Oxleas NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units (PICUs)	Woodlands Unit Green Parks House Oxleas House	RPGAH RPGAD RPGAE
Forensic inpatient / secure wards	Forensic Community and Prisons Healthcare Services Bracton Medium Secure Unit Greenwood and Hazelwood	RPGXB RPGAB RPGXA
Long stay / rehabilitation mental health wards for working age adults	Somerset Villa and Barefoot Lodge Ivy Willis House	RPGAP RPGED
Wards for older people with mental health problems	Woodlands Unit Green Parks House Oxleas House Oaktree House	RPGAH RPGAD RPGAE RPGAR
Wards for people with learning disabilities or autism	Atlas House	RPGER
Mental health crisis services and health-based places of safety	Memorial Hospital	RPGAG
Community-based mental health services for adults of working age	Memorial Hospital	RPGAG
Specialist community mental health services for children and young people	Highpoint House	RPGDV

Summary of findings

Community-based mental health services for older people	Bexleyheath Centre Oaktree Lodge	RPGDL RPGAR
Community-based services for adults with learning disabilities	TOPS and Tall Trees Day Service	RPGXF
CHS Adults	181 Lodge Hill Market Street The Source	RPGCJ RPGX3 RPGX1
CHS Adults – Inpatients	Meadowview Unit Greenwich Intermediate Care Unit	RPGFD RPGX6
CHS Children and Young People (CYP)	Highpoint House Bluebell House	RPGDV RPGX5
CHS End of Life Care (EOLC)	181 Lodge Hill	RPGCJ

This report describes our judgement of the quality of care at this provider. It 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.

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 at this Provider	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services 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

Contents

Summary of findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

We rated Oxleas NHS Foundation Trust as requires improvement overall because:

- Not all services were safe and the trust needed to take action to address areas of improvement. For example, some wards had fixtures and fittings that people at risk of suicide could use as a ligature anchor point; these potential risks had not been adequately assessed and addressed.
- The environments at some community based services did not fully promote the privacy, dignity and recovery of patients using these facilities.
- The governance arrangements in place to take action following serious incidents that required investigation and trust wide learning were limited by the pace of investigations.
- Concerns regarding the trust wide management of medicines were identified.
- At Green Parks and Oxleas House mental health acute admission services, each ward had between 16 and 19 beds. In addition to this, they each had one surge bed. Staff said the surge beds were used daily. Records showed us that patients in those rooms had a length of stay ranging from two days to a week. All staff told us bed pressures were the biggest issue, and that the situation had been intense during the previous 12 months. When the demand for beds was high, patients were moved between areas.
- Across the acute wards, patients were being admitted before discharging existing patients. This meant that patients were frequently moved to make maximum use of beds. However, we heard of three occurrences where patients had to sleep on sofas or mattresses for one night because of the lack of beds. A number of patients had experienced sleeping on sofas and mattresses on the wards waiting for a bed to become available.
- We were informed and saw evidence that that beds for patients on leave would be used for new admissions and patients were being moved between wards and locations to accommodate new admissions. We were told by patients that having to sleep on other wards during their admission this made them anxious.
- Front line staff did not receive 'refresher training' on the Mental Health Act and the revised code of practice. Some relevant trust wide policies had not been updated to reflect the revised code of practice.
- The seclusion room on Heath did not meet the guidance set down by the Mental Health Act Code of Practice (2015).
- There were a number of instances when staff did not routinely advise patients of their rights under the Mental Health Act and some patients did not have robust capacity assessments in place to confirm they were able to understand and consent to their treatment.
- The trust did not use a weighting tool to ensure health visitors deliver an equitable service across geographical locations.
- The trust data collection and collation mechanisms were not robust for health visitor service metrics and breastfeeding data at six to eight weeks postnatal.
- The trust did not complete initial health assessments within 20 days.
- The trust did not make arrangements to ensure that all the child health clinics were suitably equipped for families and children to ensure their safety.

However:

- Staff provided high quality care throughout the trust. We found examples of staff providing a high level of patient centred care and providing positive emotional support to patients who were distressed.
- In community health services we found that there were arrangements to ensure that patients were safe, and that there were systems to report, investigate and learn from safety incidents.

Summary of findings

- We saw good multidisciplinary working and generally people's needs, including physical healthcare needs, were assessed and care and treatment was planned to meet them.
- Services were clean with good infection control practices.
- In community health services, patients received adequate pain relief and were supported to eat and drink suitable food in sufficient quantities.
- The trust was meetings its obligations under the Duty of Candour and the fit and proper persons requirement regulations.
- The trust had robust processes in place to identify and report serious incidents.
- Front line staff received appropriate training, supervision and professional development. Some staff told us they had been given a lot of support to learn new skills or update their skills.
- Complaint information was available for patients and staff had a good knowledge of the complaints process.
- In community health services admissions were well managed to minimise risks to patients. Discharge from the service was well planned to ensure the needs of patients would continue to be met. Delayed discharges were usually beyond the control of the hospitals.
- The trust held bed mental health bed management meetings once a week and two daily telephone conferences. These meetings included managers from the inpatient and crisis teams. The attendees provided up-to-date information on bed status, a review of admissions waiting for beds, accelerated discharges to accommodate new admissions and patients that were in beds outside of the trust area and possible return dates. Any patients moved between wards were recorded on the trust electronic system as an incident.
- The trust had participated in a range of patient outcome audits, research and accreditation schemes. Prompt actions had been taken when concerns were identified by audits.
- The trust has a number of effective initiatives to engage more effectively with users and carers.
- Trust wide leadership was visible and proactive to front line staff.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated Oxleas NHS trust as requires improvement for safe because:

- The trust's ligature policy guided staff to carry out ligature risk assessments in areas where patients would be unobserved for periods of time, such as bedrooms and bathrooms but not in communal areas of the wards. This meant that in-patient wards had ligature risks present in the communal areas. Staff reported that there had been no incidents where a patient had successfully self-ligatured in communal areas. However, this was a potential risk to patients.
- The environment of the day treatment teams, used for high risk patients in crisis, did not ensure that ligature risks were minimised and mitigated as reasonably practicable. The Bexley day treatment team had not carried out a ligature risk assessment of the environment. Both places of safety were not fit for purpose and had several ligature anchor points exposed.
- The governance arrangements in place to take action following serious incidents that required investigation and trust wide learning were limited by the pace of investigations.
- In the learning disability inpatient ward there were two fire extinguishers stored under the desk of the reception office at the front of the ward. This meant that if they were needed they could not be adequately accessed if there was a fire at the other end of the ward. Another two fire extinguishers were found in a locked food storage cupboard on the main corridor. This impacted on patient safety if there was a fire on that ward. The trust has provided us with subsequent evidence that this was approved by their fire safety officer and the London fire service.
- The environments at the Greenwich and Bromley health-based places of safety did not promote the privacy, dignity and recovery of patients using these facilities. These issues included the location of the nurses' office. The Bromley health-based place of safety did not have a bed, clock or shower facilities. The Greenwich health-based place of safety had glass entrance doors which meant the privacy and dignity of the person using the unit was not protected.

Summary of findings

- Concerns regarding the trust wide management of medicines were identified. These included the labelling of stock controlled drugs containing patient names. These should not contain names of patients. There was an inconsistent approach to the recording of allergy to specific medicines.

However:

- Inpatient wards were visibly clean and well maintained. The corridors were clear and clutter free. Bedrooms we inspected were visibly clean. Patients told us that wards were routinely clean and tidy.
- We observed good assessment and management of risk throughout most trust services. For example, there was a robust risk management system in place within community mental health community teams that used a traffic light system of red, amber and greed to categorise risk.
- The trust was taking proactive steps to address their recruitment and retention issues. For example, we found that the mental health community teams had few staff vacancies following a trust recruitment drive. Where these existed they were being actively recruited to. Locum staff had been in post for several months and were familiar with how the service worked.
- The trust had robust processes in place to identify and report serious incidents. For example, we observed good monitoring and management of incidents throughout most trust services.
- Trust staff were trained in safeguarding and knew how to make an alert. There were safeguarding leads for adults and for children in each team. They provided advice to colleagues on safeguarding matters. We saw examples of safeguarding alerts raised by staff in response to concerns. There were good examples of provision of information about medicines (in a range of formats) for patients

Are services effective?

Good

We rated Oxleas NHS trust as good for effective because:

- Staff carried out comprehensive assessments of patients' needs. Most records we reviewed confirmed these had been completed. Some staff had received suicide prevention and self-harm mitigation training**,** which focused on developing the skills needed to help a person at risk of suicide or self-harm to

stay safe. Where particular needs had been identified there were care plans in place to address these. Patients' physical as well as mental health care needs were being addressed in in-patient services.

- The trust used the royal college of psychiatrists' health of the nation outcome scales (HoNOS). Evidence was seen that trust staff followed National Institute for Health and Care Excellence (NICE) guidance. For example, one consultant psychiatrist in older people mental health wards had developed a guidance document sourced from evidence-based standards published by NICE. This was to help staff develop their skills using national and professional guidance in working with the small number of dementia patients on the wards. The early intervention in psychosis teams offered NICE compliant packages of care to patients within two weeks of their referral to the service.
- Community based adult mental health teams offered a range of evidence based therapeutic interventions including cognitive behavioural therapy for psychosis, family interventions, family therapy and multi-family groups.
- Front line staff received appropriate training, supervision and professional development. Some staff told us they had been given a lot of support to learn new skills or update their skills. Most had been given development opportunities such as time off for study leave, time off for research and financial support to undertake higher education programmes including diplomas and master's degrees.
- We found effective multi-disciplinary meetings took place that enabled staff to share information about patients and review their progress. We noted that different professionals worked together effectively to assess and plan patient care and treatment.

However:

- Front line mental health staff did not receive 'refresher training' on the Mental Health Act and revised code of practice. There was limited oversight and scrutiny of the MHA and policy and procedures had not been refreshed to reflect the change in the MHA code of practice.
- The seclusion room on Heath did not meet the guidance set down by the Mental Health Act Code of Practice (2015). There were a number of instances when staff did not routinely advise patients of their rights under the Mental Health Act and some patients did not have robust capacity assessments in place to confirm they were able to understand and consent to their treatment.

Summary of findings

- Staff in the trust's crisis and health based place of safety teams were not ensuring that the approved mental health professionals were notified in a timely manner which meant there were delays in Mental Health Act assessments taking place. Staff were not documenting the reasons for the delay in the patient records.

Are services caring?

Good

We rated Oxleas NHS trust as good for caring because:

- The majority of patients were positive about the staff, and their experience of care on the wards. Patients and their families or carers had the opportunity to be involved in discussions about their care. Many felt their mental health had improved as a result of the service they received from the trust.
- Staff demonstrated a good understanding of the individual needs of patients. Robust trust wide systems were in place to promote patient confidentiality.
- We found staff within the end of life community health service team provided focused care for dying and deceased patients and their relatives.
- Most patients and their carers told us that patients were orientated to their ward on admission and were shown around the ward by staff. They had received an information leaflet relating to the ward.
- Patients were able to express their views, which staff reflected in the key documents they prepared. Almost all care plans were written in a person centred way and were holistic, which meant they covered all aspects of the patients's care and support needs

Are services responsive to people's needs?

Good

We rated Oxleas NHS trust as good for responsive because:

- Trust board meeting minutes and discussions with commissioners demonstrated that trust services were planned and delivered to meet the needs of people.
- The trust was taking pro-active steps to manage admissions and discharges effectively. For example, the trust's proportion of admissions to acute wards gate kept by the CHRT was above the England average for all 11 of the 12 quarters reported. They also exceeded the national 95% target in 11 of the last 12 quarters.

