Good

Oxford Health NHS Foundation Trust

Community-based mental health services for older people

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RNU10	Trust Headquarters	Older People CMHT and Memory Service- North Buckinghamshire	HP20 1EG
RNU10	Trust Headquarters	Older People CMHT and Memory Service - Central Oxfordshire	OX4 1XE
RNU10	Trust Headquarters	CMHT Older People- South Buckinghamshire	HP13 6PT

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated community-based mental health services for older people as good because:

- Documentation on patients care records was of a consistently good standard. Risk assessments were well recorded in all three teams and care plans were up-to-date, holistic, recovery-orientated and person-centered. We saw examples of thorough analysis of risk including crisis and contingency plans.
- All older adults' community mental health teams operated an extended-hours duty system. This acted as a single point of access and crisis team and could respond promptly to sudden deterioration in people's health. Patients referred in a crisis were seen within four hours. The duty team used a step-up and step-down model. Step-up services were aimed at preventing the need for hospital admission and step-down services facilitated discharge from hospital.
- Physical healthcare needs were routinely considered.
- All the teams were meeting their targets for referral to assessment times and memory clinics were meeting their targets for referral to diagnosis.
- Each team had a safeguarding lead and staff had good awareness of safeguarding procedures.
- Cognitive stimulation therapy, which is an evidence-based treatment for dementia that is recommended by NICE, was available in north Buckinghamshire and Oxford central.
- Staff had regular supervision that was of good quality.
- Staff in all the teams spoke and behaved in a way that was respectful, kind and considerate. Staff were knowledgeable and helpful.
- Patients told us that they felt able to make choices about their treatment.
- Managers demonstrated strong leadership. Staff felt supported by team managers and morale was good.

However:

- There were no fixed or portable alarms at Oxford central (Manzil resource centre) or south Buckinghamshire (Shrublands). Although there had not been any incidents as a result of the lack of alarms, staff may have been unable to summon help if required in an emergency.
- Current medication and prescription details were difficult to find on electronic care notes in all the cases that we looked at. We could not attribute any incidents to this, but it had the potential to result in medication errors and cause delays.
- Medication was kept in a room in the Whiteleaf centre that was too hot. Temperatures of fridges that were used to store medication in south Buckinghamshire had not been recorded for nearly 3 weeks.
- Access to the Manzil centre and Shrublands was difficult for people with poor mobility. Parking was very limited and cars blocked a disabled parking space outside the Oxford central team's building when we visited. The Shrublands building had a slope to the front door from the road, there were no handrails outside and the ground was uneven around a manhole cover beside the front door.
- Managers had difficulty getting quality reports for key performance indicators since the transfer from the RIO electronic patient record system to carenotes.
- Some rooms at Shrublands were at the far end of a corridor and were used by the memory service and for groups. Patients who left these rooms, for example, to use the toilet facilities, had to walk past an unsecured door that opened on to a stairwell and another door that opened into a kitchen, which had a wall-mounted water heater. There was a potential risk of a patient getting hurt if they went through these doors by mistake.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Risk assessments were well recorded in all three teams. We saw two examples of very thorough analysis of risk with crisis and contingency plans.
- All the teams had a duty system, which could respond promptly to sudden deterioration in people's health. Patients in crisis were seen within four hours.
- The duty teams used a "patient safety at a glance" board to rate risk. This gave a quick visual guide to all the patients that the duty team were involved with and was rated according to risk. There were daily teleconferences between the community teams and the inpatient wards and all patients who were RAG (red, amber, green) rated red were discussed. This meant that the ward could be aware of patients in crisis who may require admission and management plans were agreed.
- Caseloads were managed and reviewed in supervision. Caseload audits were undertaken. The Oxford central team had carried out a whole-team caseload review in August 2015 and were using a RAG rating scales to monitor the acuity and complexity of their caseloads.
- Each team had a safeguarding lead and staff had good awareness of safeguarding procedures.

However:

- There were no fixed or portable alarms for use at Oxford central (Manzil resource centre) or south Buckinghamshire (Shrublands). Few patients were seen at these buildings and two members of staff would attend if it was felt necessary. Although there had not been any incidents as a result of the lack of alarms, staff may have been unable to summon help if required in an emergency.
- Medication was kept in a room in the Whiteleaf centre that was too hot. Temperatures of fridges that were used to store medication in south Buckinghamshire had not been recorded for nearly 3 weeks.
- Current medication and prescription details were difficult to find on electronic care notes in all the cases that we looked at.

Summary of findings

It was necessary to find the most recent letter from the consultant to the patient's GP to find this information. We could not attribute any incidents to this, but it had the potential to result in medication errors and delays.

Are services effective?

Good

We rated effective as good because:

- Care plan documentation was of a consistently good standard.
- Team managers received NICE guidance updates via e-mail from the trust. They reviewed these and cascaded relevant updates to the teams.
- Cognitive stimulation therapy groups were available in north Buckinghamshire and Oxford central. Cognitive stimulation therapy is recommended by NICE as an evidence-based treatment for dementia.
- Physical healthcare needs were routinely considered.
- A range of outcome measures and symptom rating scales were used.
- An audit of consent to treatment in memory clinics had resulted in the development of a proforma, which covered consent to treatment, mental capacity assessment and consent to sharing information.
- Staff had regular supervision that was of good quality.

However:

- The trust had recently changed from using RIO electronic records to the carenotes system. Some information had not migrated accurately from RIO to carenotes. Social workers used care notes and either the Oxfordshire or the Buckinghamshire social services electronic systems. This meant that there was duplication of recording of some information.
- Annual appraisals had taken place but had not been written up.

Are services caring?

Good

We rated caring as good because:

- Staff in all the teams spoke and behaved in a way that was respectful, kind and considerate. Staff were knowledgeable and helpful, and took time with patients.

Summary of findings

- Patients told us that they felt able to make choices about their treatment and that they liked the fact that they saw the same staff members each time.
- There was a welcome pack for new patients of the older people's community mental health teams and the memory service. The packs had a range of useful information.
- Patients who needed help in an emergency said the teams had been quick to respond. Most carers we spoke to knew how to access help in an emergency.
- Information on carers support was available in the welcome packs. We spoke to carers who had received assessments of their own needs as carers and who had been referred to carers support groups.

