term Assessment and Treatment Unit (STATT) unit on the Slade House site in July 2013. A previous external review had found that the death was preventable. Staff and service users were concerned about how the trust was handling the situation as they felt the trust had not been as open and honest as it could have been. This was clearly causing distress and affecting staff morale and unrest with people using services and their families. They felt the trust had failed to communicate effectively and was acting outside of its own values.
- In addition, there was concern as to whether the trust would continue to deliver the services in the future which was affecting staff morale.

Despite this, we found that staff across the service were very committed to providing person centred care to the people using the services and displayed care and compassion. We found some very positive multi-disciplinary work particularly in supporting people with complex challenging behaviours. We also could see that staff were actively supporting people using a recovery focus with the aim of enabling people to live more independently. We heard from people using the services and their relatives about their positive experiences.

Staff were positive about their work and appreciated the training opportunities they had received although some staff, especially support workers, needed more training to enable them to understand the specific needs of the people they were supporting.

Summary of findings

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

Are services safe?

Requires Improvement

Care was not always being provided in safe physical environments with easy access to the right equipment. At the Ridgeway Centre and Evenlode work was needed to address ligature points. At the Ridgeway Centre measures to improve staff observation were needed and at Evenlode the perimeter fence needed adaptions as identified from a previous serious incident.

All the services were facing challenges in filling all their staff vacancies, but regular agency staff were being used and safe staffing levels maintained.

Staff knew how to recognise and report incidents. The knowledge and learning from incidents both locally and from across the trust was evident in the Hampshire services but had not reached all the staff in the Oxfordshire and Buckinghamshire inpatient services.

There was a good understanding of each person's individual risks and individualised behaviour support plans had been developed with the person concerned. Staff demonstrated a good understanding of how to support people with their complex behaviours and appropriate use of physical interventions.

Staff understood how to recognise abuse and how to make safeguarding alerts if needed.

Are services effective?

Requires Improvement

Staff in Oxfordshire and Buckinghamshire felt that training had improved, but many staff especially those without a professional qualification needed more training to meet the specific needs of the people they were supporting. Staff had good access to mandatory and statutory training.

Whilst medicines were stored securely, the facilities for the storage of controlled drugs were not in accordance with trust policies.

People using the services had a comprehensive assessment completed of their individual needs. They were also having their physical health needs assessed and services were in place to meet these needs.

There were excellent examples of multi-disciplinary working across the different locations which ensured that teams were able to work together to provide effective care to people using the services.

People's rights were protected through the effective use of the Mental Health Act and Mental Capacity Act.

Summary of findings

Are services caring?

Good

People using the services were cared for by staff who were very motivated and supported people with care, dignity and respect.

We found that people across all the services were supported to be involved in the development and review of their care plans.

People were encouraged to attend their review meetings and had access to advocacy services.

Relatives and friends were involved at all stages with peoples care and we were told that they felt well informed.

Are services responsive to people's needs?

Good

The learning disability services met the needs of people with complex needs. People had detailed assessments before being admitted to the service to ensure they could meet their needs.

The services had a strong recovery focus and discharges were planned and co-ordinated with risks carefully considered.

People using the services knew how to complain and staff were responsive and changes were made where needed.

Are services well-led?

Requires Improvement

The trust had recently introduced new governance processes including a system of peer review and a monthly clinical review using a trust-wide Quality Assessment Tool. These have started to be used but need longer to be properly established to bring about continuous improvement.

Staff working in the Hampshire services felt part of the trust while the staff working in Oxfordshire and Buckinghamshire felt more removed and were unclear about the details of senior staff. The trust had made an effort to address this especially through the use of training, executive and senior staff visits, roadshows, staff briefings and the people development programme. Senior staff acknowledged however that there was the continued need to improve contact and communication across all the teams.

People using the service had opportunities to be engaged with the service and the wider trust. The involovement of people who use services in peer reviews was positive.

Summary of findings

Background to the service

The learning disability health services provided by Southern Health NHS Foundation Trust consisted of a number of inpatient and community services. These were managed through the division providing specialist learning disability services.

In Oxfordshire and Buckinghamshire there were two inpatient services. This included Evenlode which is located in Littlemore Oxford. This service had 10 beds and is a medium secure service. The second service is the Ridgeway Centre located in High Wycombe. This service had 14 beds and is an assessment and treatment service.

In Hampshire there were two inpatient services. This included Willow ward at Moorgreen Hospital. This service had six beds and is an assessment and treatment service. The second service is Woodhaven in Southampton. This had 12 beds across two units, Ashford is a 6 bedded low secure ward and Westview is a 6 bedded forensic rehabilitation ward.

In addition the trust provided six social care services in Oxfordshire and twelve social care services in Hampshire for people with a learning disability. These services are managed through the trusts social care services division. The only exception to this was House 2 at Slade House which is a step down service. Whilst this was registered with the Care Quality Commission as a social care service it was managed through the division for specialist learning disability services. The registration of this service with CQC was being addressed to ensure this was correct. The social care services were separately inspected prior to the week of the comprehensive inspection and the findings will be reflected in the trust wide report.

At the time of the comprehensive inspection there was one compliance action in place for the Ridgeway Centre and one compliance action and one warning notice for Evenlode. These compliance actions were inspected as part of the comprehensive review and the requirements had been met.

Our inspection team

Our inspection team was led by:

Chair: Shaun Clee, Chief Executive, 2gether NHS Foundation Trust, Gloucestershire

Team Leader: Karen Wilson, Head of Inspection for Mental Health, Learning Disabilities and Substance Misuse, Care Quality Commission

The team included CQC inspection managers, inspectors, Mental Health Act reviewers, pharmacy inspectors, CQCs national professional advisor for learning disabilities, analysts and inspection planners.

There were also over 100 specialist advisors, which included consultant psychiatrists, psychologists, senior nurses, student nurses, social workers GPs, district nurses, health visitors, school nurses and an occupational therapist. In addition, the team included Experts by Experience who had personal experience of using or caring for someone using the types of services that we inspected. Five Experts by Experience were involved in the inspection of mental health and learning disability services and two were involved in inspecting community health services.

The team that inspected the learning disability services consisted of thirteen people, three inspectors, two experts by experience, three nurses, two mental health act reviewers and three psychologists. The team worked across two geographical areas, with nine people focusing on services in Oxfordshire and Buckinghamshire and four people visiting services in Hampshire. A pharmacy inspector also visited the two inpatient services in Oxfordshire and Buckinghamshire.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

Summary of findings

How we carried out this inspection

To get to the heart of people who use services' experience of care, 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?

What people who use the provider's services say

Prior to the week of the comprehensive inspection there were four engagement events attended by members of the inspection team for people with learning disabilities. These took place in three venues across Hampshire. There was also a separate event in Oxfordshire.

Members of the team also attended a meeting arranged by Verita who were undertaking an independent review into the commissioning, assurance and governance of learning disability services in the Oxfordshire area. They met with relatives of a person who had a suffered a preventable death whilst an inpatient on the Short Term Assessment and Treatment Unit (STATT) unit on the Slade House site in July 2013. They also met with carers who were involved in carers groups and were able to provide feedback on services.

People told us positive things about the service. They said the staff were very caring. People who used the services talked about how they were able to get involved, helping with staff interviews, helping to visit and peer review other services and reviewing literature produced by the trust. They also talked about how they were working to develop easy read appointment letters and information for people being admitted to hospital at the local acute trust and for Southern Health.

People said they were concerned that there was not always enough staff. We also heard about challenges when young people were undergoing the transition to adult services and examples of poor communication with relatives. Concerns were raised about the use of the Mental Capacity Act and the exclusion of relatives from decision making.

Summary of findings

Good practice

- Across the services we found behaviour support plans that reflected people's individual needs and where the people receiving a service had been able to contribute to the development of these plans.
- On Willow Ward the use of a specialist sensory assessment in a dedicated sensory integration room by occupational therapy staff was innovative.
- In the Ridgeway Centre the rotation of support workers to work as occupational therapy assistants was supporting the provision of improved activities across the whole week and further developing multi-disciplinary working.
- People using the service had been given bespoke training to enable them to take part in the trust peer review process. They were supported to visit other services and were given easy read guidance to assist them.
- People who used the services talked about how they are able to get involved, helping with staff interviews, helping to visit and peer review other services and reviewing literature produced by the trust. They also talked about how they were working to develop easy read appointment letters and information for people being admitted to hospital at the local acute trust and for Southern Health.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must ensure that all staff are aware of incidents that have taken place in the service and were relevant in other parts of the trust and the learning from these incidents.
- The trust must ensure the environments where people are cared for are safe.
- The trust must ensure that all staff including support workers have training to enable them to meet the specific needs of people using the service.
- The trust must ensure it supports staff working in the Oxfordshire service Evenlode so they have regular line management input, understand the changes that are taking place and receive support in an appropriate style to facilitate them to perform their roles.

Action the provider SHOULD take to improve

- The trust should ensure on Woodhaven that emergency resuscitation equipment is easily accessible across the two units.
- The trust should consider whether it is safe for staff to start working at the Ridgeway Centre prior to their disclosure and barring checks being in place.
- The trust should record at the Ridgeway Centre what steps are taken to safeguard people who have been involved in a safeguarding alert to ensure that where needed a suitable protection plan is in place.
- The trust should ensure that records of multi-disciplinary meetings at the Ridgeway Centre contain a clear record of actions and the dates for these to be completed.
- The trust should ensure on Woodhaven that blanket restrictions about the use of pens are kept under review.
- The trust should ensure that when people are in seclusion on Woodhaven they are medically reviewed at the correct time intervals. They should also ensure on Evenlode that the times of medical reviews are recorded.
- The trust should review the physical environment in the seclusion room located in the Ashford Unit in Woodhaven to ensure peoples privacy and dignity is maintained if they use the toilet. The window in the seclusion room in Evenlode should also be reviewed to ensure people's privacy is maintained.
- The trust should try and hold regular community meetings on Woodhaven to support people using the service to be engaged in how the service is operating.