Summary of findings

- In community health services, admissions were well managed to minimise risks to patients. Discharge from the service was well planned to ensure the needs of patients would continue to be met. Delayed discharges were usually beyond the control of the hospitals.
- The trust held mental health bed management meetings once a week and two daily telephone conferences. These meetings included managers from the inpatient and crisis teams. Representatives from the Woodlands unit, Oxleas House and Green Parks House were also present. The attendees provided up-to-date information on bed status, a review of admissions waiting for beds, accelerated discharges to accommodate new admissions and patients that were in beds outside of the trust area and possible return dates.
- The four main pathways into mental health crisis services were; the trust's urgent advice line, mental health liaison, community mental health teams and primary care plus (PCP) which was created for patients that were unknown to the teams.
- In community health services, patients received adequate pain relief and were supported to eat and drink suitable food in sufficient quantities.
- Complaint information posters were on display around the trust. Most patients were aware of how to make a formal complaint and had received the information for the patient advice and liaison service (PALS) which staff had given them. Patients told us that they felt comfortable to raise their concerns to the trust if required.
- The trust received 148 formal complaints in 2014/2015, a decrease of 56 from 2013/2014 (204). Feedback from complaint investigations were discussed in team meetings and in embedded learning events provided by the trust during the year. During the year 12 complainants contacted the parliamentary and health service ombudsman (PHSO) for a review of their complaint. Four were not upheld, eight remained on-going.

However:

- In community health services, there was no caseload weighting tool to ensure health visitors could deliver an equitable service across the trust. Some caseloads were very high, above the upper limits as set by their professional organisations. Allocation meetings where staff allocated work were not

recorded consistently. This meant there was no process to review staff allocation. There was no robust system regarding the allocation of families and their level of need with the capacity of the staff to meet the need.

- Average bed occupancy levels across the trust was 93% with 24 out of 29 wards having bed occupancy of over 85% between July and December 2015. This meant that when some mental health patients went on leave, the trust had used their beds for new admissions.

Are services well-led?

Requires improvement

We rated Oxleas NHS trust as requires improvement for well led because:

- There were inconsistencies in the feeding back of safe staff numbers across the acute care core service from ward level to senior management. This meant that senior management did not have a clear picture of shifts that were below numbers required. The trust had recently adopted an improved system of reporting safe staffing to the board.
- Managers escalated risks related to the service via their line managers and in regular performance meetings. A directorate wide risk register highlighted the specific risks affecting specific services. For example, the steady growth in referrals and the risk that referrals may outstrip the services' capacity to respond; was highlighted in adult mental health community services.
- Action plans were put in place following investigations in to serious incidents, but risk registers identified that not all lessons learnt were shared with all staff.
- There were gaps in the governance structures that supported the delivery of safe and effective care. For example lack of oversight and action about bed use communicated from the teams to senior management and trust board and vice versa.
- We found examples that not all policies and procedures were followed. The policies amended in line with the MHA code of practice did not reflect the recommendations laid out in 2015 and the governance arrangements in place had not captured this.

However:

- The majority of staff knew and understood the values of the trust. These were: having a user focus, excellence, learning,

being responsive, partnership and safety. Most front line staff were aware of these and could describe these. We found that the trust's vision and values were included in the trust's strategy for 2016/2017.

- Staff knew who senior managers in the trust were and said they were visible. Senior managers and trust board members had visited all locations and most services and sent reports of their visits back to teams. Non-executive directors had a good understanding of the trust's strategy and presented appropriate challenge to the executive.
- Staff were positive about the trust as an employer. They described a trust that looked after their staff, encouraged individual services to improve and had a 'no-blame' culture.
- The trust supported a range of groups, events and services to promote inclusion and employment, including; a volunteer to work scheme, a research group for people with lived experience of mental ill health and the development of paid and voluntary peer support posts.
- The trust's patient experience, patient safety and clinical effectiveness quality priorities were monitored monthly by the trust executive and board of directors; bi monthly by the trust quality committee and subgroups.
- The trust had participated in a number of applicable Royal College of Psychiatrists' (Psych) quality improvement programmes or alternative accreditation schemes. For example, the Greenwich and Bromley home treatment teams were accredited by the Royal College of Psychiatrists home treatment accreditation scheme (HTAS).

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Joe Rafferty, chief executive, Mersey Care NHS Trust

Head of Inspection: Pauline Carpenter, Care Quality Commission

Team Leaders: Peter Johnson and Shaun Marten, Care Quality Commission

The team included four CQC inspection managers, 19 Inspectors, three assistant inspectors, a mental health act policy manager, three mental health act reviewers, a pharmacy inspector, three analysts and two inspection planners.

There were also 42 specialist advisors from a variety of mental health and community health service backgrounds. Including medical directors, psychiatrists, consultants in community health services, social workers and registered mental health nurses operating in a range of roles and at various grades. Each specialist advisor had recent experience of working in services similar to these.

In addition, the team included six experts by experience that had personal experience of using either mental health or community health services or caring for someone who had used these services.

Why we carried out this inspection

We inspected this core service as part of our ongoing 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 visit, the inspection team:

- Reviewed information that we hold on the trust.
- Requested information from the trust and reviewed that information.
- Asked a range of other organisations that the trust worked in partnership with for feedback. These included NHS England, local clinical commissioning groups, Monitor, Health watch, local authority overview and scrutiny committees, Health Education England, and other professional bodies.
- Met with a number of user and carer groups, both internal and external, to hear their views on the trust.
- Reviewed information from patients, carers and other groups received through our website.
- Attended a meeting of the trust board.

During the announced inspection visit from 25 to 28 April 2016, the inspection team:

- Observed how staff were caring for patients in wards and clinics.
- Accompanied community teams on visits to people's homes, seeing 25 episodes of care in the community.
- Spoke with 318 people who used the services, carers or their family members who used the services and reviewed 180 comment cards that we had left in patient areas before the inspection.
- Spoke with 402 staff who worked within the trust, such as nurses, doctors, therapists and support staff.

Summary of findings

- Interviewed the chair of the board, lead governor, Head of Equality and Human Rights, the chief executive officer and all the executive directors.
- Held focus groups with admin staff, both qualified and non-qualified nursing staff, black, minority and ethnic (BME) staff, the trust's governors, non-executive directors and union representatives. No junior doctors were able to attend a focus group due to the junior doctors strike held on 28 April 2016.
- Interviewed the senior managers within the trust, including 56 managers of services, such as ward managers and team leaders.
- Reviewed 293 care and treatment records of people who use services.
- Visited 24 separate locations.
- Attended a trust wide meeting for people with lived experience of mental health issues.

Following the announced inspection:

- No unannounced inspections took place as the inspection team had enough information to reach their judgements.
- A number of data requests were also met by the trust.
- We received an update from the trust regarding the immediate actions taken as a result of the high level feedback provided at the end of the inspection.

Information about the provider

Oxleas NHS Foundation Trust provides a wide range of health and social care services in south east London, specialising in community health, mental health and learning disability services. The trust provides local NHS services in south London and Kent, caring for around 28400 people a month on an annual income of approximately £228 million. There are 125 sites in a variety of locations across the London Boroughs of Bexley, Bromley and Greenwich and into Kent. The trust employs approximately 3500 staff.

The trust is the main provider of specialist mental health care in Bexley, Bromley and Greenwich and has developed a comprehensive portfolio of services in community and hospital settings. The trust also provides specialist forensic mental health care across south east London and in Kent prison healthcare. The latter services were not inspected as part of this inspection.

The CQC inspection covered 10 mental health and four community core services provided by the trust:

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

And:

- Community health services for adults
- Community health services for adult inpatients
- Community health services for children and young people
- Community health services for end of life care

The trust was formed in 1994 as Bexley Community Trust, and took the name Oxleas in 1995 as its mental health services grew to cover Greenwich and then later Bromley in 1997. Oxleas received its foundation status in 2006 and took on the name Oxleas NHS Foundation Trust. It has since become a combined mental health and community trust, having taken on community health services in Bexley and Greenwich in 2010 and 2011.

Summary of findings

The trust has been inspected nine times since registration. At the time of this inspection, the Woodlands Unit had an outstanding compliance action from a previous inspection. This related to poor risk assessment and management.

Out of the nine previous inspections, there were four routine and five focussed or themed inspections, covering eight locations providing mental health services. All these locations were inspected during this comprehensive inspection visit.

There were 17 Mental Health Act reviewer visits between 1 January 2015 and 7 March 2016, all of which were unannounced visits. The highest category for issues was 'consent to treatment' with 26 issues, equating to 32% of the total. Millbrook ward at Woodlands unit had the most issues in a single visit (8). Greenwood house at Memorial Hospital had the lowest number of issues in a single visit (2).

There have also been five prison service inspections since 2011; prison services were not included in the recent inspection as these were jointly inspected with Her Majesty's Inspectorate of Prisons (HMIP).

What people who use the provider's services say

The majority of patients were positive about the staff, and their experience of care on the wards. Patients and their families or carers had the opportunity to be involved in discussions about their care.

Many felt their mental health had improved as a result of the service they received from the trust.

People receiving care from community services told us that their appointments generally ran on time and they were informed if there were any unavoidable changes. Some told us they saw different members of staff which meant they had to repeat information.

Patients knew how to raise concerns and make a complaint. They felt they could raise a concern if they had one and believed that staff would listen to them.

However, there was limited evidence of patients' involvement in the care planning process throughout the trust.

Good practice

- The community nursing teams were effective in their organisation of services to enable them to be responsive to end of life care patients especially those who were recognised as dying. The teams were able to access the necessary equipment with a central store and sufficient supply of syringe drivers at each location. Each team had end of life care champions who promoted best practice of their specialist area within the service.
- There were meaningful work opportunities available to patients using forensic services and they could gain work references from external organisations, thereby improving the likelihood they could secure meaningful employment following their discharge.
- Trust staff offered support for patients' social needs such as housing, benefits and employment. For example, in Greenwich, employment advisors supported patients to remain in work and to find paid employment or voluntary work. These advisors supported patients to self-advocate in the work place.
- Innovation was promoted by the trust. Examples of this innovation was the use of technology with the sexual health websites, electronic application 'app' for new parents and in the pilot of the rapid response team aiming to prevent hospital admission and reduce hospital stays.
- The trust responded proactively to the local high levels of obesity in children. By holding staff focus groups and speaking with commissioners a new letter for parents and a new programme had been developed. The healthy weight programme was now for specific age ranges.

Summary of findings

- The trust's advanced dementia service co-ordinated and provided palliative care to patients with dementia. Staff in the service supported and advocated for patients and carers, including decisions concerning where the patient wished to die.
- The community learning disability and autism service provided innovative support for young people in transition, working collaboratively with schools and other external agencies to assess their needs and to support them to access services.
- The trust had implemented an innovative pressure ulcer prevention strategy (Pups). Patients who were at risk were given information to help them understand how to prevent pressure ulcers. This led to a reduction in the incidents of patients acquiring grade 4 pressure ulcers whilst receiving trust in patient and community services.
- The trust supported an innovative range of groups, events and services to promote inclusion and employment for patients and ex patients.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that all patients are protected from potential ligature risks.
- The trust must ensure they have prompt processes in place to review and approve action plans following serious incidents that require investigations.
- The trust must ensure that steps are taken to manage the high bed occupancy levels on the acute and PICU wards.
- The trust must take effective action to reduce the number of same sex accommodation breaches.
- The trust must ensure that the current environments used as health-based places of safety are made safe and to fully promote people's privacy and dignity.
- The trust must ensure that it complies with all policy, practice and facilities to meet the requirements set out in the Mental Health Act code of practice.
- The trust must consider the use of a weighting tool to ensure health visitors deliver an equitable service across geographical locations.
- The trust must consider how data collection and collation mechanisms can be made robust for health visitor service metrics and breastfeeding data at six to eight weeks postnatal.
- The trust must consider how the statutory guidance for the completion of Initial Health Assessment within 20 days will be achieved.
- The trust must make arrangements to ensure that all child health clinics are suitably equipped for families and children to ensure their safety.