However:

- We spoke to three patients who said they did not have a copy of their care plan and three people who did not feel that they were given enough information.
- Three out of five care plans in north Buckinghamshire and three out of eight care plans in Oxford central were not recorded to have been given to patients. This meant that staff could not demonstrate that they had provided a copy of the care plan in seven out of 13 cases.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Older people's community mental health teams were meeting their targets for referral to assessment times and memory clinics were meeting their targets for referral to diagnosis.
- None of the teams had waiting lists for allocation of a care co-ordinator.
- All older adults' community mental health teams operated an extended-hours duty system, which acted as a single point of access and crisis team for older adults. The duty team used a step-up and step-down model. Step-up services were aimed at preventing the need for hospital admission and step-down services facilitated timely discharge from hospital.
- The memory clinics had a low rate of patient DNAs (did not attend). They contacted patients the day before to remind them of their appointment. They used a variety of methods to contact them including text, phone and e-mail.

Summary of findings

- The north Buckinghamshire team were based in the Whiteleaf centre. This was a new, purpose-built building. The building was light and spacious with colourful artwork. There was a café for patients, staff and member of the public on site. There was a good range of interview rooms and therapy rooms with comfortable furniture.

However:

- Some rooms at Shrublands were at the far end of a corridor and were used by the memory service and for groups. Patients who left these rooms, for example, to use the toilet facilities, had to walk past a door that opened on to a stairwell and another door that opened into a kitchen, which had a wall-mounted water heater. There was a potential risk of a patient getting hurt if they went through these doors by mistake
- Access to the Manzil centre and Shrublands was difficult for people with poor mobility. Parking was very limited and a disabled parking space outside the Oxford central team's building was blocked by three cars when we visited. The south Buckinghamshire team building had a slope to the front door from the road, which would be difficult to negotiate for people with poor mobility and wheelchair-users. There were no handrails outside and the ground was uneven around a manhole cover to the side of the front door.

Are services well-led?

Good

We rated well-led as good because:

- Each team used a standard supervision proforma, which was thorough and covered staff well-being, performance management and clinical issues.
- Performance managers were responsible for overseeing key performance indicators. Commissioning for quality and innovation targets were monitored to ensure these were met.
- Managers were experienced and knowledgeable and demonstrated strong leadership of the teams.
- Morale was good and staff told us that they felt supported by team managers.
- Staff felt confident to raise concerns with managers and that these concerns would be acted upon appropriately. We observed an open culture between staff and team managers.

Summary of findings

- Staff were aware of duty of candour and were able to give us examples of having been open and honest when mistakes had been made, apologising for mistakes, and learning from them.
- Staff were participating in a range of quality improvement and innovative practice initiatives

However:

- None of the teams had achieved 100% completion rates for all mandatory training courses.
- Managers had been having difficulty getting quality reports for KPIs since the transfer from the RIO electronic patient record system to carenotes.

Summary of findings

Information about the service

Community mental health teams for older people provided specialist mental health services for people aged 65 and over who lived in Buckinghamshire and Oxfordshire. There were five teams across the two counties and each team incorporated memory assessment services. The teams provided mental health services in the community to people over 65 years of age who were experiencing functional illness such as severe depression, schizophrenia and bi-polar disorder and organic mental health problems such as dementia. People under the age of 65 who had dementia were also seen by the service.

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

The service was provided on weekdays during the hours of 9am to 8pm and at weekends from 9am to 5pm. Crisis out of hours provision was provided by the adult mental health team between 8am and 9am each day, from 8pm to 9pm each weekday and between 5pm and 9pm at weekends and on bank holidays.

The teams were as follows:

Oxfordshire:

- North community mental health team for older people, which was based in Banbury
- Central community mental health team for older people, which was based in Oxford
- South community mental health team for older people, which was based in Abingdon

Buckinghamshire:

- North community mental health team for older people, which was based in Aylesbury
- South community mental health team for older people, which was based in High Wycombe and in Amersham

We inspected community mental health services for older people at:

- North Buckinghamshire, based at the Whiteleaf centre in Aylesbury
- Oxford central, based at the Manzil resource centre in Oxford
- South Buckinghamshire, based at Shrublands in High Wycombe

Community mental health services for older people had not been inspected previously.

Our inspection team

The inspection team was led by:

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

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

and Substance Misuse, Care Quality Commission

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

The team that inspected this core service comprised a CQC inspector, a senior researcher in communication and respect for people with dementia who was also a registered nurse, a clinical psychologist and a social worker/approved mental health practitioner. An expert by experience (someone with lived experience of using mental health services) worked with the team for one day of the inspection.

Summary of findings

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited three community mental health teams for older people and three memory assessment services. These were incorporated within the community teams.
- spoke with 13 patients who were using the service.
- spoke with 15 carers of people who were using the service.
- observed four home visits.
- observed three clinic appointments, including a memory service assessment.
- observed a cognitive stimulation therapy group.
- spoke with the team managers for each of the teams.
- spoke with 26 other staff members; including doctors, nurses, social workers, occupational therapists, psychologists, support workers and admin workers.
- interviewed the divisional director with responsibility for these services.
- attended and observed two multi-disciplinary meetings, a duty handover, a teleconference meeting between one of the teams and an inpatient ward, and a memory clinic meeting.
- looked at 20 electronic care records and six medication charts.
- carried out a check of the equipment in clinic rooms.
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We received mainly positive comments from patients and carers. Staff were described as kind and respectful and patients and carers felt involved in choices about their care and treatment. Patients told us they were given information about medication and its side effects. One patient told us that "you get the feeling they are on your side" and another person said they did not know how they would have coped without the service.

However, a carer of someone who had been seen by the memory service said it would be helpful if carers were offered an opportunity to talk about the person's symptoms without the person being there, as it was not always comfortable to do this in front of the person for whom they were caring. Another carer had not felt they were offered enough support after the person she cared for was given a provisional diagnosis of dementia. Five people told us that they had not been given information about how to complain.