Summary of findings

- The trust should ensure the oven on the Ashford unit Woodhaven is replaced so that people can develop their skills in preparing food.
- The trust should review the levels of psychology input available at Evenlode to ensure there are sufficient numbers of staff available to support people with complex needs in individual clinical sessions.
- The trust should explore how people using the service at Evenlode can have access to a more user-friendly copy of their care plan.
- The trust should ensure that patients who are detained have their rights explained to them as frequently as needed and that this is recorded.
- The trust should ensure that people using the service at Evenlode have sufficient activities available at the weekend.

The trust should ensure that people using the service at Evenlode are satisfied with the lunchtime arrangements where they are served a buffet lunch where people stand up to eat and cutlery is not available.

Southern Health NHS Foundation Trust

Wards for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Evenlode	Evenlode
Willow Ward	Moorgreen Hospital
Ridgeway Centre	Ridgeway Centre
Westview and Ashford Unit	Woodhaven

Mental Health Act responsibilities

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

Overall we found the Mental Health Act was well managed within the learning disability services. The key documents were in place and well maintained. The detailed findings are recorded in the effectiveness domain for each of the services.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received training on the Mental Capacity and Deprivation of Liberty Safeguards (DoLS) as part of the safeguarding training. We found examples of very good capacity assessments and multi-disciplinary best interest meetings that included advocates and relatives where appropriate. The services had worked with the local authorities to enable people to be assessed if they felt an authorisation for a DoLS was needed.

Requires improvement

Are services safe?

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

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

Summary of findings

Care was not always being provided in safe physical environments. At the Ridgeway Centre and Evenlode work was needed to address ligature points. At the Ridgeway Centre measures to improve staff observation were needed and at Evenlode the perimeter fence needed adaptions as identified from a previous serious incident.

All the services were facing challenges in filling all their staff vacancies, but regular agency staff were being used and safe staffing levels maintained.

Staff knew how to recognise and report incidents. The knowledge and learning from incidents both locally and from across the trust was evident in the Hampshire services but had not reached all the staff in the Oxfordshire and Buckinghamshire inpatient services.

There was a good understanding of each person's individual risks and individualised behaviour support plans had been developed with the person concerned. Staff demonstrated a good understanding of how to support people with their complex behaviours and appropriate use of physical interventions.

Staff understood how to recognise abuse and how to make safeguarding alerts if needed.

Our findings

Ridgeway Centre

Track record on safety

Since May 2013 the Ridgeway Centre had four serious incidents requiring investigation. Three of these took place between May and November 2013 and after this date the service was closed to new admissions until March 2014 when the investigations were complete and changes made to the service.

The final serious incident took place in April 2014. This incident had been properly notified and alerted using safeguarding processes. Actions necessary to ensure the safety of people using the service including any appropriate HR processes had taken place.The final serious incident took place in April 2014. This incident had been properly notified and alerted using safeguarding processes. Actions necessary to ensure the safety of people using the service including the suspension of staff had taken place.

Learning from incidents and Improving safety standards

We were told by staff within the service that they had received training on incident reporting and knew how to report incidents through the electronic recording system. The ward manager explained how the number of incidents being reported had increased but that this was positive as it meant that staff were correctly recognising and reporting the incidents.

We were told how the numbers and types of incidents are being monitored for the Ridgeway Centre so that trends can be identified and actions can be put into place. The ward manager explained that they have found that more incidents take place between 1-3pm which is when staff handovers take place and they are considering if changes are needed as a result of this. We also heard that a number of incidents relating to medication had led to a medication action plan being put into place and medication being checked at the end of each shift.

We spoke to a number of staff working at the Ridgeway Centre from different professional backgrounds. We asked them about learning from incidents and found that whilst more senior staff knew about incidents and changes that had been made as a result of these, most staff were not able to tell us about this. We also found that most staff were unable to talk about incidents that had occurred in other parts of the learning disability division or other parts of the trust. The ward manager and other senior staff in the unit told us that they were attending the Buckinghamshire county quality and safety meeting where incidents were discussed but these had only started in the previous three months.

Safeguarding

Staff had all completed training on safeguarding vulnerable adults and children and were able to describe how they

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would recognise abuse and how this would be reported. We saw there was information displayed for staff on how to respond to allegations of abuse. There was also an easy-read version available for people who use the service.

The Ridgeway Centre is located in Buckinghamshire and all safeguarding alerts go to the safeguarding team for this county. Where the person using the service is from another county then the persons care manager is informed. The ward manager explained that at the moment there are a high number of alerts being made and the safeguarding team are identifying a small number to go forward as a safeguarding process. We looked at the records of people involved in a safeguarding alert. It was not clear from the records what had happened following the safeguarding alert and if a protection plan had been put into place to keep the person safe.

The service has a number of systems in place to keep people safeguarded from abuse. An example of this is the system to ensure staff have recruitment checks in place. We did speak to one recently recruited nurse who explained that they had been working with supervision for a few weeks whilst waiting for a disclosure and barring check to arrive. The inspection team were concerned about the practicalities of this and how far this supervision could be maintained in practice.

Assessing and monitoring safety and risk

At the previous inspection of the Ridgeway Centre in July 2014 it was found that staffing levels were safe but that there were challenges for the service as there were vacant posts. This was still the case at the time of this comprehensive inspection where there were seven nurse vacancies and seven support worker vacancies. This is partly as a result of the staff establishment increasing since April 2014. There were also staff off for other reasons. This was being managed through the use of regular agency staff and also staff were working additional shifts. The ward manager said that they monitored staff working extra shifts to ensure they had time off. We looked at the records of when staff were working and found that there were enough staff working but some staff were working many hours. We were told there was an ongoing programme of recruitment and they were looking at how the posts could be made more attractive for example by identifying development opportunities. We heard that the turnover of staff was very low.

We were told how safe staffing levels were maintained by assessing the acuity of people using the service and the staffing levels they need reflecting factors such as the levels of observation. This meant that if individual people using the service needed higher staffing levels then other beds were left vacant in recognition that all the staff resources were being used. At the time of the inspection only ten of the fourteen beds were filled as it was recognised that the people using the service had complex needs and needed high levels of staff support people using the service had complex needs and needed high levels of staff support.

We spoke to staff and looked at individual risk assessments for people using the service. The people using the service had very complex needs and they have individual and comprehensive risk assessments in place. The team consisted of people with different professional backgrounds including medical, psychology and occupational therapy and risk management issues were carefully reviewed by the multi-disciplinary teams. Staff we spoke with were able to describe the risk assessments and how these are implemented in the service. We also saw that risk assessments were in place for when people went on leave or were being prepared for discharge. We did find an example of one person using the service who had been allowed to have a small glass bottle which they then broke and then this had to be removed to ensure the person did not harm themselves. This was a potential risk that may not have been appropriately assessed.

Potential risks

We found that people using the service all had very detailed behaviour support plans in place. These had been developed with the input of people using the service and where needed people who could support them such as carers and advocates. Where restrictions were in place they were clearly recorded with the reasons for this decision. For example one person at times needed their bathroom door to be locked. This person was able to tell us why this decision had been made and why this was needed to maintain their safety.

We were told by the ward manager that the Ridgeway Centre had worked with the police to improve their joint working. In the last six months they had called the police twice to help and they had responded promptly to assist.

The Ridgeway Centre did not have any seclusion facilities. A previous visit by the Mental Health Act Commissioner

Requires improvement

Are services safe?

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identified that seclusion was taking place but was not acknowledged. At this inspection we looked closely at the use of quiet rooms and bedrooms. We found no evidence of people being secluded. Staff described to us how they supported people in these areas based on their individual needs and their movement was not restricted.

We looked at the use of restraint at the Ridgeway Centre. From speaking to staff it was evident that they all understood the importance of supporting people using the service to manage their challenging behaviours and that restraint was only used as a last resort. Staff had completed training in a new procedure for managing physical interventions being rolled out by the trust. The only people who had not yet been trained were new staff and staff who were away from work through sickness and other reasons. Staff who had completed the training were highlighted on the rota to ensure there were sufficient staff available. This training is refreshed every 12-18 months.

The trust had alerted staff that face down restraint should not be used in line with recent guidance. There was one person using the service who had specifically requested as part of their behaviour support plan that if they needed to be restrained they wanted this to be face down and their wishes and reasons were clearly recorded. The records of restraint were appropriately completed and an incident report was completed if any form of restraint was used. The numbers and types of physical interventions were monitored for all the people using the service.

We looked at the safety of the environment. The service had completed its own risk assessment of ligature points. This identified a number of risks associated with ligature points across the Ridgeway Centre. We were told by the ward manager and divisional director that the trust had a specialist team that reviewed ligature points but they had not yet been to the Ridgeway Centre. In the meantime the staff were managing this risk through observing people using the service. At the time of our inspection one person was regularly harming themselves through the use of ligatures. The failure to review and reduce ligature points is a potential risk to the people using this service.

The Ridgeway Centre has all the inpatient facilities on one level and there are separate living areas for men and women. The layout of the building means there are a number of areas where there is not a clear line of view. This could be improved if mirrors were in place but these were not available.