Action the provider SHOULD take to improve

- The trust should ensure that staff record when they give patients a copy of their care plan.
- The trust should ensure that they comply with their own policy on banned and restricted items.
- The trust should ensure that best practice is followed in the management of all medicines.
- The trust should ensure that they review their governance arrangements in place following serious incidents that required investigation.
- The trust should work with their commissioners to ensure that the numbers of acute mental health beds provided meet the assessed needs of the local population.
- The trust should ensure that patients have access to a range of leaflets in a variety of languages including; information about independent mental health advocacy and patient rights leaflets.
- The provider should ensure that staff follow the trust's protocol for ensuring the environment on the adult ward with a CAMHS designated bed is appropriate.

Oxleas NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

- There was a governance system in place to monitor and report the administration and some aspects of operation of the MHA; this included the board receiving information from CQCs MHA visits and information from the MHA scrutiny committee.
- We saw that regular audits were completed in relation to administrative aspects of the MHA usage, section 132 rights discussions on admission and completion of section 58 paperwork. There was no audit of the patient experience of detention including deaths, incidents or complaints. There was evidence that most people had their rights under the MHA explained to them.
- Training for the MHA was not considered mandatory by the trust and some staff had not had any training since induction.
- We were concerned that the policies and procedures we reviewed had not been updated following the implementation of the revised MHA code of practice (2015).
- We found that detention paperwork was filled in correctly, up to date and stored appropriately.
- There was good adherence to consent to treatment and capacity requirements overall. However, on one ward at the Bracton Centre we noted that some patients were being treated under the authority of T2 certificates without a full understanding of the treatment proposed and with the responsible clinician, recording in some cases that patients had not consented to all the treatment listed in the certificates.

Further details can be found in the main body of this report.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity training was not a mandatory training course for staff at the Trust. However, we found that 97% of all staff had received training in the Mental Capacity Act 2005 (MCA). The trust confirmed that the renewal timeframe for this training course was 'once minimum'.
- The trust had a MCA policy and had produced a short and clear summary of the MCA for staff. Some staff were very knowledgeable and spoke confidently about the legislation. They knew about knew the five statutory principles and the capacity test. However, not all staff spoken with had a good understanding of the MCA in practice.
- Care and treatment records demonstrated that patients were informed that they could make advanced decisions regarding their care and treatment. When appropriate, best interest meetings were held. Patients in memory services were advised about lasting power of attorney arrangements.
- The trust policy for consent to examination or treatment dated February 2016 gave detailed guidance to staff on when and how to seek and document consent. Staff were well informed in terms of gaining patients' consent to treatment. Staff understood the importance of gaining the informed consent of patients. Where staff had concerns about a patient's capacity they conducted assessments. These were clearly documented.

Detailed findings

- There were 41 Mental Health Deprivation of Liberty Safeguards (DoLS) applications made by the trust between August 2015 and January 2016. The largest numbers were made by Holbrook and Oaktree lodge both older people's mental health wards. However, the Care Quality Commission had only been notified of one during this period.
- The adult mental health (AMH) quality newsletter dated April 2016 referred to a deprivation of liberty safeguards (DoLS) audit. They sampled random cases to look at adherence with the Mental Capacity Act (2005) and specifically the DoLS. This demonstrated that the trust were identifying gaps and learning around MCA and DoLS.

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

We rated Oxleas NHS trust as requires improvement for safe because:

- The trust's ligature policy guided staff to carry out ligature risk assessments in areas where patients would be unobserved for periods of time, such as bedrooms and bathrooms but not in communal areas of the wards. This meant that in-patient wards had ligature risks present in the communal areas. Staff reported that there had been no incidents where a patient had successfully self-ligatured in communal areas. However, this was a potential risk to patients.
- The environment of the day treatment teams, used for high risk patients in crisis,did not ensure that ligature risks were minimised and mitigated as reasonably practicable. The Bexley day treatment team had not carried out a ligature risk assessment of the environment. Both places of safety were not fit for purpose and had several ligature anchor points exposed.
- The governance arrangements in place to take action following serious incidents that required investigation and trust wide learning were limited by the pace of investigations.
- In the learning disability inpatient ward there were two fire extinguishers stored under the desk of the reception office at the front of the ward. This meant that if they were needed they could not be adequately accessed if there was a fire at the other end of the ward. Another two fire extinguishers were found in a locked food storage cupboard on the main corridor. This impacted on patient safety if there was a fire on that ward. The trust has provided us with subsequent evidence that this was approved by their fire safety officer and the London fire service.
- The environments at the Greenwich and Bromley health-based places of safety did not promote the privacy, dignity and recovery of patients using these facilities. These issues included the location of the nurses' office. The Bromley health-based place of safety did not have a bed, clock or shower facilities. The Greenwich health-based place of safety had glass entrance doors which meant the privacy and dignity of the person using the unit was not protected.
- Concerns regarding the trust wide management of medicines were identified. These included the labelling of stock controlled drugs containing patient names. These should not contain names of patients. There was an inconsistent approach to the recording of allergy to specific medicines.

However:

- Inpatient wards were visibly clean and well maintained. The corridors were clear and clutter free. Bedrooms we inspected were visibly clean. Patients told us that wards were routinely clean and tidy.
- We observed good assessment and management of risk throughout most trust services. For example, there was a robust risk management system in place within community mental health community teams that used a traffic light system of red, amber and greed to categorise risk.
- The trust was taking proactive steps to address their recruitment and retention issues. For example, we found that the mental health community teams had few staff vacancies following a trust recruitment drive. Where these existed they were being actively recruited to. Locum staff had been in post for several months and were familiar with how the service worked.
- The trust had robust processes in place to identify and report serious incidents. For example, we observed goodmonitoring and management ofincidents throughout most trust services.

Requires improvement

Are services safe?

- Trust staff were trained in safeguarding and knew how to make an alert. There were safeguarding leads for adults and for children in each team. They provided advice to colleagues on safeguarding matters. We saw examples of safeguarding alerts raised by staff in response to concerns. There were good examples of provision of information about medicines (in a range of formats) for patients

Our findings

Safe and clean care environments

- The trust ligature policy guided staff to assess ligature risks in areas of the ward where a patient 'may' be unobserved. This meant that staff carried out ligature risk assessments in areas where patients would be unobserved for periods of time, such as bedrooms and bathrooms but not in communal areas of the wards. This meant that in-patient wards had ligature risks present in the communal areas. These included laundry rooms with cables and pipes, non-collapsible curtain rails, hinged doors, window fasteners, ceiling frets and TV cabling. Staff told us that they observed patients in communal areas and this, along with individual patient risk assessments, was sufficient to mitigate from the risks of patients ligaturing in these areas. Staff reported that there had been no incidents where a patient had successfully self-ligatured in communal areas. However, this was a potential risk to patients.
- Staff did not carry out regular environmental ligature risk assessments within the community CAMHS service. There were several areas where ligature risks were present. For example in bathrooms, where staff were unable to mitigate risks as young people were not accompanied.
- The forensic service had a banned item list, which included plastic bags. However, there were plastic bags in all areas of the wards, including areas where patients had unsupervised access such as bathrooms and laundry rooms
- The environments at the Greenwich and Bromley health-based places of safety did not promote the privacy, dignity and recovery of patients using these facilities. These issues included the location of the nurses office in relation to the room people who used the service would be in. The Bromley health-based place of safety did not have a bed, clock or shower facilities. The Greenwich health-based place of safety had a glass entrance doors which meant the privacy and dignity of the person using the unit was not protected.
- The environment of the day treatment teams ,used for high risk patients in crisis, did not ensure that ligature risks were minimised and mitigated as reasonably practicable. The Bexley day treatment team had not carried out a ligature risk assessment of the environment. Both places of safety were not fit for purpose and had several ligature anchor points exposed.
- The 2015 PLACE (patient led assessments of the care environment) scores for cleanliness for the trust was 96%. This was slightly lower than the England average of 98%.
- We found that some medical equipment within CAMHS community services was not calibrated. For example, weighing scales and blood pressure monitors. There was no system in place across the services to remind staff when calibration was due.
- In the learning disability in-patient service, two fire extinguishers were found stored under the desk of the reception office at the front of the ward. This meant that if they were needed they could not be adequately accessed if there was a fire at the other end of the ward. Another two fire extinguishers were found in a locked food storage cupboard on the main corridor. This impacted on patient safety if there was a fire on the ward. The trust has provided us with subsequent evidence that this was approved by their fire safety officer and the London fire service.
- The trust had an effective estates strategy. This was subject to board scrutiny. Significant trust investment had taken place in providing purpose built in-patient ward areas. For example at the Bracton centre for forensic in-patients and Holbrooke ward which was a purpose built service for in-patients living with advanced dementia.

Requires improvement

Are services safe?

- We found that all in-patient wards were visibly clean and well maintained. The corridors were clear and clutter free. Bedrooms we inspected were clean. Patients told us that wards were routinely clean and tidy. Cleaning logs were available for inspection.
- Within forensic mental health services, staff carried personal alarms. Toilets and bathrooms had red button alarms so patients could summon help in an emergency. Each ward allocated a member of staff per shift to hold responsibility for carrying out environmental and perimeter checks, with the aim of identifying any security or safety risks. Each shift also allocated a dedicated person to respond to alarm calls, on the ward and across the site. This meant that it was clear which member of staff would attend emergencies.
- The trust had a ligature policy and staff adhered to it. Ligature is the term used to describe a place or anchor point to which patients, intent on self-harm, might tie something to for the purposes of strangling themselves. Front line staff carried out regular ligature risk assessments and identified areas that needed improvement. Ligature cutters were available on the wards and staff knew where they were kept.The service mitigated against the likelihood of patents ligaturing in bathrooms and bedrooms, for example by installing ligature proof door handles and collapsible curtains.
- Frontline staff informed the maintenance company or facilities department when any remedial work was required, and the improvements were carried out in a timely manner. For example on the forensic service improvements had been carried out as a result of staff identifying risks in areas where patients spent unsupervised time, such as bathrooms and bedrooms. Examples included the changing of screws used in fixtures and fittings, the replacing of door hinges and alterations to the structure of beds.
- Most patients could personalise their rooms if they wished. Many brought personal items such as pictures and we saw these displayed. Patients had a lockable space for their private possessions. Staff were also able to store patients'' possessions for safe keeping in dedicated secure storage areas on the wards.
- Wards displayed hand hygiene signs and sinks were available for patients, visitors and staff to use. Hand gels were available on entrances to wards. We saw staff observing good hand hygiene procedures. Staff conducted regular infection prevention and control audits, to ensure that patients and visitors were protected against the avoidable risks of infection.
- Each ward had a clinic room, which was clean. Records showed staff regularly maintained and serviced equipment appropriately. Servicing dates were visible. Emergency equipment, including defibrillators and oxygen, was in place. Staff checked this regularly to ensure it was fit for purpose and they could use it effectively in an emergency. Staff disposed of sharp objects, such as used needles and syringes, appropriately. The checklist cleaning logs in clinic rooms were up-to-date. The unit carried out regular safety tests for electrical items. Testing of items we looked at were mostly up to date.

Safe staffing

- Overall staff sickness rates were 4.2%. This was below the national NHS average of 5%. The community crisis and health based place of safety teams had the highest staff sickness rate of 7% over the last 12 months. Community mental health other specialist services had the lowest staff sickness rate of 0.3% over the same timescale.
- The trust's establishment level over the last year was 1178 whole time equivalent (wte) for trained nurses and 528 wte for nursing assistants. There were 436 substantive staff leavers in the last 12 months which was a percentage of 13.8%. The trust current overall vacancy rate was 9.7%. The vacancy number per staff was 178 wte for qualified nurses and 75 wte for nursing assistants. 16183 shifts had been filled by bank or agency staff to cover sickness, absence and vacancies.
- The trust was taking proactive steps to address their recruitment and retention issues. For example, we found that the mental health community teams had few staff vacancies following a trust recruitment drive. Where these existed they were being actively recruited to. Locum staff had been in post for several months and were familiar with how the service worked.
- The trust did not use a specific acuity tool to determine staffing levels. Patient acuity and staffing was assessed using the clinical judgement of the nurse in charge of

each ward, with support from the ward manager or modern matron, which was available to them 24 hours a day. Acuity is the term used to describe the level of staff need for patient care.