Summary of findings

Good practice

- All older adults' community mental health teams operated an extended-hours duty system, which acted as a single point of access and crisis team for older adults. The duty team used a step-up and step-down model. Step-up services aimed to prevent the need for hospital admission and step-down services facilitated timely discharge from hospital. Duty workers were available from 9am to 8pm Monday to Friday and 9am to 5pm Saturday, Sunday and bank holidays. A psychiatrist was available to support the duty workers on a daily basis.
- The Buckinghamshire teams were involved in a project to provide memory assessments in GP surgeries. This was called memory assessment closer to home.
- The older adult community mental health service were engaged in the dementias and neurodegeneration DeNDRoN study (a longitudinal study of dementia). They were actively recruiting patient participants through the memory clinics.
- The memory service in Oxford central had included the Hopkins Verbal Learning Test in their assessments in response to referrals of people who had been able to learn the standard memory tests despite showing signs of memory loss. The team had found this additional tool helpful in assessing people with very high levels of educational achievement.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should make fixed or portable alarms available for staff to use in all buildings where patients are seen.
- The trust should ensure that fridge and room temperatures where medications are stored are checked regularly and action taken if they are not within guidelines for safe storage of medication.
- The trust should ensure that information about current medication and prescription details are easily accessible.
- The trust should ensure that disabled parking spaces are kept clear so that people with disabilities can use them. The trust should review access to buildings for people with limited mobility to ensure they can be accessed safely.

Oxford Health NHS Foundation Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Older People CMHT and Memory Service- North Buckinghamshire	Trust Headquarters
Older People CMHT and Memory Service - Central Oxfordshire	Trust Headquarters
CMHT Older People- South Buckinghamshire	Trust Headquarters

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.

All eligible new staff had received Mental Health Act training. Mental Health Act refresher training was required every three years. 91% had completed this in North Buckinghamshire, 88% in south Buckinghamshire and 88% of eligible staff in Oxford Central

Two patients were on community treatment orders (CTOs) at the time of our inspection. We did not check CTO paperwork as it was not available because it was held by the trust's Mental Health Act administrators. We looked at electronic health records for two patients subject to section 117 aftercare. Section 117 imposes a duty on health and social services to provide aftercare services to certain patients who have been detained under the Mental Health Act. Although the legal paperwork was not available for us to check the recording on care records was of good quality.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had received training in the Mental Capacity Act (MCA). Staff demonstrated a good awareness of the Mental Capacity Act and this was embedded in daily practice.

Recording of capacity assessments was clear and thorough where it was evident that the patient showed signs of impaired capacity to make some decisions about their care and treatment.

The welcome pack for the memory service contained information about lasting power of attorney (LPA) and advance statements. LPA is a way of giving a person you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future. An advance statement can be used to express wishes about future care options.

The deputy manager at Oxford central had recently completed a master's degree in improving compliance with the MCA in older people's community mental health teams and provided training and support to the team to develop their understanding and use of the Act.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- There were portable alarms for use in the interview rooms at the Whiteleaf Centre. These were kept in a secure cabinet in reception and there was a system for signing them in and out. However, there were no fixed or portable alarms for use at Oxford central (Manzil resource centre) or south Buckinghamshire (Shrublands). Few patients were seen at these buildings as most people were visited at home although patients did sometimes use both sites and two members of staff would attend if it was felt necessary. Although there had not been any incidents as a result of the lack of alarms, that staff may be unable to summon help if required in an emergency.
- There was limited equipment for undertaking physical health monitoring as most physical healthcare checks were carried out by patient's GPs. However, there was blood pressure monitoring equipment and weighing scales. These had stickers on them showing they had been checked and the date that they were next due for checking.
- The north Buckinghamshire team were based in the Whiteleaf centre. This new, purpose-built building provided very spacious facilities and was clean and well maintained. The Oxford central team and south Buckinghamshire team were in older accommodation but both were well maintained, clean and in good decorative order.

Safe staffing

- Vacancy rates were low for all the teams. The Oxford central team had recently received additional funding for two posts and had recruited a social worker to one of these roles. One member of occupational therapy (OT) staff was on maternity leave and attempts to find a temporary replacement had been unsuccessful. The north Buckinghamshire team had very low staff turnover resulting in a well-established team. Sickness was 1.2 %, which was below the trust average of 3.6%. The south Buckinghamshire team had 1.7 whole-time equivalent (wte) vacancies for qualified staff and 1.0 wte consultant psychiatrist post, which had been filled by a locum for the past year. There was no long-term sickness within the team at the time of the inspection. All the teams had sufficient consultant psychiatrist sessions to meet the Royal College of Psychiatrists guidelines.
- The operational policy for the service stated that they planned to move towards an indicative maximum team caseload of 30 patients per full-time care co-ordinator. We looked at caseloads in all three teams. The highest caseload for a full-time nurse was 37. Most caseloads were between 20 and 31. Social workers tended to have slightly lower caseloads due to the higher level of complexity of the patients they worked with. Staff would also be on the duty rota at least one weekend a month and one late shift per week. A late shift would end at 8pm on weekdays. Staff told us their caseloads were manageable unless they had to do a lot of additional duty work.
- The trust was unable to provide detailed information about waiting times for allocation of a care co-ordinator. Team managers told us that there were no targets for allocation of a care co-ordinator within the service. However, a care coordinator would be allocated immediately a patient was admitted to hospital and other patients would be held by the duty team until a care co-ordinator was allocated. This meant that there would not be anyone who did not have a named person to contact. We observed this in practice when we attended a multi-disciplinary team meeting and a patient had been admitted to the inpatient ward.
- Caseloads were managed and reviewed in supervision. Caseload audits were undertaken. The Oxford central team had carried out a whole-team caseload review in August 2015 and were using a RAG (red, amber, green) rating scale to monitor the acuity and complexity of their caseloads.
- Arrangements were made to cover for sickness, leave and vacant posts. Urgent casework was covered by duty. Another clinician would cover if someone was absent for a long period of time.
- There was little use of bank or agency staff. The Oxford team was using no agency staff although this was due to

be considered if a temporary OT could not be found to cover maternity leave. The north Buckinghamshire team were appropriately using locum staff to fill a social work post that they had been unable to recruit to and a locum nurse to cover for someone who was working elsewhere on secondment. The south Buckinghamshire team had a locum consultant psychiatrist who had been working within the team for a year.