We observed that there were only a few bedrooms that were designed for people with higher care needs and these had observation panels in the doors that could be open or closed. This meant that some people were in rooms without observation panels and when they were in their bedroom the staff had to keep opening their bedroom doors to carry out observations which could be very disruptive. The staff said that they would find it helpful to have a few more bedrooms with observation panels so they could check on people without disturbing them or compromising their privacy.

We also found that only a few of the bedroom doors have anti-barricade facilities so they can be opened both ways if needed. The staff told us that they have requested this facility is extended to more doors so that where this is a potential risk for a person using the service, there are enough bedrooms available with this facility. The trust confirmed there are plans to increase the numbers of doors with anti-barricade adaptions.

We also found that due to the layout of the building the men had to leave their unit to reach the dining room. They would either walk across an external courtyard or if it was raining they would go through the main reception area. The main reception area had a door that was not designed to be secure and this could be a potential risk for people who are trying to abscond.

We looked at the use of blanket restrictions and found these were not used. Restrictions were based on people's individual needs. There were five people with an authorised deprivation of liberty safeguard in place. These were primarily concerning the need for people to be supported when they left the premises. The documentation was reviewed and the conditions of the authorisations were being followed. Also where authorisations needed to be reviewed and potentially updated this was being done in a timely manner.

We checked the safety of equipment being used in the service. We found the health and safety of equipment was being maintained for example the appropriate checks of fire safety equipment, portable electrical appliances and checking of fridge temperatures. We also checked the maintenance of the resuscitation equipment. This was being checked on a daily basis and once a week there was a detailed check of all the associated equipment. The oxygen cylinder had also been checked so it was available to use if needed.

Requires improvement

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Woodhaven

Track record on safety

There had been no recent serious incidents within the Hampshire low secure forensic learning disability services. Incidents were reported to the trust as necessary. Staff were able to describe the reporting system and were confident about raising any concerns.

Learning from incidents and Improving safety standards

Staff learnt from incidents which took place on both Ashford and Westview. Staff were able to describe incidents which had taken place and what plans had been put in place. This included lessons learnt from an incident relating to risk displayed by a person while they had been on leave. They also knew about and had learnt from the incident that had occurred within the Oxfordshire services.

Safeguarding

Patients we spoke with said they felt safe on the unit.

Staff knew about safeguarding and had received training. Staff were able to describe the safeguarding process. Patients were also aware of the safeguarding process and had raised concerns where appropriate. Records showed that safeguarding procedures were followed. Where needed, measures had been put in place to protect patients and to reduce the risk of recurrence.

Assessing and monitoring safety and risk

Each patient had a detailed and up to date risk assessment. Risk assessments were carried out before any leave took place, for example patients with unescorted community leave were required to spend an hour in communal ward areas prior to leave in order that staff could monitor their mental state.

Staff demonstrated a thorough knowledge of patients and their potential risks. There were clear risk management plans in place for sex offenders and details of multi-agency public protection plans were available. Section 17 leave was granted on a stepped approach, with patients having 'shadowed' leave before being allowed unescorted access to the community.

There were good staffing levels on both wards. There were vacant posts and staff were being actively recruited, however there were no concerns about how the ward used bank and agency staff to cover shortfalls.

Potential risks

Policies were in place for the management of challenging behaviour, use of seclusion and restraint.

There was minimal use of restraint and most of this consisted of 'safe holds' and walking patients away. The staff understood that restraint should only be used as a last resort and that face down restraint should be avoided.

Seclusion was rarely used on either Ashford or Westview. The seclusion room on the Ashford unit did not support patient privacy and dignity as there was no separate area for the toilet which was in full view of a large window. There was poor recording of seclusion on Ashford Ward. Seclusion records we reviewed covered a range of time periods from 15 minutes to nine hours which took place one year ago. The longest period of seclusion had no record of a medical review taking place throughout the whole period. There was no evidence the patient had been given the opportunity afterwards to record their views of their experience of seclusion.

Both Ashford and Westview were environments where they had reduced the ligature points. Despite this there was several potential fixed ligature points around the window in the lounge on Ashford ward. Staff were aware of these and they were able to say how this risk was managed through staff observation.

We noted that there was only one set of emergency resuscitation equipment across the two units which was stored on Ashford. This meant that if a person on Westfield needed this equipment staff would need to pass through three locked doors, posing a potential risk.

There were good lines of sight on the ward and there was always a member of staff on 'observations' who ensured that all areas of the ward were monitored.

Both wards had safe discharge planning arrangements and patients were involved closely in the plans. There was a dedicated social worker who worked across the learning disability service within Hampshire.

We noted one inappropriate 'blanket restriction' in regard to the number of pens patients could have in their rooms, which was currently two. We saw from staff meeting minutes and other emails we requested that there had been some discussion about this within the team but that

no solution had yet been reached. The restriction appeared to be connected to a previous risk situation which no longer existed. The trust should ensure blanket restrictions are kept under review.

Willow ward

Track record on safety

Willow ward had a very good track record of safety. We were informed by the trust in their presentation at the start of the inspection that Willow ward was a 'hotspot' in relation to recruiting staff when it first opened. However, we found that there had been no serious incidents in the service since it opened in 2012 and that all the people using the service were supported in a safe environment.

Learning from incidents and Improving safety standards

There was a robust incident reporting system. All incidents were reported and monitored. There was a staff culture of raising and discussing any concerns, and staff were able to describe examples of this and how they were addressed.

All incidents of restraint were reported and there was a system in place to monitor the type and frequency of restraint. All incidents of self-harm by patients were reported and these were used to monitor patient progress and as flags for any increasing distress.

Incidents were discussed at multi-disciplinary meetings and used to inform care plans, risk assessments and behaviour support plans.

Safeguarding

Staff demonstrated a thorough knowledge of the safeguarding policy and procedures. Staff told us they had a good relationship with the local safeguarding team who they contacted regularly for advice. They told us that they had made quite a lot of safeguarding alerts. Some of these had been around poor practice they had identified and others around not being able to meet people's needs. Where needed, strategy meetings took place.

Assessing and monitoring safety and risk

Safety and risk were monitored closely on the ward. Staff were encouraged to identify any risks and to be involved in developing plans to manage risk. An example was a member of staff who identified potential risks in the use of one patient's car. They were encouraged to lead on developing a policy for vehicle safety.

Where it was felt that an incident could have been managed better this was reviewed by the team. In most cases this was because the staff member had not followed the care plan. Reflective practice sessions were held and care plans clarified and updated to reduce the risk of any ambiguity.

We were told that when the unit opened there were not enough staff, however staffing had been increased and the manager felt that the current staffing levels of seven staff on duty during the day was safe.

Potential risks

Policies were available on the management of challenging behaviour. The unit used positive behaviour support to manage challenging behaviour. There was no use of seclusion on the unit.

Willow ward had ample space for the people living there and the layout enabled staff to ensure that male and female patients could be accommodated separately. Arrangements could also be made to ensure that where needed patients could spend time in separate communal areas.

There was a high use of restraint on Willow ward and this reflected the needs of the people using the service. Detailed records were kept of type and reason for the restraint. This showed that restraint was used only when needed. The record of restraint showed that most of the incidents related to one person. We saw that there was an incident of prone restraint, and staff explained why this had been used and how in that case it prevented further harm to the person.

We saw good practice where one person had an advance directive in place for when they agreed restraint should be used. We saw that following a recent incident of restraint there had been a post-restraint session with the person where a discussion had taken place to check they still wished the advance directive to remain in place. Both the person's social worker and the unit psychologist had been informed of the incident and both had contacted the unit to check if their input was needed.

There was a model of the unit in the manager's office. This was used for fire training for staff so that they could plan and practice fire safety procedures without distressing patients by carrying out these drills on the ward.

Requires improvement

Are services safe?

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

Evenlode

Track record on safety

Since the last CQC inspection in January 2014, there have been no serious incidents requiring investigation. Following the last inspection, work had been undertaken to rectify environmental issues found with the seclusion room where the last serious incident had occurred. The seclusion room was closed for six months whilst refurbishment took place. Whilst the incident was reported appropriately internally, it had not been raised as a safeguarding matter with the local authority. The ward manager told us that they had now changed their process for reporting incidents of self-harm with the local authority. Any incident that is 'out of the ordinary' then gets reported to the local authority safeguarding team.

Learning from incidents and Improving safety standards

Staff were aware of incidents that had taken place on the ward and at another unit in the area. They were aware of learning from these incidents and changes that had been made as a result. However, staff were not clear about learning from incidents in other areas of the Trust and how this may impact on their practice.

The Trust advised us that as the building was a private finance initiative (PFI), maintenance works are dependent on third parties. Oxford Health, have reviewed the whole of the unit and agreed to undertake the work with the PFI contractor, Semperian, scheduled to commence in April 2015. This work on the perimeter fence had been outstanding for approximately 18 months. The ward manager was not aware of a proposed start date for this work. Although work had been undertaken to remove ligature points from the seclusion room, this had not been carried out for the rest of the ward and no clear timescale for when this would commence was known. Staff are managing the risks by undertaking more observations.

Safeguarding

People told us they felt safe. Where they were concerned, they told us they spoke to staff. Staff had completed relevant safeguarding training for both children and adults. They demonstrated a good level of knowledge about what constituted safeguarding and how they would report any incidents. The ward is located within Oxfordshire and safeguarding alerts go to the team for this county. The ward manager informed us that they have also had discussions with Hampshire local authority about their safeguarding thresholds where these differed from Oxfordshire, for example in notifying of self-harm incidents.