- The trust told us they were considering adopting the Hurst patient acuity staffing tool but this was dependent upon the outcome of a pilot. The trust submitted monthly safe staffing figures to NHS England and published them on their website in line with current guidance.
- Throughout the trust, staff received and were up to date with appropriate mandatory training and the average mandatory training rate for staff was 95%. Community Mental health adult teams had the lowest aggregated rate of training of 93%. The prevention of management of violence and aggression (PMVA) course had the lowest rate of completion at 86%.

Assessing and managing risk to patients and staff

- We observed good assessment and management of risk throughout most trust services. For example, there was a robust risk management system in place within community mental health community teams that used a traffic light system of red, amber and greed to categorise risk. Teams held zoning meetings where the multidisciplinary teams discussed and reviewed the risks affecting individual patients. Zoning meetings for high risk patients, those categorised red and amber, were held several times a week. Red zone patients included those in hospital, those being supported by the home treatment team, pregnant patients and patients in crisis. Staff reviewed lower risk patients at zoning meetings once a week. There were clear plans in place to manage the risks identified and these were updated at each zoning meeting. Staff increased the frequency of patient visits in response to increasing risk.
- There were inconsistencies in where risk assessments were completed by home treatment teams in the electronic care records, which meant that it was possible for staff (especially in other teams) to miss updates in risk information.
- The quality and documentation of risk assessments was inconsistent within community mental health crisis teams. Risk management plans did not clearly demonstrate how risk was being managed by this service. There was a lack of evidence to demonstrate that all patients received a crisis plan. There was a lack of physical health monitoring. Records did not demonstrate that these patients were always receiving a comprehensive initial assessment and subsequent monitoring.
- Mental health community patient care and treatment records contained crisis plans outlining what patients should do and who they should contact in an emergency. Crisis plans for these teams contained information on relapse indicators and warning signs.
- PICU and forensic show the highest number of restraints (194 and 130 episodes respectively). Of these incidents, 87 were prone restraints. The forensic ward is the only ward to have used seclusion in this period (61). There were no instances of long term segregation recorded by the trust.
- Prone position restraint is when a patient held in a face down position on a surface and is physically prevented from moving out of this position. The latest Department of Health guidance stated that if such a restraint is unintentionally used, staff should either release their holds or reposition into a safer alternative as soon as possible. The trust informed us that they were taking steps to reduce the use of prone restraints in line with best practice guidelines issued by the Department of Health to reduce the use of outdated restrictive practices and published as 'positive and proactive care' (April 2014). For example through trust wide clear processes in place to report and investigate incidents and complaints.
- Trust staff were trained in safeguarding and knew how to make an alert. There were safeguarding leads for adults and for children in each team. They provided advice to colleagues on safeguarding matters. We saw examples of safeguarding alerts raised by staff in response to concerns. Several staff had been trained as safeguarding adults' managers and inquiry officers. Staff considered and made safeguarding referrals in multidisciplinary team discussions we attended. Managers attended local multi-agency risk assessment conferences where women at high risk of domestic violence and abuse were discussed. Staff had good understanding of their responsibilities in respect of protecting children.

Requires improvement

Are services safe?

- There were good examples of provision of information about medicines (in a range of formats) for patients. Patient Group Directions were found to be in date across the Trust. The range of emergency medicines held at services across the Trust met both NICE NG10 and Resuscitation Council guidelines.
- Staff had good awareness of how to report clinical errors. They demonstrated an understanding of the processes around the use of rapid tranquilisation of mental health patients, and the physical monitoring required afterwards.
- Prescription charts developed for use at Eltham community hospital promoted medicines optimisation.
- Medicines were stored securely. Where present, prescription pads were stored securely. Spot checks on medicines found them to be within their expiry date. Processes around waste medicines were good. Where possible, people were encouraged to self-administer medicines.
- The monitoring of potential physical health issues through the use of national early warning (NEWS) was being used at some locations. There were some good examples of proactive quality improvement processes across the trust, particularly at both the older people's community and home treatment teams in Greenwich.
- Trust labelling of stock controlled drugs for ward use was confusing as it included the name of a patient on the ward. Allergy recording was not always undertaken. There was disparity between allergies recorded on people's charts and their electronic records.
- Some people's prescribed medicines were not covered by T2 and T3 forms.
- Fridge temperatures were not always monitored and/or recorded correctly, although this was limited to a few wards rather than being widespread across the trust. Opening dates were not always written on liquid medicines to ensure they were used within the correct expiry date.

Reporting incidents and learning from when things go wrong

- The trust had robust processes in place to identify and report serious incidents. However, the governance arrangements in place to take action and learn were limited by the pace of investigations. For example, the trust had taken steps to carry out a thematic review of the three patient suicides reported by one ward within 8 weeks of each other. However, the thematic review took over 120 days to complete and was submitted to the board 20 days before a fourth suicide occurred in the same area. The fourth suicide investigation team had an independent chair assigned but the rest of the panel were people who currently work or have previously worked for the provider. The fourth investigation had still not been signed off during the visit, over 150 days since the suicide. This is later than the agreed 90 day completion time for investigations with the clinical commissioning group, 30 days longer than the national serious incident framework guidance issued by NHS England.
- Regular reports were provided to the board, executive team, council of governors and quality committee to share information and learning. The approach to disseminating information included involvement of directorate staff in trust wide groups who could share messages with clinical and local team meetings. There was a lack of triangulation of information in the reports and the impact this would have on the ability to identify themes and issues. For example, the suicide report presented to the trust board in April 2016 which referred to the number of suicides but failed to include the number of attempted suicides or reviewed other data such as incidents of self-harm or near misses. The review report also excluded the cluster of suicides in particular areas or rises in suicides from previous years, 13 suicides in 2014/15 to 21 in 2015/16.
- There was no evidence that the trust was triangulating information from investigations and actions plans for the suicides with their corporate risk register. For example, the four action plans we reviewed had separate action plans and these had not been translated to the trust wide risk register.
- We reviewed four investigation reports for suicides in 2015/16. All patients were being cared for by the same ward at the time of their death, although only one took place on the ward with two patients on leave and one discharged earlier in the day that they had committed suicide. All of the investigation reports had taken longer than the 90 days agreed with the clinical commissioning group, which was 30 days longer than the expected time

in the Serious Incident Framework. We were unable to find any record of the reasons for the delays. All four investigations, and the separate thematic review on three of the suicides, had a member of the board leading the investigation. We saw evidence in one of the deaths of direct communication between the chief executive and the family of the patient who were very positive about the support they had received from the patient safety team throughout the investigation.

- Ten reports relating to the deaths of patients from the learning disability service and the older people's mental health services were reviewed. The information added by clinical staff and the governance team was comprehensive, included rationale for decision making on investigations and provided a clear audit trail and chronological history of actions taken following these deaths.
- The trust shared information about risk and safety in a transparent and timely way with their council of governors. We saw evidence that this led to effective challenge by the governors, although it wasn't clear that actions to respond to the challenge had been taken from the trust papers we reviewed.
- The trust had processes in place to review and approve action plans following investigations. This included discussion with local clinical teams and updates being made to the action plans held on the trust's electronic incident recording system. The trust did not meet the target dates for all improvement actions in the plans reviewed and we did not see evidence of the decision to delay actions for a later date. Due to the delays in action plans being completed, in some cases over 150 days after the incident, some key actions had been delayed as a result and this caused concern for the responsiveness to risks for patients.
- The trust used the adult mental health (AMH) quality newsletter to share information about learning from incidents with staff in all services. For example, the AMH quality newsletter from March 2016 identified learning from the death of a patient in the community. Learning included the need for patients to have a crisis plan in place, the importance of reviewing and updating patient risk assessments and direct liaison with other agencies working with the patient.

Track record on safety

- The trust reported a total of 7,531 incidents to the national reporting and learning system (NRLS) between 1 December 2014 and 1 December 2015. 71% of incidents (5,324) reported resulted in no harm. 20% (1,513) of incidents were reported as resulting in low harm. 8% (636) in moderate harm, 0.2% (16) in severe harm and 0.6% (42) in death. Of the incidents reported to NRLS 18% were related to 'Infrastructure' 5% to 'Implementation of care and on going monitoring / review' and 3% to 'Patient Accident.'
- In the period 03/12/2014 - 01/12/2015, the trust reported 93 serious incidents through its SIRI reporting system. Of these 92 were incidents that were unexpected or avoidable death or severe harm of one or more patients, staff or members of the public. 31 of these incidents relate to grade three pressure ulcers 22 of these relate to suicide. One was an incident of allegations, or incidents, of physical abuse and sexual assault or abuse.
- The trust did not report any 'never events' in the last 12 months. These are defined as 'serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers'.
- The trust reported 84 serious incidents between 1 December 2014 and 1 December 2015 to the . Mental health and community medicine accounted for 23 of the incidents reported. Apparent/actual/suspected self-inflicted harm accounted for 18 of the mental health incidents reported. Twenty one of the community medicine incidents were pressure ulcers (grade 3 and 4) with the remainder being slips, trips and falls.
- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Between February 2015 – February 2016, the trust reported 67 new pressure ulcers with the highest monthly number being 11 in August 2015 with a prevalence rate of 1.6%. The prevalence rate declined to 0.35% in October 2015. The trust also reported 35 falls with harm. The highest monthly number reported was seven in July 2015 with prevalence rates of 0.9%. The trust reported 14 new Catheter and Urinary Tract Infection cases. The highest monthly number reported was four in July 2015 with a prevalence rate of 0.7%.

Requires improvement

Are services safe?

Duty of Candour

- In November 2014 a CQC regulation was introduced requiring NHS trusts to be open and transparent with people who use services and other 'relevant persons' in relation to care and treatment and particularly when things go wrong.
- The trust had taken a number of actions to meet this requirement. These included training for the executive and managers, information for staff and a review of all relevant policies and procedures. Duty of candour considerations had been incorporated into the serious investigation framework, tools and report, and complaints procedures. The trust told us that they were about to appoint an investigation lead who will also be the trust's Duty of Candour guardian. The board were sighted each month via the integrated performance report on any concerns were duty of candour considerations have been included.
- Duty of candour consideration had been include in trust induction training and training for incident investigators. Staff were aware of the duty of candour requirements in relation to their role. The trust had also provided an information leaflet for staff explaining the duty of candour.
- We examined care and treatment records where patients had experienced a 'notifiable event' to check that staff had been open and honest in their dealings with patients and carers. We found that the trust was meeting its duty of candour responsibilities.

Anticipation and planning of risk

- The trust had emergency contingency plans in place for dealing with foreseeable emergencies. For example, within community services for adults, staff were clear about appropriate procedures to follow if people did not attend their appointments. These included telephone contact, making home visits and sending letters.
- We saw trust wide contingency arrangements in place for adverse weather, IT failure and local systems for working collaboratively with local acute trusts for civil emergencies and major incidents.

Good

Are services effective?