- All the teams felt that they could get rapid access to a psychiatrist when required. Consultant psychiatrists worked a one in six on-call rota and felt this was reasonable. There was a separate pool of section 12 doctors to undertake assessments under the Mental Health Act, although the consultants told us they would attempt to undertake these assessments on patients that they knew.
- Mandatory training was divided in to personal and patient safety training (PPS) and clinical care and competency skills (CCCS). In north Buckinghamshire, the team had achieved 94% PPS and 83% CCCS. The lower level was due to limited availability of some courses. The team manager had an action plan to spread re-training dates more evenly throughout the year so that the whole team did not require re-training within a very short space of time. The Oxford central team had 94% PPST and CCCS was 84% and had escalated their concerns regarding lack of availability of some CCCS courses to the Director of Nursing. The training dashboard provided by the trust confirmed that all the older adults' community mental health teams were falling below target on classroom based courses relating to pressure sores. The team manager in Oxford central had mitigated against the lack of availability of medication management training by arranging for a pharmacist to train the team. The south Buckinghamshire team were at or below 80% completion rates for three-yearly safeguarding children's training, some elements of resuscitation training and infection prevention and control. All three team were below 90% for clinical risk assessment and management training.

Assessing and managing risk to patients and staff

- We looked at risk assessments in 20 sets of electronic care records and found that these were well recorded in all three teams. Seven out of seven risk assessments in south Buckinghamshire had up-to date assessments and we saw two examples of very thorough analysis of risk with crisis and contingency plans. Seven out of eight records in Oxford central had up-to-date risk assessments but one had no assessment of risk documented. We observed risk being assessed thoroughly at a memory clinic assessment at south Buckinghamshire.
- All the team had a duty system that could respond promptly to sudden deterioration in people's health and allowed good access to help at times of crisis. There were two qualified staff on duty from 9am until 8pm on weekdays and 9am until 5pm at weekends and bank holidays. Crisis referrals were seen within four hours. Out of hours work was covered by the adult services and trust wide night team. All work was handed over to the older person's team in the morning. We observed duty workers in all three teams. They provided care to prevent admissions and to support timely discharge from hospital. We asked patients and carers to share their experience of accessing help in crisis. Those people who had used the duty system had been able to get help quickly and easily and gave positive feedback about the service.
- None of the teams we inspected had waiting lists. The duty teams used a PSAG (patient safety at a glance) board to rate risk. This gave a quick visual guide to all the patients that the duty team was involved with, and was rated according to risk. (red, orange, green) We observed a daily teleconference between the Oxford central team and the inpatient ward and saw that all patients who were RAG rated red were discussed so that the ward could be aware of patients in crisis who may require admission and management plans were agreed.
- Safeguarding training was mandatory. Safeguarding vulnerable adults training was required three yearly and could be undertaken as e-learning or classroom based. 100% of staff in north Buckinghamshire, Oxford central, and 82% of staff at south Buckinghamshire were up-to-date. All eligible staff in Oxford central and 18 out of 19 eligible staff in north Buckinghamshire had undertaken three yearly safeguarding children training, although only 75 % of south Buckinghamshire staff were up-to-date. Each team had a safeguarding lead and there was good awareness of safeguarding procedures. We observed safeguarding being discussed in multi-disciplinary team meetings. Staff at Oxford central told

Good

Are services safe?

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

us that they received regular updates on safeguarding from the lead worker and they were able to give us examples of how they would respond to safeguarding concerns. We looked at the quality of recording of safeguarding information in two sets of electronic case notes in Oxford central and found that this was clearly documented.

- All the teams had safe lone-working procedures. These included using in/out boards and calling in at the end of the day. Staff had mobile phones. Team managers kept contact sheets for staff with their personal details including details of their car. Staff worked in pairs if necessary.
- Medication management varied. The north Buckinghamshire team kept medication in a locked cabinet and fridge temperatures were recorded daily. However, medication was kept in a room that was too hot (28 degrees centigrade) but staff were aware, checked regularly and tried to keep the room cool by opening the window. The Oxford central team did not keep medication on the premises but obtained it from the nearby pharmacy when needed. In south Buckinghamshire, drug charts and medication was kept in a locked cabinet and medication that required refrigeration was kept in a locked fridge. However, the fridge temperature had not been recorded for nearly 3 weeks. We reviewed training records for mandatory medicine management training. There were two types of e-learning module. Only 33% of eligible staff in north Buckinghamshire had completed the training, and 50% in the south Buckinghamshire and Oxford central teams.
- We looked at recording of medication in electronic care notes. Current medication and prescription details were difficult to find on care notes in all the cases that we looked at and it was necessary to track through to find the most recent letter from the consultant to the patient's GP. We could not attribute any incidents to this, but it had the potential to result in medication errors and could cause delay.

Track record on safety

- There had been no serious incidents requiring investigation in the last 12 months for north Buckinghamshire or Oxford central. There had been two suspected suicides of patients of the south Buckinghamshire team in the past 12 months, one of which was within the previous month.
- Changes in practice had been made as a result of learning from incidents. Although the teams had not yet received any formal lessons learnt from the recent suspected suicide, the south Buckinghamshire team had reviewed supervision for clinical staff. They were now including regular discussion of patients who had been on a clinician's caseload long-term. Case notes had been reviewed to check for risk assessments and quality of recording.

Reporting incidents and learning from when things go wrong

- The trust used the Ulysses system for incident reporting. Staff were able to demonstrate how to use this and could give examples of what should be reported.
- Staff were aware of duty of candour and were able to give us examples of having been open and honest when mistakes had been made, apologising for mistakes, and learning from them. Incidents were discussed at monthly team meetings. The Oxford central team had received a training session from the trust's risk team to develop their understanding. All the older people's community mental health team managers and ward managers attended clinical governance team meetings where lessons learnt from incidents were shared so that they could be disseminated to staff in the teams.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- We observed an initial assessment in a memory clinic. This was thorough, with a comprehensive interview, and consideration of the result of a CT scan, Montreal cognitive assessment and "activities of daily living" report. The memory clinic's referral protocol required patient's GP to undertake a full physical health check and dementia screen prior to referral.
- We reviewed 20 electronic care records and saw that care plan documentation was of a consistently good standard. All the patient records we looked at had up-to-date care plans. All the care plans were holistic, recovery orientated and personalised.
- The trust had recently changed from using RIO electronic records to the carenotes system. This was a secure electronic system. Some information had not migrated accurately form RIO to carenotes. For example, three weeks of memory clinic appointments had not been accessible on the new system. However, managers told us that the trust's IT department were helpful in resolving these difficulties and teams had found ways around the problems so that no serious incidents had occurred. Social workers used carenotes and either the Oxfordshire or the Buckinghamshire social services electronic systems. This meant that they had duplication of recording of some information.