We looked at the records for some recent safeguarding alerts. There had been three recent incidents within the same week and staff had organised a meeting to discuss how to manage these in addition to an alert being made to the local authority safeguarding team. Safeguarding plans were completed for people involved in safeguarding incidents and these were incorporated into care plans. However, we found safeguarding issues had not been recorded using the computer system for the trust, therefore making it difficult to easily access the information and update on progress. For one person we found the safeguarding alert recorded on the clinical team meeting notes.

Assessing and monitoring safety and risk

We were told that safe staffing levels were maintained. The ward had two nurse vacancies and four support worker vacancies. These were being filled by staff deployed from other units and during our inspection, two nurses started their induction. All staff told us there were enough staff to meet people's needs and the ward never went below a safe level of staffing. When agency staff were needed, the ward used regular agency staff who were familiar with the service and the people using the service. The staff team each have assigned roles so areas of the ward as well as people can be observed. The design of the building means there are some blind spots but the staff were aware of these.

The staff team consists of people from different professional backgrounds including medical, psychology and occupational therapy. The psychology staffing at Evenlode consisted of one qualified and two unqualified members of staff. The qualified member of staff provided support across the whole staff team and facilitated them to ensure their approaches are consistent and therapeutic. We saw this approach was having very positive benefits for people using the service. The unqualified staff were providing individual input to people with very complex needs. Whilst the unqualified staff were closely supervised there were concerns about whether they had the skills to undertake this individual work. The psychologist explained that additional funds are being sought to increase the numbers of hours of qualified psychology input available in the service.

Requires improvement

Are services safe?

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

Referrals to the service are discussed as part of the multi-disciplinary team and members of the team carry out the assessments prior to admission to the ward. Risk assessments are drawn up before a patient moves into the ward and reviewed regularly at the multi-disciplinary team meetings. Copies of up to date risk summaries were kept on paper files for ease of access although we found instances where some were buried in the progress notes and hard to find. The clinical team manage the occupancy levels. The ward had one vacancy at the time of admission. As the patient required one of the two high dependency rooms, which were both occupied, they were on a waiting list.

Potential risks

People were involved with their care plans and with their behavioural support plans. Staff described how people informed their plans detailing what they would like to happen if they were distressed. They gave examples of where one person needed to use the seclusion room rather than being restrained. Discussions with staff demonstrated they all understood the importance of supporting people to manage their behaviours and used restraint as a last resort. There was an emphasis on managing and deescalating challenging situations.

Staff had completed training in a new procedure for managing physical interventions being rolled out by the trust. The ward manager and two other staff had not yet been trained. Staff expressed mixed feelings about the introduction of the training and some of the methods to be used.One member of staff was concerned about the lack of recognised breakaway techniques as part of the course.

People and staff told us the use of physical restraint was low and people felt safe on the ward. An audit of incidents was kept and we reviewed the record for the 12 month period up to 31 July 2014. The record showed there were four incidents of prone restraint in this time.The nature and level of restraint was regularly monitored. Behaviour management plans had been amended in some files but we were unable to locate an amended plan in one file.

Since June 2014 there had been two incidents of seclusion being used, both involving the same person. Records were kept of these episodes showing the length of time in seclusion but we noted there was no space to record the time the doctor had been called following seclusion and therefore it could not be ascertained if the requirements of the Code of Practice had been followed.

Evenlode is a medium secure ward and all people on the ward are subject to detention under the Mental Health Act 1983. As such there were necessary restrictions in place. People did not have access to their own mobile phones but these could be used following a risk assessment for some people during unescorted leave. People had access to a fenced garden area for ten minutes every hour for smoking. Additional time in the garden could be requested and was dependent on staff availability. Staff told us they worked with the other trust to share lessons about security arrangements on the site.

Are services effective?

Requires Improvement

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

Summary of findings

Staff in Oxfordshire and Buckinghamshire felt that training had improved, but many staff especially those without a professional qualification needed more training to meet the specific needs of the people they were supporting. However, staff had good access to mandatory and statutory training.

Whilst medicines were stored securely, the facilities for the storage of controlled drugs were not in accordance with trust policies.

People using the services had a comprehensive assessment completed of their individual needs. They were also having their physical health needs assessed and services were in place to meet these needs.

There were excellent examples of multi-disciplinary working across the different locations which ensured that teams were able to work together to provide effective care to people using the services.

People's rights were protected through the effective use of the Mental Health Act and Mental Capacity Act.

Our findings

Ridgeway Centre

Assessment and delivery of care and treatment

We looked at people's assessments and found they were very thorough and addressed people's physical health and social care needs. We heard and could see from the documentation that people and their carers had been involved where possible in these assessments. These assessments were multi-disciplinary with at least two members of the team involved. We also saw the assessments were reviewed and updated. We saw these assessments were reflected in people's individual care plans. In addition people had individual support plans so staff were clear about how to support them during the different shifts.

We looked at how people had their physical healthcare needs met during their stay at the Ridgeway Centre. The service had an arrangement with a private GP which had started in September 2014. The GP would visit the centre once a week for a two hour session and this took place during the inspection. They would also assess new patients within 24 hours of their admission. People could be taken to the surgery for appointments and visits could be made to the service when needed.

People using the service were supported to attend their usual dentist for appointments as long as this was not too far away. Referrals could be made to a specialist dental service if needed and one person was receiving treatment at the time of the inspection. People use local opticians and if needed one local optician will visit the service.

We looked at how people with epilepsy were supported in the centre. At the time of the inspection one person had epilepsy. They had a comprehensive care plan in place and staff knew how they needed to support this person.

We looked at how medication was managed in the service and found that whilst medicines were stored securely, the facilities for the storage of controlled drugs were not in accordance with trust policies. We were told that work was underway to create a door so that when people who use the service come to the treatment room to receive their medication the risk of them taking other medication is reduced. Relevant medicines storage temperatures were recorded and monitored. The service had identified that the treatment room where medicines were stored "may have been getting too hot". Therefore, they had started monitoring the room temperature, prior to taking further actions if required. Controlled Dugs were required infrequently by the patients and when asked staff were not aware of how to obtain controlled drugs in line with trust procedures and the legislation.

Medication was prescribed and administered within trust guidelines and "if required" medicines all had an indication and maximum dose recorded. We saw that the medication administration records were now completed accurately and there was a system in place for this to be checked on a daily basis. This meant that the compliance action from the last inspection had been met. We identified that the initiation of antibiotic had been delayed by four days due to failure to supply by the supplying pharmacy and this had not been followed up. Processes to ensure medicines were available when away from the service for short term leave were in place.

Outcomes for people using services

Are services effective?

Requires Improvement

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

We were told that the Ridgeway Centre had previously been accredited with the Royal College of Psychiatrists for AIMS-LD when part of the Oxfordshire Learning Disability Trust. The service is hoping to seek accreditation again in the coming year.

We saw a piece of work undertaken by the psychologists at the Ridgeway Centre in March 2014. This looked at outcomes for people using the service and this showed that using a number of measures there were improvements in people's challenging behaviours and mental health after using the service.

Staff skill

We talked to staff about induction training. We found that this had been improved. In addition to the corporate induction the Ridgeway Centre had its own induction checklist to ensure new staff were inducted to the service. A specific guide had been produced for support workers and an employee handbook for all staff explaining all the operational aspects of the service.

We saw from records maintained in the service that most staff had completed the necessary mandatory and statutory training. We also heard that qualified staff had completed the recently introduced epilepsy training and this was now being rolled out to support workers. We also heard that the multi-disciplinary team provide additional in-house training. This has included positive behaviour workshops developed by the psychologists. They have also identified the need for Makaton training and this has been requested.

From speaking to the staff, particularly the support workers, it was evident that they felt they needed more training to enable them to meet the needs of the people they were supporting. This included training on caring for people with a learning disability, autism awareness (although there had been a couple of in-house sessions), communication skills, training on mental health including how to support people with a personality disorder. From speaking to the ward manager and divisional director it was recognised that this training is not yet in place although some in-house training was starting to be planned.

Senior staff at the Ridgeway Centre said that they had the opportunity to complete the 'going viral' leadership development programme and they enjoyed having the opportunity to meet and learn with other people from the trust.

We looked at the record of supervision for staff working in the service. The aim is for the management supervisions to take place every 4-6 weeks. When we looked at the records most staff had only had two or three supervisions since April and some fewer. The managers were working to improve the frequency of supervisions. All the staff who were at work had a record of a completed appraisal. We were also told that team meetings had not been taking place and information was shared during handovers and was displayed in the team office. The service has introduced weekly reflective practice sessions and these were very well received.

The staff from the Ridgeway Centre took part in four days of team building with an external facilitator during May and June 2014.The staff we spoke with told us they felt well supported and that they worked well as a team. They also told us that after an incidents they was a thorough debrief and that they received individual support as well as completing an appropriate incident form.

Multi-disciplinary working

We saw many examples of multi-disciplinary working at the Ridgeway Centre. The multi-disciplinary team has recently been extended with new psychology and occupational therapy staff being appointed. A speech and language therapy post had been created but not yet filled. In addition there was funding approved for a music or art therapy post. We joined staff handover meetings and multi-disciplinary meetings which enabled us to see the team working very effectively together. We looked at some records of multi-disciplinary meetings and these did not always have clear actions with the date they needed to be completed.

Information and Records Systems

The records in relation to the operation of the service and the care of people using the service were well organised and ensured peoples confidentiality was maintained. Staff have received training in information governance.