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

Summary of findings

We rated Oxleas NHS trust as good for effective because:

- Staff carried out comprehensive assessments of patients' needs. Most records we reviewed confirmed these had been completed. Some staff had received suicide prevention and self-harm mitigation training, which focused on developing the skills needed to help a person at risk of suicide or self-harm to staysafe. Where particular needs had been identified there were care plans in place to address these. Patients' physical as well as mental health care needs were being addressed in in-patient services.
- The trust used the royal college of psychiatrists' health of the nation outcome scales (HoNOS). Evidence was seen that trust staff followed National Institute for Health and Care Excellence (NICE) guidance. For example, one consultant psychiatrist in older people mental health wards had developed a guidance document sourced from evidence-based standards published by NICE. This was to help staff develop their skills using national and professional guidance in working with the small number of dementia patients on the wards. The early intervention in psychosis teams offered NICE compliant packages of care to patients within two weeks of their referral to the service.
- Community based adult mental health teams offered a range of evidence based therapeutic interventions including cognitive behavioural therapy for psychosis, family interventions, family therapy and multi-family groups.
- Front line staff received appropriate training, supervision and professional development. Some staff told us they had been given a lot of support to learn new skills or update their skills. Most had been given development opportunities such as time off for study leave, time off for research and financial support to undertake higher education programmes including diplomas and master's degrees.
- We found effective multi-disciplinary meetings took place that enabled staff to share information about patients and review their progress. We noted that different professionals worked together effectively to assess and plan patient care and treatment.

However:

- Front line mental health staff did not receive 'refresher training' on the Mental Health Act and revised code of practice. There was limited oversight and scrutiny of the MHA and policy and procedures had not been refreshed to reflect the change in the MHA code of practice.
- The seclusion room on Heath did not meet the guidance set down by the Mental Health Act Code of Practice (2015). There were a number of instances when staff did not routinely advise patients of their rights under the Mental Health Act and some patients did not have robust capacity assessments in place to confirm they were able to understand and consent to their treatment.
- Staff in the trust's crisis and health based place of safety teams were not ensuring that the approved mental health professionals were notified in a timely manner which meant there were delays in Mental Health Act assessments taking place. Staff were not documenting the reasons for the delay in the patient records.

Our findings

Assessment of needs and planning of care

- Staff carried out comprehensive assessments of patients' needs. Most records we reviewed confirmed these had been completed.

Good

Are services effective?

- Some staff had received suicide prevention and self-harm mitigation training**,** which focused on developing the skills needed to help a person at risk of suicide or self-harm to stay safe.
- Where particular needs had been identified there were care plans in place to address these. Patients' physical as well as mental health care needs were addressed. Care and treatment records contained up to date information about patients. Most care plans were detailed, person centred and holistic. For example, forensic services had the capacity to screen patients for learning disabilities and autistic spectrum disorders to ensure they received the right support. The trust employed a physical health care nurse and trained healthcare assistants in phlebotomy. In the early intervention teams over 95% of patients had received a six month review of their care and treatment.
- Staff stored patient care records electronically. Trust information was held securely. Staff needed a card and password to access the system. Staff in other teams, such as the home treatment teams, could access patient records when they needed to in order to treat patients out of hours.
- Staff held care programme approach meetings to collect and monitor patient outcomes. Patients, their families and relevant professionals were involved in these reviews.

Best practice in treatment and care

- The trust used the royal college of psychiatrists' health of the nation outcome scales (HoNOS). This is the most widely used routine clinical outcome measure used by English mental health trusts. Patients on the older people mental health wards had food and fluid charts started on admission and malnutrition universal screening tools (MUST) were completed. 'MUST' was a five-step screening tool to identify adults, who were malnourished, at risk of malnutrition (undernourished), or obese. It also included management guidelines that could be used to develop a care plan.
- The trust had participated in the 2014 National Audit of Schizophrenia. Whilst most of the findings were positive it was noted that a below average proportion of patients reported knowing how to get help in a crisis. Trust performance on prescribing of antipsychotic medication was around the national average but was poor for those patients being prescribed higher doses than normally expected.
- Evidence was seen that trust staff followed National Institute for Health and Care Excellence (NICE) guidance. For example, one consultant psychiatrist in older people mental health wards had developed a guidance document sourced from evidence-based standards published by NICE. This was to help staff develop their skills using national and professional guidance in working with the small number of dementia patients on the wards. The early intervention in psychosis teams offered NICE compliant packages of care to patients within two weeks of their referral to the service.
- In community health services, the trust delivered care in line with current evidence-based guidance, standards, best practice and legislation. For example, policies, guidelines and training was in place to ensure that all staff delivered suitable care and treatment for a patient in the last year of their life.
- Do not attempt cardio-pulmonary resuscitation (DNACPR) forms were generally completed in accordance with national guidance.
- Community based mental health teams offered a range of evidence based therapeutic interventions including cognitive behavioural therapy for psychosis, family interventions, family therapy and multi-family groups. We noted that new staff had been given copies of NICE guidelines when they started work in the ADAPT team in Bexley, such as guidelines for anxiety, depression and post-traumatic stress disorders.
- Of the 23 individual clinical effectiveness goals the trust performed against in 2014/15, 18 (78%) were achieved, four (17%) were mostly achieved and one (4%) where the target was not achieved. For example, to ensure 95% of mental health patients have a recorded electronic care plan was green at 99%. To ensure that 90% of district nursing patients have a recorded electronic care plan was amber at 87%.
- The trust used outcome measures. For example, clozapine clinic staff assessed the side effects of medicines experienced by patients at each visit. Staff

used the Glasgow anti-psychotic side-effects scale every six months to assess the effects on patients. Staff were able to compare medication changes with any increase or decrease in side-effects.

- School nursing for 2014/15 achieved 100% uptake in the reception year National Child Measurement Programme and 99.9% in year 6. A new healthy weight programme had been introduced for those children classed as overweight to meet the high rate of obesity.
- Community adult mental health teams used a range of tools to measure outcomes for patients. These included positive and negative symptom scales, Warwick-Edinburgh mental wellbeing scale, psychotic symptom rating scale, beliefs about voices questionnaire and target complaint scales. These helped measure the effectiveness of the treatments offered. Some teams were piloting the use of clinical outcomes in routine evaluation, a short measure of psychological distress for routine use in psychological therapies.
- Community based learning disability and autism teams used three separate and recognised outcome measures in order to best understand the effectiveness of the support they gave to people. Staff used these measuring tools when they first supported people and then a second time when this support was complete. HoNOS was used to rate individual health in relation to 12 key indicators; the second tool was called 'my targets' which asked people to identify their treatment goals; the third was the 'quality of life measure' where they rated their quality of life in answer to nine questions.
- Frontline trust staff had participated in clinical audits. For example, care plans caseloads and physical healthcare checks. Actions identified had been addressed. For example, following an audit of learning from suicides in the community, recommendations were identified and an action plan was in place to address these. Team meeting records showed that audits were discussed in team meetings and relevant action plans drawn up.

Skilled staff to deliver care

- All new staff to the trust including locum staff received an induction to their area of work and responsibilities. Permanent staff received a three day corporate induction when they started. Some new staff told us their induction had been the best they had ever experienced.
- Front line staff received appropriate training, supervision and professional development. Some staff told us they had been given a lot of support to learn new skills or update their skills. Most had been given development opportunities such as time off for study leave, time off for research and financial support to undertake higher education programmes including diplomas and master's degrees.
- Staff on the older people mental health wards were provided with specialist training. For example, malnutrition universal screening tool **(**MUST) training around nutrition monitoring and diabetes care. These wards had a 'champion' in specific areas, for example, safeguarding, to encourage improvement in practice.
- A total of 238 (89.5%) permanent non-medical staff had an appraisal within the last 12 months at 1 February 2016. In the NHS Staff Survey 2015, 91% of staff said they had been appraised in the last 12 months. This was in line with the national average. This score had reduced by one percentage point from 2014 to 2015.

Multi-disciplinary and inter-agency team work

- Each service had access to a comprehensive multi-disciplinary team. Members included nurses, occupational therapists, doctors, social workers, psychologists, psychotherapists and health care support workers. Each team had clearly structured meetings. There were standard items for discussion at these meetings and families were involved where appropriate.
- We found effective multi-disciplinary meetings took place that enabled staff to share information about patients and review their progress. We noted that different professionals worked together effectively to assess and plan patient care and treatment.
- In community health services, there was good engagement with primary care and other providers and across disciplines; we saw some excellent examples of multidisciplinary working.
- Community mental health adult teams worked closely with the home treatment teams to prevent patients being admitted to hospital if they could be supported

more intensively at home. Managers attended meetings with community child and adolescent mental health service (CAMHS) teams to identify young people about to transfer to adult teams, which enabled them to provide support to the young person and facilitated information sharing. Similarly the early intervention teams worked closely with CAMHS teams. Managers attended regular meetings with improving access to psychological therapies teams (IAPT), that frequently referred patients to primary care plus.

- The trust's forensic service maintained contact with commissioners and with patients in other services who were due to be admitted to the Bracton centre as part of their proactive discharge plan.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- The board delegate the operation of the Mental Health Act (MHA) to the head of mental health legislation and safeguarding. There was a non-executive director lead for the MHA who chaired the MHA scrutiny committee and acted as a panel member for the hospital manager hearings. A monthly report was provided to the trust board.
- There was a governance system in place to monitor and report the administration and some aspects of operation of the MHA; this included the board receiving information from CQCs MHA visits and information from the MHA scrutiny committee.
- The MHA scrutiny committee had combined with the safeguarding committee in 2014 which we were told has resulted in a lack of time for discussion of the MHA items. The trust had rectified this and one meeting had taken place since the decision was made.
- We saw that regular audits were completed in relation to administrative aspects of the MHA usage, section 132 rights discussions on admission and completion of section 58 paperwork. There was no audit of the patient experience of detention including deaths, incidents or complaints.
- There was good administrative support available for staff and ward staff told us they knew who to contact if required. The process of admission document scrutiny appeared to be robust and timely. However, the MHA offices did not have any involvement in the arrangements for conditional discharged patient reports to be returned to the Ministry of Justice and the administration for the 54 patients currently on conditional discharge was managed between the clinicians and the Ministry of Justice case worker. There was no assurance process to confirm this is carried out.
- Training for the MHA and the Mental Capacity Act (MCA) was not considered mandatory by the trust. We were informed that junior doctors and preceptorship nurses received an induction session and some training on demand. Although the uptake of this was not clearly documented by the trust.
- Additional training was provided in 2015 to the nurse advisory forum following the introduction of the revised MHA code of practice. Additional training on the MHA was provided if requested and focussed on administration processes rather than the principles or practices set out in the code of practice. There was no set training programme in relation to learning from incidents, issues raised within MHA monitoring visits or training to support the implementation of the revised code of practice.
- We were concerned that the policies and procedures we reviewed had not been updated following the implementation of the revised MHA code of practice. For example, we were shown a copy of the 'prevention and management of violence and aggression' policy on Avery ward that had been updated in October 2015, and we accessed the 'absent without leave' policy which had been updated in November 2015 but both continued to refer to the previous code of practice. Both policies had been reviewed and approved by the MHA scrutiny committee. The revised code sets new standards and increased the good practice expectations for existing areas covered in the code for providers and professionals when making decisions about care and treatment for people affected by the Act. CQC stated on the publication of the revised Code that it would expect services to have such policies and procedures in place by October 2015.
- We found that detention paperwork was filled in correctly, up to date and stored appropriately.
- There was good adherence to consent to treatment and capacity requirements overall. Copies of consent to treatment forms and appropriate certificates were

attached to medication charts where applicable. However, on one ward at the Bracton Centre we noted that some patients were being treated under the authority of T2 certificates without a full understanding of the treatment proposed and with the responsible clinician recording in some cases that patients had not consented to all the treatment listed in the certificates.