Best practice in treatment and care

- Team managers received national institute for health and clinical excellence (NICE) guidance updates via e-mail from the trust. They reviewed these and cascaded relevant updates to the teams. We saw the shared-care protocol for acetylecholinestarase inhibitors and memantine, which included references to NICE guidance, information on drug interactions, dosages, contra-indications and side-effects along with details of the responsibilities of the GP and the consultant psychiatrist. We observed a duty team member provide guidance to a GP to avoid inappropriate use of anti-psychotic medication for a patient with dementia.
- Psychological therapies were available. North and south Buckinghamshire had 1.8 whole time equivalent psychology provision and Oxford central had a full time clinical psychologist. Approximately two thirds of referrals were for neuropsychology and the remainder for therapy. A range of therapies were available including cognitive behavioural therapy, anxiety management, family therapy, and psychodynamic psychotherapy. Waiting times were approximately three months for neuropsychology assessments and four months for therapy. We observed a cognitive stimulation therapy (CST) group in north Buckinghamshire. CST is recommended by NICE as an evidence-based treatment for dementia. The group had a clear function and purpose and was well attended although the group had to be adapted to accommodate the needs of a rural community by running one long session per week rather than two shorted sessions. It was unclear whether this would affect the efficacy of the therapy.
- Physical healthcare needs were routinely considered. We looked at 15 sets of electronic healthcare records to check if physical healthcare was monitored. 14 out of the 15 showed an evaluation of physical health. The notes of a patient prescribed lithium showed that the GP was checking lithium levels and that the mental health worker had checked that these were within normal range. All patients referred to the memory service were required to have undergone a physical healthcare check prior to referral and we observed a memory clinic assessment where physical healthcare was considered. Mental health staff monitored blood pressure and weight, but all other physical health checks were managed by GPs. However, there was no system for ensuring annual health checks were undertaken. We were told that this was not a commissioning requirement.
- A range of outcome measures and symptom rating scales were used including health of the nation rating scales, Montreal cognitive assessment (MoCA), hospital anxiety and depression scale, and the geriatric depression scale. We looked at the use of clustering and HoNOS in 13 sets of electronic records and found that this was up-to-date in all of them. We observed a memory clinic assessment where MoCA was used and this was done in a way that showed understanding and sensitivity. Psychologists used satisfaction surveys and the core outcomes in routine examination system (CORE-OM). This is a 34-item generic measure of psychological distress, which was used to monitor the

Are services effective?

Good

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effectiveness of their interventions. The cognitive stimulation therapy groups used MoCA, CORE-10 (a brief version of CORE-OM) and QOL-AD (quality of life – Alzheimer's disease) to evaluate the effectiveness of the therapy.

- The duty teams undertook a daily audit to help them understand the range of issues that they were dealing with. All the teams had recently undertaken the memory service national accreditation scheme which had led to them undertaking a range of audits for the purpose of learning and service improvement. An example of this was an audit of consent to treatment in memory clinics, which resulted in the development of a proforma that covered consent to treatment, mental capacity assessment and consent to sharing information.

Skilled staff to deliver care

- All of the teams had a full range of mental health disciplines including social workers and occupational therapists. Some nurses were trained as nurse prescribers. The north Buckinghamshire team were having difficulty recruiting social workers and had put this on their risk register.
- The teams all had experienced staff and there was low staff turnover. Qualified staff were employed at band 6, which reflected their level of experience.
- New staff undertook trust induction and a local induction. Unqualified staff were able to complete the care certificate.
- Staff had regular supervision that was of good quality. There was an electronic recording system that recorded dates of supervision. This enabled managers to ensure regular supervision was taking place. Most staff kept written notes but were being encouraged to use the electronic system to record supervision notes. We looked at the standard supervision proforma that the Oxford central team used. This was thorough and included well-being, caseload, and performance within the team, training, leave, development and leadership. The south Buckinghamshire team included a random review of case records in each supervision session.
- Annual appraisals were taking place. In north Buckinghamshire and Oxford central team 100% of staff had been appraised or were booked in for an appraisal. 95% of staff had been appraised in south Buckinghamshire. We reviewed the quality of appraisals in Oxford central and found they were thorough and clear, with specific and measurable objectives and timelines. However, none of the teams had completed all the formal write-ups of the appraisals.
- Consultant psychiatrists spoke positively about the quality of medical appraisals and their re-validation programme.
- Clinical supervision training was a mandatory e-learning course. All three teams were above the 90% target for completion.
- Consultants told us that continuing professional development (CPD) was supported by the trust and there were quarterly CPD meetings for medical staff. Training for non-medical staff included courses on dementia, delirium, anxiety disorders, personality disorder and psychological therapies. Nurses were able to undertake nurse prescribers training. The Oxford central team had a team training and development session once a month. Advanced assessment training was available for all staff.

Multi-disciplinary and inter-agency team work

- We observed two multi-disciplinary team meetings. They were both well attended and detailed holistic discussions took place. We observed a patient-centred and respectful approach. Risk and safeguarding concerns were discussed. We observed a presentation that was given to the Oxford central team. This gave an update from around the locality and included learning from incidents from other teams within the locality.
- The duty teams had handover meetings, and we observed teleconference meetings that the north Buckinghamshire team and Oxford central team held on a daily basis with the inpatient wards. These meetings took place seven days a week to discuss patients who may need an admission and those who were in hospital and ready for discharge back to the community.
- There were close links with social services. The senior adult social care practitioners within the Oxford central team could agree funding for care up to a set amount. This meant that standard care packages could be arranged without delay. There was a clear process for obtaining funding at higher levels. In Buckinghamshire, there was a social care lead who was a budget holder

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and could authorise up to four weeks respite. High cost packages of care had to be agreed by a funding panel, and this included emergency care. Interim funding was available to facilitate discharge form hospital so that this did not have to be delayed to obtain panel approval. The Oxford central team was due to be re-located to a site which would also house reablement workers and podiatry. Whilst awaiting relocation, meetings took place every 2 months between the different teams to discuss staffing, best practice, and appropriate cases.