Consent to care and treatment

Staff are trained in the use of the Mental Capacity Act as part of the safeguarding training. A few staff had completed training with Buckinghamshire County Council. We found that there was a good use of capacity assessments in the service and recognition of when multi-disciplinary meetings needed to take place to consider what was in the

Are services effective?

Requires Improvement

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

person's best interest. There was also an understanding of when an authorisation was needed for a deprivation of liberty safeguard and at the time of the inspection five authorisations were in place.

Assessment and treatment in line with Mental Health Act

At the time of the inspection four of the people using the service were detained under the Mental Health Act. Copies of the MHA documents were all present and in good order. People told us they had been informed of their rights and a leaflet was available, but this was not always clearly recorded. There was also no record of an assessment to establish if the person had capacity to consent to treatment on admission. We looked at the risk assessments for people taking section 17 leave and found these were completed to a high standard although two needed to be reviewed. We did find that a request for a second opinion doctor had not taken place in a timely manner and this had led to the use of section 62 to authorise urgent treatment.

Woodhaven

Assessment and delivery of care and treatment

Each patient was thoroughly assessed on admission. Patients' risk assessments and care plans were detailed, current and regularly reviewed. There were detailed positive behaviour support plans in place and these were followed consistently. Each patient had a detailed physical health care assessment and good access to local GPs. Patients we spoke with confirmed they had been involved in the development of their care plans.

There was a range of activities available on both wards and where possible patients were supported to access the community for activities. The emphasis on both wards was rehabilitation and preparing people to return to live in the community.

There was access to appropriate group therapy for patients. There was an adapted sex offenders' treatment program available within the community and a firesetting treatment program. Patients were also able to receive treatment for anger management. Patients were supported to take part in activities and fishing was very popular. There was access to a kitchen however the cooker on Ashford had been condemned and staff were still waiting for a replacement.

Outcomes for people using services

The Ashford unit had recently been peer reviewed as part of the Royal College of Psychiatrists quality network for forensic mental health services. They were waiting for the report from this so that they could benchmark their service and develop action plans to promote improvements.

Staff skill

Staff working in the service had completed mandatory and statutory training. Eighty per cent of the staff had completed the recently rolled out training in epilepsy management. Staff told us they had good access to training and support. We were told that staff had opportunities for personal development, for example two health care assisstants who were being supported by the trust to undertake nurse training. The ward manager had completed the "going viral" leadership development programme.

Multi-disciplinary working

There was good multi-disciplinary working and patients had access to consultant psychiatrists, occupational therapists, psychologists, speech and language therapists and social work input. Multi-disciplinary meetings and care program approach meetings were held weekly. The records were updated electronically during the meeting to ensure important updates were available.

The multi-disciplinary team had links with the forensic learning disability service in Oxfordshire. They were part of a forensic pathway service across Southern England.

Information and Records Systems

Records were kept on the electronic records system. Records were clear, up-to-date and accessible. Nurses were given time when they were not supporting people using the service to enable them to update care plans and risk assessments in a timely fashion. There was good use of real-time electronic recording for multi-disciplinary team meetings.

Where appropriate records of people's physical health checks were completed by the nursing staff and these were available in the clinic room.

Consent to care and treatment

Are services effective?

Requires Improvement

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

Staff were knowledgeable about the use of the Mental Capacity Act and could describe when it would be necessary to carry out an assessment. People using the service had been involved in the development of their care plans and had agreed them.

Assessment and treatment in line with Mental Health Act

Mental Health Act paperwork was in order across both wards.

Patients we spoke with understood their section 17 leave conditions and relatives were given copies of S17 forms.

Whilst patients had their rights explained every three months some patients could not remember this being done and may need the frequency increased.

Willow Ward

Assessment and delivery of care and treatment

Willow ward had a ten week period to complete a thorough assessment and care plan following a person's admission. This included a specialist sensory assessment in a dedicated sensory integration room by occupational therapy staff.

We saw that care plans were individual, detailed and regularly updated. Each person had a positive behaviour support plan. Each person's care plan had a health action plan and patients with epilepsy had all been reviewed by the specialist epilepsy nurse. People had been screened for tissue viability, falls, nutrition and dysphagia. Speech and language input was available.

There were excellent examples of person centred behaviour support plans. One person described how he had access to paper he could rip when he felt the need to do this and how this ensured important pictures were not damaged.

We saw that all challenging behaviour was recorded and mapped. Challenging behaviour was regarded by staff as communication. One person's self-harm had recently started to increase and staff were investigating if the person had dental pain as this had been the antecedent of previous similar behaviour.

Outcomes for people using services

Willow ward is accredited with AIMS which is a project to improve service quality operated by the Royal College of Psychiatrists.

The unit has purchased and implemented the IABA (Institute of Applied Behaviour Analysis) training package which is an internationally recognised program of positive behavioural support. They were also using a model developed by the IABA to record the outcomes for people and this demonstrated positive outcomes for people in terms of reductions in challenging and self-harming behaviour and the need for restraint.

People from the unit and their families were intending to attend a learning disabilities conference.

Willow ward had also taken part in an NHS England review which they told us had been a positive experience.

Staff skill

Staff were very positive about their training and support.

A specialist behavioural training package had been purchased by the ward and training was regularly cascaded to all staff. Staff we spoke with were consistent in their knowledge of behavioural approaches and use of any physical interventions.

There were opportunities for support workers to undertake training. One member of staff was about to be sent for nurse training by the ward and the manager told us it was very important to consider the nurses of the future.

The ward had two full time occupational therapists who were coaching staff in how to undertake activities with people.

Staff told us there was a reflective practice group which enabled them to learn and develop and apply this learning to the care they provided. Staff understood the need to know as much about people as possible to understand their challenging behaviour. When we commented this must be difficult we received the reply, "think how much more difficult it is for them not being able to make their needs known".

Multi-disciplinary working

The ward operated with an integrated multi-disciplinary approach. Members of the team included a consultant

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Requires Improvement

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psychiatrist, psychologist, nurses, occupational therapist, social worker, speech and language therapists and health care support staff. An art therapist had recently been employed on a six month trial basis.

The ward worked closely with the intensive support team (IST) to facilitate discharge. This team were involved in discharge planning and for a three month period following discharge to ensure people were being supported appropriately.

Information and Records Systems

Comprehensive records were available. Care plans and risk assessments were recorded using the electronic patient records system. In addition to these progress notes were kept and detailed records of any challenging behaviour or incidents of restraint. These records were used to inform multi-disciplinary discussions and to formulate positive behaviour support plans.

Records of medication were monitored, checked regularly and were discussed in staff handovers.

Consent to care and treatment

We observed that staff routinely sought consent from people before carrying out any intervention.

One person was not detained under the Mental Health Act and staff had supported the person to develop an advance directive for times their capacity may fluctuate. This was reviewed regularly to ensure the person still agreed with it. This person had an application completed on their behalf for an urgent Deprivation of Liberty authorisation however the assessment found the person had capacity and was able to consent to remaining in the service.

Assessment and treatment in line with Mental Health Act

All the Mental Health Act paperwork was in order. Approved mental health professional reports were generally available and completed to a good standard.

People were informed of their rights regularly and in a format they could understand and this was documented. However, trust policy is that they should be discussed at three monthly intervals. In come cases it was recorded on care plans that they needed to be discussed more frequently and this was done, but in other cases, patients complained that they could not remember their rights. There was an independent mental health advocacy service available for patients and the IMHA visited the wards regularly to support patients.

Section 17 leave was correctly recorded and in date.

There was a clear understanding of the different legal position of informal patients and that they could not be restricted to the same level as a detained patient without their consent.

All medication was authorised in accordance with the provisions of Part IV Mental Health Act 1983. All referrals for a second opinion appointed doctor (SOAD) were preceded by the responsible clinician undertaking an assessment of the patient's capacity to consent with the discussion with the patient clearly documented. There was evidence that the responsible clinician had discussed the outcome of the SOAD visit with the patient or documented why this conversation could not take place. The statutory consultees had documented their conversations with the SOAD on the patient records.

Evenlode

Assessment and delivery of care and treatment

We were told the assessment process involves the members of the multi-disciplinary team. All new referrals to the service were discussed at a multi-disciplinary team meeting and members of this team visit the person and carry out an assessment. Further visits were carried out as needed to assess the suitability of the referral.

People's physical health was reviewed on admission to the ward and reviewed regularly. People were registered with and supported to see a local GP who would also visit the ward by appointment if necessary. Support was provided for people to access dentist, chiropodist and other relevant services in the community. Each person had an individual health action plan. The ward psychiatrist maintained a system to ensure health checks were up to date for all people on psychotropic medication.

People had detailed, up to date care plans. There was evidence of discharge planning in all the case files we reviewed. People were actively involved in their care plans and in their reviews. Regular meetings take place with each person and the clinical team. These involved families and representatives and where a person does not wish to attend, a form was completed with them for issues they

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would like to raise and a record is kept of the feedback given to that person to keep them informed of what is happening as a result of the meeting. We were told that staff had been updating the care plans and putting information on the trust's computer system. Paper files were also kept. The length and detail of the care plans, when printed from the computer system, were not user friendly and people often did not want to sign these regularly after their six weekly reviews. A previous user friendly format used prior to transferring plans to the electronic record showed people had signed these plans.