- There was evidence that most people had their rights under the MHA explained to them. However at the Bracton Centre, we were unable locate consistent evidence that all patients had been informed of their rights on admission and regularly thereafter.
- A majority of the care plans we reviewed were comprehensive and individualised. At times however we found inconsistent evidence of patient involvement and the recording of patient's views in relation to their care and treatment in line with the code of practice.
- With the exception of Atlas ward where the Independent Mental Health Advocacy (IMHA) service was not available for patients from other boroughs, patients had access to and information on IMHA services. Patients and staff appeared clear on how to access IMHA services appropriately. Representatives from the three Local Authorities providing IMHA services attend the Safeguarding Committee and any issues would be taken to that meeting for discussion.
- All wards had separate sleeping and bathroom areas for male and female patients. However, some of the acute admission wards were not MHA code of practice compliant in regard to gender separation and some patients were being placed in bedrooms in the opposite gender areas. This issue had been raised during past MHA monitoring visits.
- The seclusion room on Heath did not meet the guidance set down by the Mental Health Act Code of Practice (2015). There were a number of instances when staff did not routinely advise patients of their rights under the Mental Health Act and some patients did not have robust capacity assessments in place to confirm they were able to understand and consent to their treatment.
- Staff in the trust's crisis and health based place of safety teams were not ensuring that the approved mental health professionals were notified in a timely manner which meant there were delays in Mental Health Act assessments taking place. Staff were not documenting the reasons for the delay in the patient records.

Good practice in applying the Mental Capacity Act

- Mental Capacity training was not a mandatory training course for staff at the Trust. However, we found that 97% of all staff had received training in the Mental Capacity Act 2005 (MCA). The trust confirmed that the renewal timeframe for this training course was 'once minimum'.
- The trust had a MCA policy and had produced a short and clear summary of the MCA for staff. Some staff were very knowledgeable and spoke confidently about the legislation. They knew about knew the five statutory principles and the capacity test. However, not all staff spoken with had a good understanding of the MCA in practice.
- Care and treatment records demonstrated that patients were informed that they could make advanced decisions regarding their care and treatment. When appropriate, best interest meetings were held. Patients in memory services were advised about lasting power of attorney arrangements.
- Where staff had concerns about a patient's capacity they conducted assessments. These were clearly documented.
- The trust policy for consent to examination or treatment dated February 2016 gave detailed guidance to staff on when and how to seek and document consent. Staff were well informed in terms of gaining patients' consent to treatment. Staff understood the importance of gaining the informed consent of patients.
- There were 41 Deprivation of Liberty Safeguards (DoLS) applications made by the trust between August 2015 and January 2016. The largest numbers were made by Holbrook and Oaktree lodge both older people's mental health wards. However, the Care Quality Commission had only been notified of one during this period.
- The adult mental health (AMH) quality newsletter dated April 2016 referred to a deprivation of liberty safeguards (DoLS) audit. They sampled random cases to look at

adherence with the Mental Capacity Act (2005) and specifically the DoLS. This demonstrated that the trust were identifying gaps and learning around MCA and DoLS.

Good

Are services caring?

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

Summary of findings

We rated Oxleas NHS trust as good for caring because:

- The majority of patients were positive about the staff, and their experience of care on the wards. Patients and their families or carers had the opportunity to be involved in discussions about their care. Many felt their mental health had improved as a result of the service they received from the trust.
- Staff demonstrated a good understanding of the individual needs of patients. Robust trust wide systems were in place to promote patient confidentiality.
- We found staff within the end of life community health service team provided focused care for dying and deceased patients and their relatives.
- Most patients and their carers told us that patients were orientated to their ward on admission and were shown around the ward by staff. They had received an information leaflet relating to the ward.
- Patients were able to express their views, which staff reflected in the key documents they prepared. Almost all care plans were written in a person centred way and were holistic, which meant they covered all aspects of the patients's care and support needs

Our findings

Kindness, dignity, respect and support

- We found that patients were treated with kindness, dignity and respect. We saw patients were able to approach staff freely when they wanted help and support or if they were upset. Staff were able to identify when patients needed emotional support and we saw them offering this in an individualised way.
- Staff interacted with patients in a caring and compassionate way, showing appropriate levels of humour. They responded to patients in a calm and respectful way. The observed interactions were supportive and enabling.We saw staff listening to and having productive discussions with patients.
- Throughout the trust staff demonstrated a good understanding of the individual needs of patients. Robust trust wide systems were in place to promote patient confidentiality.
- We found staff within the end of life community health service team provided focused care for dying and deceased patients and their relatives.
- In relation to privacy, dignity and wellbeing, the 2015 PLACE score for Oxleas NHS Foundation Trust was 92% which was better than the England average of 86%. The trust's friends and family test score for privacy dignity and wellbeing over the six months between August 2015 and January 2016 averaged 97%. This was better than the national average of 95% over the same period.
- The CQC Community Mental Health Survey 2015 surveyed people who had been in contact with community mental health services in England between 1 September and 30 November 2014. The survey involved 55 NHS trusts in England and had 13,292 respondents, a response rate of 29%. Oxleas had a return of 23% and scored about the same as other trusts for all ten questions asked during this survey.
- The trust encouraged patients to complete a patient experience questionnaire (PEQ) on discharge. We reviewed the results of 127 PEQs received in the previous three months for the community OPMH service. 94% of responses indicated they were likely to recommend a family member or friend. Overall, 74% of responses were extremely likely to recommend a family or friend. In March 2016 67% of patients using mental health community services for adults said they were extremely likely or likely to recommend the service to their friends or family. In community health services, 98% of patients would recommend the trust as a place to receive care

The involvement of people in the care they receive

Good

Are services caring?

- Most patients and their carers told us that patients were orientated to their ward on admission and were shown around the ward by staff. They had received an information leaflet relating to the ward.
- Patients were encouraged to attend the trust's "user forum" and carers to attend the "carers' forum".
- Throughout the trust, staff ensured patients could use an independent mental health advocacy (IMHA) service if they needed to. Information about the service was displayed on each ward and other patient areas.
- Patients were able to express their views, which staff reflected in the key documents they prepared. Almost all care plans were written in a person centred way and were holistic, which meant they covered all aspects of the patients'' care and support needs
- The forensic service wards held weekly community meetings where patients could have a say in the running of the ward. They could give suggestions and make requests for changes to things like menu plans or activities. Patients took responsibility for chairing the meetings. Staff circulated the minutes for future reference.
- Staff had placed suggestions boxes in reception areas where patients and carers could post suggestions for improvements and other feedback.
- Trust community mental health staff offered carers assessments to carers. The number of carers assessments carried out was monitored by the trust. Staff facilitated carers groups.
- Some trust wards displayed "You said We did" posters. This showed patients what the service had done to respond to their feedback.
- Trust community learning disability staff supported people to sit on recruitment panels for new staff members as part of a trust initiative to involve patients in the selection and hiring of staff.
- However, some care and treatment records did not fully record the extent of patient involvement in drawing these up. For example for patients receiving care and treatment at the Bracton centre.

Good

Are services responsive to people's needs?

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

Summary of findings

We rated Oxleas NHS trust as good for responsive because:

- Trust board meeting minutes and discussions with commissioners demonstrated that trust services were planned and delivered to meet the needs of people.
- The trust was taking pro-active steps to manage admissions and discharges effectively. For example, the trust's proportion of admissions to acute wards gate kept by the CHRT was above the England average for all 11 of the 12 quarters reported. They also exceeded the national 95% target in 11 of the last 12 quarters.
- In community health services, admissions were well managed to minimise risks to patients. Discharge from the service was well planned to ensure the needs of patients would continue to be met. Delayed discharges were usually beyond the control of the hospitals.
- The trust held mental health bed management meetings once a week and two daily telephone conferences. These meetings included managers from the inpatient and crisis teams. Representatives from the Woodlands unit, Oxleas House and Green Parks House were also present. The attendees provided up-to-date information on bed status, a review of admissions waiting for beds, accelerated discharges to accommodate new admissions and patients that were in beds outside of the trust area and possible return dates.
- The four main pathways into mental health crisis services were; the trust's urgent advice line, mental health liaison, community mental health teams and primary care plus (PCP) which was created for patients that were unknown to the teams.
- In community health services, patients received adequate pain relief and were supported to eat and drink suitable food in sufficient quantities.
- Complaint information posters were on display around the trust. Most patients were aware of how to make a formal complaint and had received the information for the patient advice and liaison service (PALS) which staff had given them. Patients told us that they felt comfortable to raise their concerns to the trust if required.
- The trust received 148 formal complaints in 2014/2015, a decrease of 56 from 2013/2014 (204). Feedback from complaint investigations were discussed in team meetings and in embedded learning events provided by the trust during the year. During the year 12 complainants contacted the parliamentary and health service ombudsman (PHSO) for a review of their complaint. Four were not upheld, eight remained on-going.

However:

- In community health services, there was no caseload weighting tool to ensure health visitors could deliver an equitable service across the trust. Some caseloads were very high, above the upper limits as set by their professional organisations. Allocation meetings where staff allocated work were not recorded consistently. This meant there was no process to review staff allocation. There was no robust system regarding the allocation of families and their level of need with the capacity of the staff to meet the need.
- Average bed occupancy levels across the trust was 93% with 24 out of 29 wards having bed occupancy of over 85% between July and December 2015. This meant that when some mental health patients went on leave, the trust had used their beds for new admissions.

Good

Are services responsive to people's needs?

Our findings

Service planning

- Trust board meeting minutes and discussions with commissioners demonstrated that trust services were planned and delivered to meet the needs of people.
- There were clear care pathways within community mental health services. Primary care plus provided the single point of access to trust community mental health services. All referrals coming into primary care plus on a particular day were reviewed by a consultant psychiatrist to see if the person was known to the service and identify whether any routine referrals should be reclassified as urgent.
- The trust had an operational policy which clearly stated which patients were suitable for the service. There were no age restrictions for patients and access was based on need. For example, memory services provided assessment and treatment to people of all ages.

Access and discharge

- Staff in community adult mental health services told us that referrals categorised as urgent by GPs were always treated as urgent. Staff tried to contact urgent referrals on the same day or within 24 hours.
- Across the three boroughs of Bexley, Bromley and Greenwich the average waiting time from referral to initial assessment for the home treatment team was two days in the past 12 months. The trust told us that it was assumed that a patient would be provided with an initial assessment at the first appointment. Historically the trust did not have a target for this and had agreed a target time with the service commissioners in the past 12 months. The average waiting time from the first appointment/assessment to treatment was two days. The teams commenced treatment from the first appointment by beginning the engagement process and exploring patient need.
- The four main pathways into crisis services were; the trust's urgent advice line, mental health liaison, community mental health teams and primary care plus (PCP) which was created for patients that were unknown to the teams. PCP made it easier for GPs to refer into which included the home treatment team (HTT). Referrals made from PCP were fast-tracked and responded to as a priority.
- The trust's proportion of admissions to acute wards gate kept by the CHRT was above the England average for all 11 of the 12 quarters reported – ranging from 1% - 3.7% above the England average. They also exceeded the national 95% target in 11 of the last 12 quarters.
- Access to day treatment teams would be mainly from the inpatient wards and HTT. Mental health liaison teams referred patients that required an admission to the duty senior nurse (DSN). They were made aware of the referral and a bed would be sourced.A senior manager told us that at times beds were unavailable and a patient would be made comfortable on another inpatient ward until a bed became available. Responsibility was then passed on to the in-patient ward to manage the admission.
- Within community mental health adult teams the target for patients who did not attend appointments (DNAs) was set at 10% or lower. In the three months from January to March 2016 the DNA rates in the ICMP and ADAPT teams ranged from 6% in the Bromley East locality team to 11% in the Bexley and Greenwich teams. In the early intervention in psychosis service the DNA rate was below 10% in all of the borough teams over the same time period. Trust staff made determined efforts to keep in contact with patients who were reluctant to engage with the team. For example, we saw that phone calls and text messages were sent to individual patients.
- In community children and young people services, there was no caseload weighting tool to ensure health visitors could deliver an equitable service across the trust. Some caseloads were very high, above the upper limits as set by their professional organisations. Allocation meetings where staff allocated work were not recorded consistently. This meant there was no process to review staff allocation. There was no robust system regarding the allocation of families and their level of need with the capacity of the staff to meet the need.
- Care and treatment records showed that community appointments usually ran to time and that patients were informed of any delays caused by traffic or other issues.