Adherence to the Mental Health Act and Code of Practice

- We looked at staff training records in north Buckinghamshire all eligible new staff had received Mental Health Act training. Mental Health Act refresher training was required every three years. 20 out of 22 staff (91%) had completed this in North Buckinghamshire, 21 out of 24 (88%) in south Buckinghamshire and 15 out of 17 (88%) eligible staff in Oxford Central.
- Two patients were on community treatment orders (CTOs) at the time of our inspection. We did not check CTO paperwork as it was not available. This was because it was held by the trust's Mental Health Act administrators. We looked at electronic health records for two patients subject to section 117 aftercare. Section 117 imposes a duty on health and social services to provide aftercare services to certain patients who have been detained under the Mental Health Act. Although the legal paperwork was not available as it was held by the Mental Health Act administrators, the recording on care records was of good quality.
- We looked at recording of consent to treatment in patient's electronic records. This was clearly recorded in all of the care records we reviewed. Consent to treatment forms were included in a shared-care agreement between Buckinghamshire Healthcare, Buckinghamshire NHS and Oxford Health for acetylcholinestarase inhibitors and memantine for the treatment of Alzheimer's disease.

Good practice in applying the Mental Capacity Act.

- We looked at training records in north Buckinghamshire. All staff had received training in the Mental Capacity Act (MCA). MCA training was included in the trust induction for new staff. The teams were 100% compliant for this training.
- Staff demonstrated a good awareness of the Mental Capacity Act and this was embedded in daily practice. We looked at assessments of mental capacity at south Buckinghamshire and found that this was recorded on all seven of the records we reviewed.
- Staff in the Oxford teams had to provide capacity and best interest assessments when applying for local authority funding for care. All qualified mental health staff completed these assessments. The deputy manager at Oxford central had recently completed a master's degree in improving compliance with the MCA in older people's community mental health teams and provided training and support to the team to develop their understanding and use of the Act. Both Buckinghamshire teams were required to complete capacity forms to obtain funding for care from the local authority. Social workers used a capacity tool kit on the Buckingham county council electronic records. Capacity and consent were recorded on local authority electronic records.
- We looked at the recording of capacity assessments in five sets of patient records in north Buckinghamshire. Documentation about capacity was clear and thorough where it was evident that the patient showed signs of impaired capacity to make some decisions about their care and treatment.
- The welcome pack for the memory service contained information about lasting power of attorney (LPA) and advance statements. LPA is a way of giving a person you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future. An advance statement can be used to express wishes about future care options. We observed a memory clinic appointment and saw that LPA was discussed with the patient and their carer.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed a range of interactions between staff and patients. This included home-visits, clinic appointments, a therapy group and telephone calls. Staff in all the teams spoke and behaved in a way that was respectful, kind and considerate. We saw duty staff manage calls in a way that was responsive and provided reassurance. Staff were knowledgeable and helpful and took time with patients.
- We spoke to 13 patients and 15 carers and asked them how staff behaved towards them. We were given very positive feedback. Patients told us that they felt able to make choices about their treatment and that they liked the fact that they saw the same staff members each time. We were told that staff were kind and respectful.

The involvement of people in the care they receive

- There was a welcome pack for new patients of the older people's community mental health teams (OPCMHT) and the memory service. The packs for OPCMHT had a range of information including a letter with space for completing the name of the care coordinator, psychiatrist and office phone number; information on care plans and risk assessments, advance statements, the patient advice and liaison service, and how to become a member of the foundation trust. The memory service pack had a similar range of appropriate information.
- A patient in north Buckinghamshire told us her psychiatrist had worked with her to reduce her medication successfully and that she had emergency numbers and a copy of her care plan. She said she felt involved in her care. A carer of a patient from the same team told us that they had been involved in writing the care plan of the person they cared for.
- A patient in Oxford central showed us his copy of his care plan. It was detailed, person-centred and had a clear crisis plan. A carer of a patient that we spoke it in Oxford central also had a copy of their care plan.
- We observed a patient appointment in south Buckinghamshire and saw that the patient was involved in making decisions about their care and that they were offered choices. We went on a home visit with a staff member and the patient told us they had a copy of their care plan. We spoke to a patient who had needed to get help in an emergency on two occasions and said that the team had been quick to respond.
- However, we spoke to three patients who said they did not have a copy of their care plan and three people who did not feel that they were given enough information. Three out of five care plans in north Buckinghamshire and three out of eight care plans in Oxford central were recorded to have been given to patients. This meant that staff could not demonstrate that they had provided a copy of the care plan in seven out of 13 cases. Two people told us that they felt it took too long to get an admission to hospital and that they did not like the way that inpatient wards no longer separated people with functional illness, such as depression, from people with dementia.
- Most carers that we spoke to had received information and knew how to access help in an emergency. Information on carers support was available in the welcome packs. We spoke to carers who had received assessments of their own needs as carers and who had been referred to carers support groups.
- However, a carer of someone who had been seen by the memory service said it would be helpful if carers were offered an opportunity to talk about the person's symptoms without them being there, as it was not always comfortable to do this in front of the person they were caring for. One carer told us that they had sought a second opinion which had resulted in a change of diagnosis from dementia to Parkinson's disease, and another carer had not felt they were offered enough support after the person she cared for was given a provisional diagnosis of dementia.
- POhWER and Age Concern provided information, advice, support and advocacy services. Most staff we spoke to knew how to access advocacy services and we spoke to two patients who had used advocacy services. However, information about advocacy and complaints were not discussed at a memory service outpatient appointment that we observed in south Buckinghamshire and we were not able to find advocacy leaflets in the waiting area.

Good

Are services caring?