We heard that the staff team felt well supported by the pharmacy department through visits and access to telephone advice. We observed that when staff were administering medication that the people using the service could be in the treatment room and as the cupboards were open this could present a potential risk of patients taking medication other than those prescribed for them. In terms of storage we saw that the facilities for the storage of controlled drugs and the separation of medicines taken by mouth from creams and ointments were not in accordance with trust policies. Relevant medicines storage temperatures were recorded and monitored. Controlled drugs were required infrequently by the patients and when asked staff were not aware of how to obtain controlled drugs in line with trust procedures and the legislation.

Medication was prescribed and administered within trust guidelines and "if required" medicines all had an indication and maximum dose recorded. Patients were risk assessed prior to being allowed to undertake limited self-administration of medicines for example inhalers. Processes to ensure medicines were available when away from the service were in place for example attending court. We were unable to find a monitoring plan for one patient whose diabetes was "tablet controlled" and their asthma monitoring plan was incomplete.

Outcomes for people using services

External professionals (NHS England commissioners) told us they were satisfied with the quality of interventions provided by the staff at Evenlode. People have had targeted interventions and been able to move on to low secure services. They gave examples of people who they had placed in the ward who had changed positively in terms of appearance and behaviours that challenge due to being in the therapeutic environment.

Staff skill

We spoke with one member of staff who was on the first day of their induction. They were following a plan to get familiar with the service and the people living there.

Staff told us they were undertaking a lot of training, mostly online training. Some staff commented that not all the training was applicable to the work they carried out or the ward they worked on.

Records showed the majority of staff had completed mandatory and statutory training. Qualified and support workers were also completing epilepsy training which had recently been introduced. The service provides some in house training on topics such as managing risk, Mental Health Act and patient rights, fire evacuations and use of resuscitation equipment. Qualified staff had received training in some of the therapeutic techniques used in the service to enable them to provide therapy.

Qualified staff told us they could ask for training in a variety of topics to meet people's needs. One person gave an example of attending training on autism. Unqualified staff did not get access to specific training about the needs of the people they are supporting such as understanding mental health, working with people who have personality disorders or autism awareness.

Senior staff told us they were able to participate in the "going viral" leadership training and felt this was a good programme, enabling them to meet other people within the trust.

All staff told us they worked in a supportive environment and received regular supervision. A new supervision system has recently been introduced. Qualified staff could access peer supervision and clinical supervision. Due to the absence of the clinical services manager, the ward manager was not always receiving regular support and there was no system in place for their clinical supervision. They were aware of people they could go to for support. The ward staff worked in teams and had regular team meetings and effective handovers between shifts.

Multi-disciplinary working

The multi-disciplinary team worked together to support the smooth functioning of the ward. We saw many examples of the team working well together to ensure adequate staffing on the ward when people had commitments to go out. The

Are services effective?

Requires Improvement

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team worked together to create safe relationships and a therapeutic environment. People were invited to clinical team meetings when their care was being discussed and were engaged in decisions made.

Information and Records Systems

Evenlode had experienced difficulties with the change over from the previous provider o Southern Health. This meant that many staff could not access the new computer system and we observed staff struggling to get to grips with the particular requirements of the system. We saw one example where there was an entry about another person in one person's record. Records were securely stored and staff had received training in information governance. We were told that plans are in place to ensure staff have access to the trusts IT system.

Consent to care and treatment

Staff told us that the relevant professionals carried out mental capacity assessments for particular decisions such as financial decisions. Staff we spoke with were aware of consent issues and the right of people to be supported to make decisions they may consider to be unwise. We looked at a number of capacity assessments including consent to treatment, consent to treatment under the MHA and capacity assessments for complex decisions such as financial management. The capacity assessments were appropriate and detailed. People told us their medication was explained to them and they were involved in their care plans.

Assessment and treatment in line with Mental Health Act

All the people at Evenlode were detained under the Mental Health Act. Mental Health Act documentation was held in hard files and was generally in good order. The trust had recently taken legal advice about restricted patients accessing occupational therapy and gym facilities outside the trust's own area but within the same grounds. This resulted in people requiring section 17 leave for these activites and staff and people expressed concern about the delay this was causing for people getting to activities. The trust had written to the Ministry of Justice to request permission to include the shared corridor and activity rooms as part of the trust's hospital area for the purpose of section 17 leave. Risk assessments were in place for section 17 leave and staff told us they included monitoring a person's mood prior to their leave.

Records showed that people were informed of their rights and people we spoke with were able to explain their rights. We found that the section 132 forms were not consistently available in the files for each month. The evidence in the files indicated people were not always informed of their rights on the day of detention.

Are services caring?

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

Summary of findings

People using the services were cared for by staff who were very motivated and supported people with care, dignity and respect.

We found that people across all the services were supported to be involved in the development and review of their care plans.

People were encouraged to attend their review meetings and had access to advocacy services.

Relatives and friends were involved at all stages with peoples care and we were told that they felt well informed.

Our findings

Ridgeway Centre

Dignity, respect and compassion

Throughout the inspection we heard positive feedback from people using the service and their relatives about the support being given by the staff. People told us they felt able to talk to the staff and that they felt very involved in decisions about their care. We were told about a number of examples of how people felt well supported and one person said that they can use the phone in the office each day to speak to their family.

Staff told us how they ensured they respected people's privacy and dignity and we could see that they spoke to people politely and ensured doors to bedrooms were closed when delivering personal care.

We heard staff talking about people who use the service in a respectful manner during staff handovers and they demonstrated a good understanding of their individual needs.

We also noticed that despite the complex and at times challenging needs of the people using the service the atmosphere was very calm and relaxed.

Involvement of people using services

We heard about how people using the service have opportunities to be involved in decisions about their care.

People told us that their care plans were discussed with them, they were encouraged to attend their review meetings and that they had a copy of their plan if they wished.

We heard about how people using the service had access to advocacy services. We met an advocacy worker who said the staff were very receptive to advocacy. The advocacy service provides drop-in sessions, advocates for the care programme approach (CPA) meetings if requested, and an advocate once a month to attend the community meeting. Information about how to access the service was available in an easy-read format.

We looked at how therapeutic activities are provided in the service. These were mainly arranged by the occupational therapists and include group and individual activities. Support workers in the service are having the opportunity to undertake an occupational therapy assistant role on a rotating basis. The recruitment of additional occupational therapists means that they are moving towards providing a seven day a week service. The staff in the units had access to a wide range of games and art materials to support activities in the service. We also saw and heard that people were getting the opportunity to regularly go out. Where people needed more than one member of staff to go with them this took place during the staff handover period when there were more staff on duty.

Emotional support for people

All the staff we spoke with told us they recognised the importance of involving families and carers. The service had an information booklet to give to families and carers. We saw that families were invited to meetings and were involved in assessments unless the person did not want this to happen. We met relatives who told us they were invited to review meetings and they felt well informed. We saw that comment cards were available for visitors, relatives and carers to complete. A carer's survey had been sent out in September 2014.

Woodhaven

Dignity, respect and compassion

During our visit we observed staff speaking with patients in a courteous and respectful manner. Patients told us that some staff were "absolutely brilliant". One person was not satisfied with their treatment but having spoken to staff we were satisfied that staff were trying to address the persons individual concerns.

Are services caring?

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

Staff spoke respectfully about patients when discussing their care with us and we observed that during handover attention was paid to people's physical and emotional needs. People using the service told us that there was time available to speak with staff whenever they needed.

Staff we spoke with were keen to tell us about the progress that people had made on both wards. They were genuinely proud of the progress people had made with their recovery.

It was observed that both wards were very calm and settled and patients were keen to talk with us about their future.

Involvement of people using services

People using the service were involved in the development and review of their care plans.

Patients had good access to advocates and were able to raise issues with the ward. We saw that where patients had requested specific activities the service had endeavoured to provide these.

One person on Westview told us the food was "terrible" however there were no records of this being raised at meetings. People using the service on Ashford were satisfied with the food. Staff told us that some complaints had been addressed in the past.

Emotional support for people

People were encouraged to remain in contact with their families and staff were made available in order to support this. We heard about one person who had needed several members of staff to escort them when they first re-established contact with their family. Staff had worked hard to understand the family's culture and explained how important this had been. Another person was excluded from going to a particular area and staff had ensured they were able to meet family in a café outside of this zone.

Willow Ward

Dignity, respect and compassion

It was evident from our conversations with people using the service, staff and our observations that care provided by staff was outstanding. In all of our conversations with staff they demonstrated a person-centred approach and were very positive about the people they supported.

Staff knew people very well and understood their individual needs. Staff understood that challenging behaviour was about the person trying to communicate and discussed how this was used to develop positive behaviour support. There was good understanding of the person and their backgrounds. Routines were based around the person and their needs and preferences.

Staff we spoke with talked to us very much in the context of 'working with' rather than 'doing to'.

Whilst being shown around the ward we noted that observation panels had not been closed on people's bedroom doors. We commented on this and were met with an open acknowledgement that this had slipped and would be addressed immediately.

Involvement of people using services

People using the service were involved in the recruitment of staff. When potential staff came for interview they would be shown around the unit by a person in order that an assessment could be made of how the prospective staff member interacted with people.

One person had responsibility for maintaining the garden on Willow ward. They enjoyed gardening so had been supported to take charge of the garden.

Emotional support for people

Staff told us that they worked closely with people and their families. The manager told us, "we help put families back together". All of the people on Willow ward were in touch with their families. One person had a poor relationship with their parent prior to their admission to Willow ward but staff had worked with the person and their parent and they now had regular contact. Another person had been re-united with their sibling after several years and was escorted to London monthly to see them.

Willow ward involved families and and carers during the persons assessment and arranged for pre-admission family visits. Psychology staff met with the family and the family were able to review any reports. CPA meetings were made as family-friendly as possible and focused on making the language simple and understandable.