Good

Are services responsive to people's needs?

- The trust provided details of bed occupancy rates for 29 wards between 1 July 2015 and 31 December 2015. The average bed occupancy rate was 93.1% across all wards. 24 out of 29 wards had bed occupancy over 85%. The five wards with the highest bed occupancy were all adult mental health acute admission and PICU wards, and the highest three wards were at the Queen Elizabeth's Hospital site; Avery, Maryon and Shrewsbury wards. The only core service with average bed occupancy below 85% was learning disabilities, which had average bed occupancy of 72%.
- At Green Parks and Oxleas House mental health acute admission services, each ward had between 16 and 19 beds. In addition to this, they each had one surge bed.The PICU had 13 beds and no surge beds, however two sleepover beds were located at the end of the ward separated by locked doors and managed by extra staff.Staff said the surge beds were used daily. Records showed us that patients in those rooms had a length of stay ranging from two days to a week.
- All staff told us bed pressures were the biggest issue, and that the situation had been intense during the previous 12 months. When the demand for beds was high, patients were moved between areas. Any patients moved between wards were recorded on the trust electronic system as an incident.
- Three patients shared their experience of admission to the hospital. There were no beds available at the time, so two of them slept on a sofa for the first night and reported that another patient slept on a mattress in the activity room. One of the patients waited 12 hours for a bed to become available.
- The trust held bed management meetings once a week and two daily telephone conferences. These meetings included managers from the inpatient and crisis teams. Representatives from the Woodlands unit, Oxleas House and Green Parks House were also present. The attendees provided up-to-date information on bed status, a review of admissions waiting for beds, accelerated discharges to accommodate new admissions and patients that were in beds outside of the trust area and possible return dates.
- The trust identified 131 services where assessment to treatment time was measured. Depending on the service and relevant target, either 95% or 92% patients were expected to be treated within 18 weeks. The trust overall had a mean assessment to onset of treatment of 96%.The trust missed the target in 14 out of 131 services and were the services that had the lowest performance. However, whilst Bromley CAMHS and Bexley Adults AHP each had 50% compliance rates, in both instances, the 50% statistic equated to one out of two patients against targets of 95%.Community mental health for older people and Mental Health Crisis and place of safety were the only core services where all services met their targets.
- The trust recorded 99.5% of patients on CPA who were followed up within 7 days after discharge between October and December 2015. This was above the England average of 97%.
- There were a total of 178 re-admissions within 90 days reported by the trust between the July and December 2015 across 28 wards. The wards with the highest number within 90 days were Millbrook with 32, Maryon with 26 and Shrewsbury with 23.
- Between 1 July 2015 and 31 December 2015 there were a total of 30 delayed discharges within 30 days reported across all wards. Adult mental health wards overall were among the highest in both delayed discharges and re-admissions within 90 days. Wards at Queen Mary's Hospital site had both the highest number of delayed discharges and the highest number of re-admissions within 90 days.
- There was a total of 5816 delayed discharge days over 2015.The reasons provided by the trust were as follows: 1814 (31%) were due to awaiting residential home placement or availability, 1018 (17.5%) were due to awaiting completion of assessment, 997 (17%) were due to awaiting nursing home placement/availability.
- Access to trust services for people with protected characteristics was supported by a range of roles and projects and monitored through the following audits/ report
    - Care and treatment reports across all protected characteristics.
    - Interpreting service data.
    - Analysis of complaints and incidents data.
    - Estates and facilities review of disabled access.

Good

Are services responsive to people's needs?

The facilities promote recovery, comfort, dignity and confidentiality

- There was a range of community based meeting and clinical rooms available to support care and treatment and these were adequately sound proofed. Staff displayed information leaflets on a range of relevant topics for patients and carers in patient waiting areas. These supported people to make decisions about their care and treatment.
- Waiting areas were welcoming. They were bright and well-lit. There were interview rooms available at all the team premises. They were adequately furnished. Waiting areas were equipped with a water dispenser so that people waiting could have a drink. People had access to toilet facilities. However, Greenwich West facilities were in need of improvement, the trust hoped to upgrade the facilities to provide more a pleasant environment for patients and staff.
- The trust had a range of rooms and equipment for staff and patients to use as part of the in-patient treatment and therapy programme. This included space for therapeutic activities, relaxation and treatment. Most buildings were modern and purpose built. The furniture provided was mostly comfortable and modern.
- In community health services, patients received adequate pain relief and were supported to eat and drink suitable food in sufficient quantities.

Meeting the needs of all people who use the service

- Patients with mobility concerns, including wheelchair users, could access community health services. Consultation rooms were generally located on the ground floor. Primary care plus sometimes carried out home visits to complete assessments if the patient was unable to come to the team's base.
- Information leaflets were available in different languages in some services. Patients who had difficulties understanding English confirmed they had been offered these. Staff could print information in different languages for patients. If information was not available in a particular language staff could request this. Staff teams were diverse and spoke a range of different languages between them.
- However, in the Greenwich locality teams there was no information in other languages on display in the waiting rooms although the local areas were very diverse and many different languages spoken.
- Teams tried to honour patient requests to work with staff of a particular gender.
- Staff respected patients' diversity and human rights. They had received training in equality and diversity as part of their mandatory training programme.
- There was a multi-faith room at the Bracton centre but not all patients were aware of it. The service had a linked spiritual advisor and most patients knew of them and said they could get spiritual guidance if they wanted it.
- The trust had set up a lived experience network for staff that had experience of using mental health services themselves. This was an innovative and inclusive service.

Listening to and learning from concerns and complaints

- Complaint information posters were on display around the trust. Most patients were aware of how to make a formal complaint and had received the information for the patient advice and liaison service (PALS) which staff had given them. Patients told us that they felt comfortable to raise their concerns to the trust if required.
- Staff that we spoke with understood the complaints process and felt comfortable in raising concerns that they had. Complaints investigations take place within each directorate. Each service director had ownership of this process. All complaint investigations were reviewed by the relevant service director. Frontline staff told us that their service director regularly visited and discussed issues from complaints with them. The trust had a website around complaints with case studies for staff to review.
- The trust received 148 formal complaints in 2014/2015, a decrease of 56 from 2013/2014 (204). With the exception of 'other', nursing, midwifery and health visiting received the highest number of complaints with 47 (31%); a decrease of 16 from 2013/2014 (63 complaints). Eighty-four of these were upheld by the trust. Feedback from complaint investigations were

Good

Are services responsive to people's needs?

discussed in team meetings and in embedded learning events provided by the trust during the year. We were informed that there were 34 open complaint investigations across the trust.

- During the year 12 complainants contacted the parliamentary and health service ombudsman (PHSO) for a review of their complaint. Four were not upheld, eight remained on going.
- The trust had received 798 compliments between April 2015 and March 2016. The highest number, 471, received from adult community health services.
- Senior staff confirmed that the patient experience of care was being captured through a variety of methods. We found examples of this through the Oxleas patient experience questionnaire (OPEQ), the friends and family Test (FFT) feedback forms patient experience trackers and online surveys. Evidence was seen of the trust following up on specific concerns highlighted by people's individual feedback. For example, on their web site.

Requires improvement

Are services well-led?

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

Summary of findings

We rated Oxleas NHS trust as requires improvement for well led because:

- There were inconsistencies in the feeding back of safe staff numbers across the acute care core service from ward level to senior management. This meant that senior management did not have a clear picture of shifts that were below numbers required. The trust had recently adopted an improved system of reporting safe staffing to the board.
- Managers escalated risks related to the service via their line managers and in regular performance meetings. A directorate wide risk register highlighted the specific risks affecting specific services. For example, the steady growth in referrals and the risk that referrals may outstrip the services' capacity to respond; was highlighted in adult mental health community services.
- Action plans were put in place following investigations in to serious incidents, but risk registers identified that not all lessons learnt were shared with all staff.
- There were gaps in the governance structures that supported the delivery of safe and effective care. For example lack of oversight and action about bed use communicated from the teams to senior management and trust board and vice versa.
- We found examples that not all policies and procedures were followed. The policies amended in line with the MHA code of practice did not reflect the recommendations laid out in 2015 and the governance arrangements in place had not captured this.

However:

- The majority of staff knew and understood the values of the trust. These were: having a user focus, excellence, learning, being responsive, partnership and safety. Most front line staff were aware of these and could describe these. We found that the trust's vision and values were included in the trust's strategy for 2016/2017.
- Staff knew who senior managers in the trust were and said they were visible. Senior managers and trust board members had visited all locations and most services and sent reports of their visits back to teams. Non-executive directors had a good understanding of the trust's strategy and presented appropriate challenge to the executive.
- Staff were positive about the trust as an employer. They described a trust that looked after their staff, encouraged individual services to improve and had a 'no-blame' culture.
- The trust supported a range of groups, events and services to promote inclusion and employment, including; a volunteer to work scheme, a research group for people with lived experience of mental ill health and the development of paid and voluntary peer support posts.
- The trust's patient experience, patient safety and clinical effectiveness quality priorities were monitored monthly by the trust executive and board of directors; bi monthly by the trust quality committee and subgroups.
- The trust had participated in a number of applicable Royal College of Psychiatrists' (Psych) quality improvement programmes or alternative accreditation schemes. For example, the Greenwich and Bromley home treatment teams were accredited by the Royal College of Psychiatrists home treatment accreditation scheme (HTAS).

Our findings

Vision, values and strategy

Requires improvement

Are services well-led?

The trust vision was 'improving lives' and the aim to improve lives by providing the best quality health and social care for patients and carers. The trust had six values and belief that set out how they behave as an organisation. These were:

- user focus
- excellence
- learning
- responsive
- partnership
- safety
- Trust board members interviewed were clear about the trust's vision and strategy. Senior clinicians were clear about their role and the trusts direction.The vision and values were on display in the trust and were available on the intranet. The majority of staff knew and understood the values of the trust.
- Staff knew who senior managers in the trust were and said they were visible. The executive team carried out regular walkabouts and each year were assigned a directorate which meant that they visited all locations and most services and sent reports and any actions of their visits back to teams and reported this activity to the board.
- The trust's vision and values fed into the trust's strategy for 2016/2017. The trust identified four priorities:-
- Enhancing quality - offer a guarantee of excellence for every patient
- Promoting innovation - redesign services with patients, families and carers
- Increasing productivity - be resilient and resourceful to thrive in difficult times
- Transformational change - delivering best practice services, for the future, today
- The trust had appointed a new chair in November 2105 and the chief executive post was open for advert at the time of the inspection. We were told once this process was complete the strategy would be refreshed. We are told the strategy will be underpinned by the values and aims of the trust. The trust had made a patient promise and there were four 'must dos' which were:
- Increase support for families and carers
- Enhance care planning
- Provide better information for service users and carers
- Improve the way we relate to both our service users and carers by treating them with dignity and respect.

Good governance

- The trust had recently had a review of their governance arrangements carried out by an independent audit firm. The review was based on Monitor's (now NHS improvement) well led governance frameworks and regarded the trust as having effective systems in place with some recommendations and actions.
- The details of risks to the strategic objectives were included in the corporate risk register (CRR) reported each month to the board and expectations for this being set out within the risk management framework. We saw evidence of the risks to the strategic objectives being discussed at the board meetings and sub-committees which informed updates to the corporate risk register. We were told that work had been completed to improve the clarity between the terminology within the BAF and the CRR following a previous audit, carried out by an independent consultancy company in February 2015.
- The trust had a clear reporting structure and staff knew what they were accountable for. The following committees reported directly to the board:-
- Audit committee
- Business committee
- Quality committee
- Workforce, learning and development committee
- Risk committee.
- There were a range of sub groups, with clinical and management representation, that reported into these committees.
- Managers had access to real time information about the training and supervision of staff in their teams. They also received monthly reports of mandatory training, which highlighted when staff needed to renew or complete training. This supported the high levels of compliance with mandatory training, supervision and annual appraisals that we found during the inspection.