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- The welcome packs contained a feedback form for people to give their views about the usefulness of the pack
- The memory service in north Aylesbury undertook a quarterly postal survey. We were told that the most recent report on the results had been in July and had been mostly positive.
- The memory assessment clinics had recently undergone accreditation with the memory service national accreditation scheme which had included the views of patients and carers

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- Target times for referral to assessment were four hours for emergency and crisis referrals; five working days for urgent referrals and 20 working days for routine referrals. Memory clinic targets were 40 days from referral to assessment. There were no targets for assessment to treatment timescales except for the memory service. Older people's community mental health teams (OPCMHT) and memory services were meeting their targets. The mean times from referral to assessment for OPCMHTs was two days for urgent referrals and ten days for non-urgent.
- Team managers were unable to directly report on waiting times using the new electronic records system (carenotes) but were keeping their own records until electronic reports were available. North Buckinghamshire were able to show that they were 100% compliant for older people's community mental health team referral to assessment targets and 96% compliant for the memory service.
- None of the teams had waiting lists for allocation of a care co-ordinator. All patients that were admitted to an inpatient ward were allocated a care co-ordinator on admission or managed by the duty teams.
- The Oxfordshire teams had completed 100% of seven-day follow ups from April to August 2015. The Buckinghamshire teams breached the target three times out of 31cases. Two of these were by one day. The third was an informal patient who was initially discharged on a period of trial leave from hospital and received follow up during that period. Seven day follow-up compliance was overseen by the performance and administration managers.
- Recent commissioning changes had led to strict transfer arrangements from adult services. This meant that all patients receiving a service from the adult community mental health team were to be transferred to the older adult community mental health teams when they reached their 65th birthday. This had created transfer arrangements based on age rather than need although people with dementia who were under age 65 were all care co-ordinated by the older adults community mental health teams.
- All older adults community mental health teams operated an extended-hours duty system, which acted as a single point of access and crisis team for older adults. The duty team used a step-up and step-down model. Step-up services were aimed at preventing the need for hospital admission and step-down services facilitated timely discharge from hospital. Duty workers per team were available from 9am to 8pm Monday to Friday and 9am to 5pm Saturday, Sunday and bank holidays. A psychiatrist was available to support the duty workers on a daily basis. Out of hours cover was provided by the adult community mental health team.
- We spoke to the duty teams and observed them in practice at all three of the teams that we inspected. We observed the Oxford central team handle an urgent referral and saw that they responded effectively and within their target timescales. We spoke to patients who had used the duty system who told us that they had been able to get help quickly and easily.
- Although the step-up system of the duty team provided effective support to avoid hospital admission, we heard from staff and carers in Oxford central that it could be difficult to find a bed when a patient did need to be admitted to an inpatient ward. Two carers told us about the stress they had experienced when they felt that the person they cared for remained at home longer than they could cope with.
- There were clear eligibility criteria which stated that services would be provided in the community to people who were over 65 years old and experiencing functional or organic mental health problems, and younger people with dementia. Examples of functional illnesses are depression, bi-polar disorder and schizophrenia. Organic illness refers to dementia including Alzheimer's disease. Services included assessment and diagnosis, psychological intervention, medication management, support, advice and health information. Memory clinics provided diagnosis of dementia and treatment and support for people newly diagnosed with dementia.
- We observed the memory clinic staff in north Buckinghamshire working to engage a new patient who did not feel they needed to be seen by the service. This was done in a skilled way so that the patient was kept informed and remained engaged and was able to express choices regarding the next stage of the assessment.

Are services responsive to people's needs?

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- The memory service in Oxford central had included the Hopkins Verbal Learning Test in their assessments in response to referrals of people who had been able to learn the standard memory tests despite showing signs of memory loss. The team had found this additional tool helpful in assessing people with very high levels of educational achievement.
- The memory clinics had a low rate of patient DNAs (did not attend). They contacted patients the day before to remind them of their appointment. They used a variety of methods to contact them including text, phone and e-mail. Staff in the older people's community mental health teams telephoned patients who did not attend.
- The trust was unable to provide information on the number of appointments that were cancelled from April 2015 due to problems with data migration from the RIO electronic system to carenotes. However, the clinic appointments that we observed started on time and we did not receive any feedback from patients or carers that would lead us to believe that appointments were cancelled unnecessarily.

The facilties promote recovery, comfort, dignity and confidentiality

- Most people were seen in their own homes. The north Buckinghamshire team were based in the Whiteleaf centre. This was a new, purpose-built building. The building was light and spacious with lots of colourful artwork. There was a café for patients, staff and member of the public on site. There was a good range of interview rooms and therapy rooms with comfortable furniture. The building was clean and well maintained. The buildings at Oxford central and south Buckinghamshire were older and did not offer purpose-built facilities, however they were clean and well maintained but they did not have dementia-friendly signage. For example, there was a lack of signs to assist people with memeory problems to find their way around the building and the sign at the entrance of the building was unclear. There was a lack of interview rooms at Oxford central but very few people were seen on the site. The south Buckinghamshire site had previously been a day hospital and had a selection of large comfortable rooms which were suitable for therapies and activities. However, some rooms were at the far end of a corridor and were used by the memory service and for groups. Patients who left these rooms, for example, to use the toilet facilities, had to walk past a door that opened on to a stairwell and another door that opened into a kitchen which had a wall-mounted water heater. We were told that patients were always accompanied through the building by staff and we were not aware of any incidents arising from this.
- Interview rooms at the Whiteleaf centre had adequate sound-proofing. We did not test the sound-proofing at Oxford central. A room in south Buckinghamshire had poor soundproofing so that voices could be heard in the corridor. However, few patients were seen in the building and it was unlikely that anyone other than staff would be able to over-hear.
- The team at Oxford central adapted their welcome packs to individual patients to ensure the amount of information was not overwhelming. All the teams had a range of information available.

Meeting the needs of all people who use the service

- The north Buckinghamshire team building at the Whiteleaf centre was in a purpose built building with level access, lifts and an evacuation chair at the top of stairs in case the lifts were out of use. There were disabled toilets on both floors of the building. There was a large car park in front of the building. At Oxford central there was a disabled parking space outside the building, but on the day of our inspection it was blocked by three cars. We were told that Wednesday was the worst day for parking due to meetings and patients were rarely seen at the building. There was level access into the building and a disabled toilet. The south Buckinghamshire team building had a slope to the front door from the road which would be difficult to negotiate for people with poor mobility and wheelchair-users. There were no hand rails outside and the ground was uneven around a manhole cover beside the front door. Staff cars were parked in front of the building which made access via the slope more difficult. There was a raised area at the bottom of the entrance door. There was no allocated disabled parking. There was on-road parking with parking meters. Signage outside the building was not clear. We asked patients and carers for their views about the building's access. Most had not been there as the teams tried to see people in their own homes. However, memory service appointments took place in the building and one carer said the person she

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cared for had mobility difficulties and she thought access would be very difficult in winter. We saw that administration staff went to meet people at the door when they arrived.

- Leaflets in waiting rooms were in English but there was information about accessing them in different formats and languages on the back. Staff were able to print information leaflets from the trust intranet in a variety of languages.
- Interpreting services were available.