We saw a lot of positive feedback from families which expressed gratitude to the staff on the unit and acknowledged their family member was making progress. One piece of feedback stated, "to know your child is safe is one of the most important worries that any parent will experience, especially if that child has learning difficulties combined with challenging behaviour".

Are services caring?

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

We noted there was no visiting room on the unit and the manager explained that in the light of Winterbourne View it was important to be transparent and not restrict families or visitors to just one part of the building.

Evenlode

Dignity, respect and compassion

During the inspection we observed positive interactions between staff and the people using the service. Staff demonstrated a good knowledge of the needs of people using the service.

People told us they were able to talk to staff if they had any concerns. They told us they were treated with care and respect. One person's relatives told us the staff looked after their relative very well. "They give him excellent care." The atmosphere on the ward was relaxed. People were busy engaged in a variety of activities both on and off the ward.

People told us they had a key to their rooms and the rooms were kept locked. The communal bathroom was kept locked so people had to ask to use this if they wanted a bath. This was made clear in the guide given to people prior to admission. All bedrooms had ensuite facilities. People had access to a payphone though we noticed the telephone hood did not afford much privacy. A phone was available in the interview room for private calls and people often arranged to be called on this phone.

The seclusion room had a large window looking out to the ward garden. Whilst this allowed natural light into the room, it meant people could see into the room if they were in the garden. There was a blind but this would block out the light if used. This did not protect the privacy and dignity of the person in the room.

Involvement of people using services

People told us they were involved with their care plans and had regular meetings to discuss and review these. They were able to have a copy of their care plans if they wanted. The Independent Mental Health Advocacy (IMHA) service provided a weekly drop in service on the ward. The advocates could also attend the care programme approach meetings if the person wanted. A poster advertising the service was displayed on the meeting room window. We did not see any other information about the service. People told us they were aware of the advocacy service and if they were not able to visit they could contact them. People told us there was not enough to do at the weekends and relatives told us the weekends can be quite boring. Staff told us weekends could be quite busy managing visitors.

We discussed the lunchtime meal with the ward manager and with people using the service. Cutlery was not provided as the process of checking cutlery in and out caused delays in access to activities, particularly if any went missing. People told us this had been in place the whole time they had been on the ward. We also observed that lunch was served as a buffet and food was placed in a central area of the ward, rather than in the dining area where people could sit and eat. No one told us they were concerned about this approach.

Emotional support for people

Staff recognised the importance of involving relatives and supporting family contacts. Staff had received training in safeguarding of children and were aware how to support people with children to have visits. Relatives told us they felt listened to and involved in their relative's care. A relative told us they feel the staff "understand him" and they treat parents with respect.

Are services responsive to people's needs?

Good

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

Summary of findings

The learning disability services were all very specialist and met the needs of people with complex needs. People had detailed assessments before being admitted to the service to ensure they could meet their needs.

The services had a strong recovery focus and discharges were planned and co-ordinated with risks carefully considered.

People using the services knew how to complain and staff were responsive and changes were made where needed.

Our findings

The Ridgeway Centre

Planning and delivering services

The Ridgeway Centre is a specialist assessment and admission service for people with a learning disability. The service has reviewed its admission criteria and now assesses people carefully to ensure it can meet that persons needs before offering them a service.

Diversity of needs

We were told and could see in people's records that their individual needs in terms of their religion, culture, language, relationships and other choices were assessed as part of their admission. Staff told us about how they supported people for example to access interpreters or to eat a particular diet. We were told that where people wish this to happen spiritual leaders can visit the home, but we also received feedback that this can take a while to arrange and should be more responsive.

Right care at the right time

At the time of the inspection people had been accessing the service for varying lenths of time. One person had been there for over two years, two people had been at the service for about a year and the rest had been there for six months. Three people had active discharge plans in place.

We heard about and saw records which showed that discharges were carefully planned. Each person had a detailed needs profile that identified risk. The community team attended discharge planning meetings and this information was shared with them. The team at the Ridgeway Centre contributed to contingency plans and relapse prevention plans. A clinical handover between psychiatrists took place that also considered risk.

Learning from concerns and complaints

We heard from people using the service that they knew how to complain and we saw the complaints process was displayed and was available in an accessible format. Staff knew how to respond to complaints and how to refer the complainant to the trusts complaint process if needed. We were told that there had been very few complaints and these had been addressed immediately in the service.

Woodhaven

Planning and delivering services

Ashford and Westview have a clear set of admission criteria. Ashford is a low secure service and Westview is a forensic rehabilitation supporting people with their recovery with the aim of enabling them to return to live in the community. Staff paid attention to the mix of people on the rehabilitation ward and only accepted people onto this ward if they could meet their needs.

Diversity of needs

Staff worked hard to ensure they met patients' diverse needs. They told us how they had worked as a team to understand people's individual cultural needs. Staff were able to explain people's needs within the context of their cultural and family background. Staff told us how they had learnt about one patient's culture in order to support them to establish contact with their family. People using the service told us that they met their individual needs.

Right care at the right time

Patients were assessed before moving to Ashford and Westview in the Woodhaven unit to ensure that the services could meet their needs. This process was effective as we heard of only one patient who had needed to be discharged to another unit.

Discharge planning was an integral part of service delivery on the ward. There was effective social work input to help devise appropriate discharge plans for patients. All of the people we spoke with knew their discharge plans and had

Are services responsive to people's needs?

Good

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

been involved in them. Staff and the social worker had advocated for individual people with commissioners in order to obtain the most suitable post discharge accommodation and support.

We saw that one person who had been in secure services for many years was now being prepared to move to the community. Staff told us how they had advocated for the person to be housed in an area of their choice which the patient confirmed.

Learning from concerns and complaints

Patients knew how to complain and complaints were addressed appropriately. There was a complaint log available which recorded outcomes and copies of letters were available to evidence that responses had been within the required timescale. Where needed patients had access to an advocate to support them to make a complaint.

We saw that where complaints had been upheld measures had been put in place to address issues.

Willow Ward

Planning and delivering services

There was information for people in easy read and picture format. We saw the pre-admission pack which was available for people. This contained photographs of Willow ward and information about the unit in accessible format.

Diversity of needs

Staff had a clear knowledge of people's needs and understanding of how they related to both their families and other people on the unit.

Staff were able to tell us about people's life histories and experiences in other services. They were able to describe how they met people's individual needs.

Right care at the right time

Willow ward only accepted planned admissions and had clear criteria for patients they admitted in terms of their learning disability and challenging behaviour. The majority of people were from Hampshire with one person admitted from Dorset which was also nearby. Where needed staff could work with the local intensive community team to admit people within 48 to 72 hours. The ward had an assessment suite available so that new people could be admitted into a low-stimulus environment and introduced to the rest of the unit at their own pace. Following admission the team completed a full assessment and care plans and were able to achieve this within 10 weeks.

Willow ward put a great deal of effort into discharge planning and putting plans in place to ensure that the person's move was successful. The discharge planning took place over a three month period and involved input from the unit social worker and the intensive support community team. When a suitable placement was identified the future staff who would support the person began working alongside ward staff. Their input was gradually increased so that for the person's final month on Willow ward all support was provided by their future community staff.

One person was preparing for discharge and staff went to check on how their accommodation was progressing. They had visited to make sure the environment was suitable and that the person's needs would be met.

People generally stayed on the unit for about a year. Following discharge the person was supported by the intensive support team for three months and the community team for a further three months in order to ensure support was available as needed.

Learning from concerns and complaints

The manager kept a log of any complaints that had been received and the outcome. We saw that people's complaints had been recorded and investigated. Where appropriate a safeguarding alert had been made.

One complaint by a person using the service had resulted in a review of their care plan in a care plan workshop and a review of how staff supported that person. Another complaint had resulted in the purchase of additional equipment.

Evenlode

Planning and delivering services

Evenlode provides assessment and treatment for men over the age of 18 who have a learning disability and need to be in a medium secure environment. The ward was located on the site of another trust and the building was connected to another ward managed by that trust. There were activity

Are services responsive to people's needs?

Good

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

rooms, family visiting rooms and a gym available to use but these were part of the other trust. The building was not owned by Southern Health and this impacted on the trust's ability to carry out works to improve the facilities.

Diversity of needs

We were told and saw in the records kept that people's religious and cultural needs were met. The staff worked with people and their families to facilitate access to religious activities and dietary needs. An example was given of how the staff work to support families to visit and respect the particular cultural differences which may mean a larger group visiting at times. People were supported to maintain relationships.

Right care at the right time

Most people had been using the service for over two years. Staff were actively supporting a discharge plan for one person and involving their family. At the time of the inspection, staff were going to visit a possible new placement and their family had been able to visit another service being considered. People had clear discharge plans in place and worked with new placements to share information and risks to make the process as effective as possible.

Learning from concerns and complaints

People told us they knew how to complain and did not express any concerns that their complaints were not acted upon. Staff told us the process was usually for the person to put their complaint on a form so they had it in writing but they would take verbal complaints if the person did not want to put it in writing.

Staff told us they try to resolve complaints wherever possible, at the time they are raised. The ward manager confirmed that they try to sort out complaints as soon as they receive them and they are then passed to the trust complaint department.

Records were not available on the ward of complaints received. Staff were able to give some examples of issues people had raised and changes they had made as a result. Information about how to complain was available in the guide for people using the service.

Are services well-led?

Requires Improvement

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

Summary of findings

The trust had recently introduced new governance processes including a system of peer review and a monthly clinical review using a trust-wide quality assurance tool. These had started to be used but need longer to be properly established to bring about continuous improvement.

Staff working in the Hampshire services felt part of the trust but staff working in Oxfordshire and Buckinghamshire felt more removed and were unclear about the details of senior staff. The trust had made an effort to address this especially through the use of training, executive and senior staff visits, roadshows, staff briefings and the people development programme. Senior staff acknowledged that there was the continued need to improve contact and communication across all the teams.

People using the service had opportunities to be engaged with the service and the wider trust. The involvement of people who use services in peer reviews was positive.

Our findings

The Ridgeway Centre

Vision and strategy

The vision and values of the trust were displayed in the service. When we spoke to staff their knowledge of what they said was very mixed.

Governance

The service had undertaken a range of audits to quality assure its own services. This included health and safety audits and audits of medication. There was also an audit of the quality of discharge summaries and CPA reviews.

The trust had introduced other governance processes. This included a system of peer reviews of which one had taken place in July 2014. There was also a monthly clinical review using a trust-wide quality assessment tool that started in August 2014. This had a number of areas that were being resolved as some of the questions did not apply to some of the learning disability services.

The managers in the service attended a monthly quality and governance meeting for Buckinghamshire that started 3 months ago. In addition the ward manager said they attended the nurses steering group.

Leadership and culture

We heard that staff felt very well supported locally and knew they could access support out of hours. The ward manager had been in an interim role for a year. The head of services was also in an interim role. There was also the clinical service director. The management arrangements in the learning disability division had recently changed and staff found it hard to say who the senior managers were in the division.

While staff were able to talk with confidence about the service at the Ridgeway Centre they had very little knowledge of services provided by the trust, even those located in Oxfordshire. Senior staff in the division recognised the challenges of supporting staff to feel connected to the division and the trust, especially as they were geographically very separate.

Engagement with people and staff

We heard from people who use the service about the opportunities they have to get involved in the organisation. There is a weekly community meeting and everyone can attend. Feedback has demonstrated that people using the service wanted staff to eat meals with them and as a result this has been reintroduced in the service. People using the service are encouraged to show visitors around, help with interviews and attend wider trust meetings to contribute to engagement events.

Staff working in the service felt they could raise issues within the service and knew how to access the whistle-blowing line if needed. They said they received the trust bulletin by email and some people talked about senior staff visiting the service. Most staff told us they did not feel connected to the work of other parts of the trust.

Continuous Improvement

We heard from members of the multi-disciplinary team how they are working well together to continue to improve the service for the people using the Ridgeway Centre. People were very proud of their achievements over the last nine months.

Are services well-led?

Requires Improvement

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

Woodhaven

Vision and strategy

The ward manager was aware of the trust's vision and strategy. They described how they aimed to recruit staff who had the right values.

Governance

There was a system of audits in place to monitor the Mental Health Act documentation, health and safety, infection control and ligature audits. Our observation of the ward environment confirmed that these areas were well-managed and in good order.

There was a good system of communication on the ward between staff and the manager. Regular handovers took place where information about patient care was communicated.

A system of peer review had been introduced and one visit had taken place on the unit. Monthly clinical reviews using a trust-wide quality assessment tool had also started.

Leadership and culture

Staff were positive about the Trust and were particularly positive about access to training. Staff felt supported by the ward manager. It was evident in talking to the manager of Woodhaven that they had a good knowledge and understanding of patients on both wards.

Senior clinical staff told us they felt that they were supported by the trust and were able to describe where and how information from the ward was communicated at senior level. The ward manager attended the forensic management meeting and the nurse leadership meeting.

Engagement with people and staff

People using the service had been given bespoke training to enable them to take part in the trust peer review process. They were supported to visit other services and were given easy read guidance to assist them.

There were not always regular meetings for people using the service on this unit. One member of staff on Westview told us it was difficult to get people using services to attend meetings.

We saw that regular staff meetings took place. Records we looked at evidenced that staff were able to challenge ideas and practices on the ward.

Continuous Improvement

Staff discussed ideas for improvement. There was a current plan to move Ashford to a larger ward as it was felt that with six people using the service the ward was too small. There was a plan to gradually increase to 10 beds.

Willow ward

Governance

There were a range of audits in place on the ward and the monthly clinical review using a trust-wide quality assurance tool was in use.

Leadership and culture

There was outstanding clinical leadership on Willow ward. The ward manager had a clear vision and had been supported by the trust to develop a service that was clinically led.

Staff felt well supported by the trust and the ward manager told us that the team had been given freedom to develop the service.

There was a system of supervision and management in place for staff which focused on key performance indicators and monitored staff performance in relation to care plans.

The ward manager told us he observed staff behaviour on the ward and got involved in managing incidents in order to model positive behaviour. The ward manager told us he was confident to go on leave as he knew staff would continue to provide a high standard of care.

Evenlode

Vision and strategy

Staff told us they were aware of the trust's vision and values and thought they were similar to the trust previously responsible for the service.

Governance

The ward manager and staff told us they carried out a range of audits to quality assure the service. Some staff commented that they did not think all the audits were tailored to their service, for example some elements of the kitchen audit were more suited to a hospital kitchen. The service was using a recently introduced monthly clinical review using the trust-wide quality assessment tool

Are services well-led?

Requires Improvement

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

and this had been completed for August but only partially for September. The action plan part of the tool was not complete and the ward manager told us they would like to have more time to complete these tools.

One of the occupational therapy team told us they were involved in a forensic audit group across the Southampton and Oxfordshire areas. They reviewed all the audits and looked at what worked or did not work. All tools generate an action plan. One person from the ward had been involved with a peer review of another unit.

The August clinical review identified the need for regular supervisions and these have now taken place, team meetings and ligature work. The ward manager was aware of the trust dashboard for quality but was not clear on how to access this. The ward had carried out an audit of physical interventions but staff told us the electronic system where the information was uploaded to did not provide ward level analysis to support effective monitoring.

Leadership and culture

Staff told us they were well supported locally and the ward worked well.

We noticed that the ward manager did not always appear confident in answering questions about the service, particularly in relation to governance arrangements and audits. We were told that the management arrangements had changed and the clinical services manager (who line managed the ward manager) had not been working on the ward since June. Staff commented that this person was the link between them and the rest of the trust. The ward manager told us that this was the person who knew where to go to sort things out such as invoices and whilst there had been some contact with the head of forensic services not enough had been put in place to provide alternative guidance and support. Staff felt very concerned about the lack of leadership.

Whilst senior staff were involved with meetings and networks across the trust the rest of the team did not have a clear link with the rest of the trust and did not fully identify with the trust they worked for. The ward was situated within buildings owned and run by another trust and was geographically isolated from the wider trust and senior management. Some staff commented that they only saw senior management from the trust if something was wrong. Staff received a bulletin from the trust which gave news on the trust and policy changes. Difficulties with the computer system access meant not all staff could easily access emails.

Staff were aware of the whistleblowing policy for the trust and who they could take concerns to. The majority of staff said they felt confident to report concerns affecting people's welfare and they would be acted on. Some staff told us they did not feel confident in raising concerns or that they would be listened to. Where staff had raised concerns they did not feel these were being addressed due to the leadership issues with the service.

Engagement with people and staff

Staff told us they had lead responsibilities and some staff were involved with project groups across the trust.

People told us they had weekly meetings where they could discuss things with staff. They also had community meetings and can get involved with how the ward is run. People told us they had not been involved with recruitment other than showing applicants around. The ward manager told us there had not been any recent recruitment to involve people with but this had been done previously.

Continuous Improvement

We were told by members of the multi-disciplinary team about their work to continually improve the service. Staff and people told us the environment needed to be improved but they were waiting for funding to be agreed for this.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered provider had not protected people at risk of inappropriate or unsafe care. There was not an effective system to ensure that all staff were aware of incidents either in their service or in other relevant services provided by the trust in order to reflect on this information and make changes to the treatment or care provided. This is a breach of Regulation 10(2)(c)(I)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The registered person must ensure that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises, by means of— (a) suitable design and layout: The trust must assess and remove ligatures at the Ridgeway Centre, complete the removal of ligatures at Evenlode, provide sufficient rooms with observation panels at the Ridgeway Centre, provide observation mirrors to improve the line of view at the Ridgeway Centre, ensure male service users can move around the building safely at the Ridgeway Centre and provide a secure external fence at Evenlode. This is a breach of regulation 15(1)(a)

Compliance actions

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The provider had not ensured that staff had received appropriate training to enable them to deliver care and treatment to service users safely and to an appropriate standard. The trust had not provided training, especially to support workers on caring for people with a learning disability, autism awareness, communication skills, training on mental health including how to support people with a personality disorder. This is in breach of Regulation 23 (1) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment The provider had not ensured that equipment was available in sufficient quantities in order to ensure the safety of service users. The emergency resuscitation equipment on Woodhaven was kept in one unit and was not easily accessible if it was needed in the other unit. This is a breach of Regulation 16 (2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The provider had not ensured that persons employed for the purposes of carrying on a regulated activity were appropriately supported in relation to their responsibilities.

Compliance actions

The ward manager and staff team at Evenlode had not received regular interim line management support in the absence of their usual line manager.

This is a breach of Regulation 23(1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The provider had not protected people against the risks associated with the unsafe use and management of medicines The trust had not ensured at Evenlode that treatment rooms are designed to facilitate the safe administration of medicines. The trust had not ensured at Evenlode and the Ridgeway Centre that Controlled Drugs are stored in accordance with trust policies. This is a breach of Regulation 13