Listening to and learning from concerns and complaints

- There had been two formal complaints in the last 12 months. These had both been resolved. Attempts were made to manage complaints at a local level by team managers. This approach meant that they rarely progressed to formal complaints. Managers gave us examples of apologising to patients and carers when mistakes had been identified. Staff knew about duty of candour. Complaints were discussed in team meetings so that staff could learn from them.
- Welcome packs contained information on complaints and the patient advice and liaison service. However, we spoke to 13 patients and 15 carers. Five people told us that they had not been given information about how to complain. Most people who did not know about the formal complaints procedure said they would ring the staff member that they see if they needed to make a complaint.

Are services well-led?

Good

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

Our findings

Visons and values

- Staff were able to tell us the trust's values.
- Staff in the Buckinghamshire teams told us that the head of service visited regularly. We were also told by staff that board members sometimes visited the teams.

Good governance

- Mandatory training was divided in to "personal and patient safety" training and "clinical care and competency skills". None of the teams had achieved 100% completion rates for all courses. However, team managers had a clear system for monitoring mandatory training and had escalated issues around insufficient availability of some courses to their senior managers. The Oxford central team had worked creatively to obtain training on medicine management from a pharmacist when trust courses were not available to them.
- Staff spoke very positively about the quality of supervision that they received. All three teams were above the 90% target for completion of clinical supervision training. Caseloads were managed and re-assessed in supervision. There was an electronic recording system that recorded dates of supervision which meant that managers were able to ensure that supervision was taking place. Each team used a standard supervision proforma which was thorough and covered staff well-being, performance management and clinical issues.
- The trust used the Ulysses system for incident reporting. Staff were able to demonstrate how to use this and could give examples of what should be reported.
- Staff undertook a range of local audits in addition to taking part in national audits. National audits included the prescribing observatory for mental health (POMH-UK) topic 4b prescribing anti-dementia drugs and POMH-UK topic 6 assessment of the side effects of depot medication in older people's and adult services. Local audits included caseloads and duty work. The safeguarding lead in Oxford central undertook a monthly safeguarding audit of referrals and outcomes. A memory service capacity and consent case note audit had led to a service-wide registration form being developed.
- All the older people's community mental health team managers and ward managers attended clinical governance team meetings where lessons learnt from incidents were shared so that they could be disseminated to staff in the teams. Complaints and incidents were discussed in team business meetings. The teams had learned from an incident which had highlighted poor record keeping and as a result had incorporated random reviews of case notes by managers and regular checking of case notes as part of supervision.
- Safeguarding vulnerable adults training had been completed by 100% of staff in north Buckinghamshire and Oxford central and 82% of staff at south Buckinghamshire. Each team had a safeguarding lead and there was good awareness of safeguarding procedures. Safeguarding was discussed in multi-disciplinary team meetings and safeguarding information was clearly documented. All staff had received training in the Mental Capacity Act. Staff demonstrated a good awareness of the Mental Capacity Act and this was embedded in daily practice. Recording of capacity assessments was clear and thorough. The majority of eligible staff had received Mental Health Act training and record keeping for patients subject to section 117 aftercare was of good quality.
- Performance managers were responsible for overseeing key performance indicators (KPIs). There had been difficulty getting quality reports for KPIs since the transfer from the RIO electronic patient record system to carenotes. However, the trust IT team were working to resolve this problem. The teams were meeting targets such as referral to assessment times and memory clinic referral to diagnosis targets. Commissioning for quality and innovation targets were monitored to ensure these were met.
- Administration teams had recently been remodelled and included a performance and admin manager role to oversee performance. There was a clear operational structure and governance arrangements. Managers were experienced and knowledgable and demonstrated strong leadership of the teams.
- The risk register for older people's mental health was reviewed and discussed at the older adults pathway

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meeting. This was attended by all older people's community team managers and ward managers. Team managers were able to give examples of items that they had submitted to the register.

Leadership, morale and staff engagement

- Staff sickness and absence rates were low in all the teams that we inspected.
- There were no cases of bullying and harassment that we were made aware of.
- Staff knew how to whistleblow and told us they would feel confident in doing so if necessary.
- Staff felt confident to raise concerns with managers and that these concerns would be acted upon appropriately. We observed an open culture between staff and team managers.
- The teams had all undergone a number of changes over the previous 18 months. This included a service redesign, introduction of extended hours and a new electronic computer system. It was acknowledged that the amount of change had been difficult but morale was good and staff told us that they felt supported by team managers.
- Opportunities for leadership development were available. The teams had structures that supported career development. One manager was undertaking training in compassionate and mindful leadership.
- The teams were cohesive and supportive of each other. Staff were respectful of each other's roles and we observed that staff contributed fully in team meetings. New staff and students were supported well.
- Staff were aware of duty of candour and were able to give us examples of having been open and honest when mistakes had been made, apologising for mistakes, and learning from them. Incidents were discussed at monthly team meetings. .
- The Oxford central team had used an away day to discuss ideas for improvement and had a planned follow-up session booked. Staff in all the teams felt able to take ideas to their managers.

Commitment to quality improvement and innovation

- The memory assessment clinics had recently undergone accreditation with the memory service national accreditation scheme (MSNAP). Involvement with MSNAP had led to the introduction of cognitive stimulation therapy (CST) groups in north Buckinghamshire and Oxford central. A CST group was planned for south Buckinghamshire.
- Staff were participating in a range of quality improvement and innovative practice initiatives. A professor within the older adult psychiatry team was leading national work in the field of 'biomarkers' in dementia diagnosis and treatment. A consultant old age psychiatrist was working with the neurobiology of ageing group of the department of psychiatry in Oxford university on transcranial direct current stimulation in the treatment of low mood and depression. A member of staff was involved in the evaluation of the prime minister's challenge fund initiative for the development of a stepped model of intervention for people with challenging behaviour in care homes.
- The older adult community mental health service were engaged in the dementia and neurodegeneration (DeNDRoN) study. This was a longitudinal study of dementia and staff actively recruited patient participants through the memory clinics.
- The north Buckinghamshire team were piloting "knowing me dementia passport" for people who were newly diagnosed. This was due to be audited in March 2016.
- The Buckinghamshire teams were involved in a project to provide memory assessments in GP surgeries. This was called memory assessment closer to home (MACH).