Requires improvement

Are services well-led?

- Managers and staff met to discuss summaries of learning from incidents and complaints related to the service, reviewed monthly patient experience reports and considered team performance data.
- Managers escalated risks related to the service via their line managers and in regular performance meetings. A directorate wide risk register highlighted the specific risks affecting specific services. For example, the steady growth in referrals and the risk that referrals may outstrip the services' capacity to respond; was highlighted in adult mental health community services.
- Across the children and young people's core service there had been problems with data collection and quality. Minutes of directorate meetings and quality board meetings also relayed concerns about data quality. There was no health visitor caseload weighting to ensure staff had the capacity to meet people's needs. This meant the service could not be assured of how services were performing however, there were plans to set up a data governance leadership group and develop case load weighting tool in line with best practice.
- We found examples that not all policies and procedures were followed. The trust had designated a bed on an adult acute ward for use when an inpatient CAMHS bed was not available. The trust had a protocol on the use of this bed. However, we found several examples where staff had not followed the procedures outlined in the trust protocol. One example was that the for the most recent admission, no attempt had been made to find an inpatient CAMHS bed following a mental health act assessment. It was not clear that senior CAMHS staff had ensured the ward provided an appropriate and safe environment for a young person or participated in the care planning and delivery for this patient..
- Staff were trained in safeguarding adults and children, understood trust procedures and made appropriate safeguarding referrals.
- From the GMC Training Survey 2015. The trust had four positive outliers for; clinical supervision out of hours, access to educational resources and study leave in forensic psychiatry and regional teaching in old age psychiatry. There had one negative outlier; educational supervision for psychiatry of learning disability
- Clinical team leaders said they had enough time and autonomy to manage their wards effectively. They said they were able to get support from the senior nursing team and from each other when they needed it. The trust held regular senior nurse meetings at directorate level, which records showed were well attended and documented. This gave local managers the opportunity to learn and share information while providing consistency in approach across the different wards.
- The trust had limited systems to audit their compliance with the Mental Health Act (MHA). We found that these were not always effective because records on some wards showed long gaps when staff had not advised patients of their rights under the MHA and staff did not routinely record if they gave patients a copy of their section 17 leave authorisation.
- The trust carried out regular audits to assure themselves they were providing safe and quality care. Audits included infection prevention and control, medication management, patient satisfaction, fire safety, the use of seclusion and ligature risks. However, we found it was difficult for front line staff to evidence a timeline between when they carried out the ward based ligature audit and when the work to remove or modify risks had taken place. Although, a sample of ligature audits from two wards showed that ligature risks identified in 2014 had been mitigated by the service when the next audit was carried out in 2015.
- The trust participated in all of the relevant national audits as prescribed by NHS England. For example, of schizophrenia, intermediate care and the chronic obstructive pulmonary disease (COPD) audit programme.
- The trust had defined safety goals and these were monitored and acted against**.** However, the trust had designated a bed on an adult acute ward within the trust to be used in the occasion that an inpatient CAMHS bed was not available in adjoining London trusts. The trust had a protocol on the use of this bed in an emergency; however, we found several examples that not all procedures outlined in the trust protocol were being followed. One example was that no attempt had been made to find an inpatient CAMHS bed and this young person had been immediately referred to the bed on the adult ward following a mental health act assessment.

Requires improvement

Are services well-led?

- Overall, the trust had good working arrangements with commissioners, local authorities and other partners and third party organisations.

Fit and proper persons test

- In November 2014 a CQC regulation was introduced requiring NHS trusts to ensure that all directors were fit and proper persons. As a consequence of this the trust had checked that all senior staff met the necessary requirements. The trust had set up policies and procedures to ensure that all future senior staff had the relevant checks. During the inspection the trust provided us with details of all the checks they had undertaken to meet this regulation. We reviewed eight individual files at random and these met the required standard.

Leadership and culture

- The trust had had a period of senior leadership change. The chair was appointed in November 2015 and there was an interim chief executive in post. Most staff were positive about the new chair and the interim CEO appointment. Several staff we spoke with raised that the outgoing chief executive had been a huge influence across the trust. Some staff became emotional speaking of his departure and the loss this had been to the trust. It was too early to tell what impact these changes will have on the trust.
- Most staff were positive about the trust as an employer. They described a trust that looked after their staff, encouraged individual services to improve and had a 'no-blame' culture.
- The trust had a head of partnership and freedom to speak guardian. They led staff focus groups of similar grade staff across the trust and met directorate leads to feedback to them. A twice yearly report containing focus group themes and any action taken was sent to the trust board for discussion. Unannounced walk rounds took place with the head of employee relations so that any concerns could be identified by front line staff and addressed if possible by the trust.
- The trust had three active staff networks: BME, LGBT and the Lived Experience Network (for staff with experience of mental ill health). Time off for network activities had been agreed, which was set out in the trust's partnership agreement. All networks had elected chairs and executive teams and regular executive and member meetings, stalls at the annual members meeting and nursing conference.
- The trust had 24 trained bullying and harassment advisers, with staff from all four networks included as advisers. The advisors were based across all areas of the trust. From the 2015 NHS staff survey - 18% of staff reported that they experienced harassment, bullying or abuse from staff in the last 12 months. This was four percentage points better than the 2014 survey and 3% better than the national average for mental health / learning disability and community trusts. 28% of staff reported that they experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months. This was 3% better than the 2014 survey and the same as the national average for combined mental health / learning disability and community trusts.
- Equality, diversity and human rights was led by the quarterly equality and human rights (E&HR) governance group. This group reported to the workforce learning and development committee, which subsequently reported direct to the board.
- The trust produced an annual equality report, which included workforce data and examples of equality work, providing evidence of compliance against the three main headings of the general duty. The trust had published service user equality data by protected characteristic and the four equality objectives covering workforce and service users, in line with the requirements of the public sector equality duty (PSED).
- The trust had implemented the workforce race equality standard (WRES) metrics, along with an action plan to address the differences in measures for black minority and ethnic staff (BME). The board have discussed these and reviewed the action plan throughout the year. We noted that most of the trust's action plan had been achieved. The trust have been involved in providing advice and developing the WRES as part of the national technical steering group.
- The trust had a disability action group (DAG), where disabled staff, human resources, occupational health, staff side, health and safety, estates and facilities staff worked together to make improvements for disabled staff in the trust. DAG had regular meetings and

information was available on the intranet. The network chairs attended the staff partnership forum and met quarterly to organise cross collaboration, cross network events, discuss common themes and share information. The network chairs were available to offer advice to staff and to the bullying and harassment advisers.

- The trust had undergone assessment against the equality delivery system framework (EDS). It is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS. The results, update and actions are available on the public facing website. The trust was working with NHS England on a project to develop disability as an asset and the national development of the workforce disability equality standard (WDES).
- Managers gathered performance data and used it to address quality and staff performance issues.
- Managers made sure that staff had regular supervision and appraisals. These were documented and recorded.
- The trust scored above average for similar trust for overall staff engagement in the 2015 NHS staff survey. For example, 75% of staff would recommend the trust as a place to receive treatment to a family member or friend. The 2015 national average was 67%.
- From the 2015 NHS staff survey - the trust reported a score of 3.85 in reporting staff confidence and security in reporting unsafe clinical practice. This figure was marginally higher than the 2014 survey and similar to the national average for combined mental health / learning disability community trusts
- From the 2015 NHS staff survey - 92% of staff reported errors, near misses or incidents witnessed in the last month. This figure decreased by 5% from the 2014 survey and was the same as the national average for combined mental health / learning disability and community trusts.

Engagement with the public and with people who use services

- The trust supported a range of groups, events and services to promote inclusion and employment, including:-
  - A Volunteer to Work scheme [all groups]
  - A research group for people with lived experience of mental ill health, Research net [lived experience]
  - The development of paid and voluntary Peer Support posts [lived experience]
  - A service for women survivors of sexual abuse [gender]
  - A group for young people looking at gender identity [gender identity]
  - Koestler awards, arts by offenders [disability – forensic services]
  - Regular social and group events at a local community venue, led by volunteers called 'Tramtastic Fridays' [ALD]
- The trust collected patient experience feedback across all of their services using a number of methods including; the Oxleas patient experience questionnaire (OPEQ), the friends and family Test (FFT) feedback forms patient experience trackers and online surveys.
- From the trust's friends and family test; the quality report for 2014/2015 stated that 89% of patients recommended the service to friends and family if they need similar care or treatment. 93% of patients reported that staff have treated them with dignity and respect. The latest results available for February 2016 showed that 82% of mental health patients and 98% of community health service patients would recommend the trust as a place to receive care and treatment.
- The council of governors is the body that binds the trust to its patients, service users, staff and stakeholders. The trust had 42 elected members and appointed individuals who represent members and other stakeholder organisations. They each represent a constituency across the three boroughs and cover the diversity of the trust. The group felt they held the trust to account via the non–executive directors on key issues and were confident that the response they received was timely, open and transparent. They reported they are able to call individual directors to the meetings should this be required. We saw documents that supported the involvement of the governors in investigations of serious incidents

Quality improvement, innovation and sustainability

- The trust's patient experience, patient safety and clinical effectiveness quality priorities were monitored monthly

by the trust executive and board of directors; bi monthly by the trust quality committee and subgroups. In addition to these priorities, this committee and subgroups monitored important quality projects such as clinical outcomes; physical health care of people with mental illness as part of the national CQUIN; personalised care planning; pressure ulcers; sign up to safety; NICE guidance and development of positive practice prompts from this guidance; and monitored the clinician task tool and dashboard

- The trust had participated in a number of applicable Royal College of Psychiatrists' (Psych) quality improvement programmes or alternative accreditation schemes. For example, the Greenwich and Bromley home treatment teams were accredited by the Royal College of Psychiatrists home treatment accreditation scheme (HTAS).
- The forensic service took part in self and peer reviews as part of the quality network for forensic mental health services. The trust's community CAMHS team were members of the child outcomes research consortium (CORC) and submitted data from outcome measures in order to receive aggregated reports and comparison to similar services in the region and countywide.
- CAMHS community services implemented a model of care called THRIVE which was developed by The Anna Freud Centre and The Tavistock and Portman NHS Foundation Trust. The model was based on identifying a young person's needs regardless of their diagnosis or the severity of the illness. For example, some young people may benefit from support in self-management of their illness and others may benefit from extensive support and treatment.
- The early intervention service had developed a partnership with a local football club. Patients were able to join an activity programme once a week, increase their confidence, and improve social relationships as well as their physical fitness. Some patients had gained football coaching qualifications. The group undertook a range of activities including foot golf, fishing and indoor bowls. All early intervention service patients were invited to the group.
- Early intervention team staff were members of the London early intervention reference group and were working with others to deliver new standards of care and treatment introduced in April 2016.
- Consultants were involved in research in collaboration with other institutions. The re-designed community mental health service model was being evaluated during its first year of implementation in conjunction with Oxford Brookes University. This would enable learning and identify any improvements needed in the model and pathways.
- Across the community health teams the majority of staff used electronic tablets in their work to access the electronic records and the trust's intranet. The trust was piloting the use of 'face time' which enabled effective use of resources as one member of staff physically checked a patient and administered intravenous medication whilst another member of staff observed over the internet. Therefore reducing the requirement to have two nurses present.
- At the time of the inspection the trust was operating within budget and had a history of ending the year in financial surplus.They recognised the area where the most control on costs was needed was staff spending. All cost improvement programmes include clinical input and were required to demonstrate positive implications on patient care.
- Evidence was seen in board meeting papers that any cost saving improvements were discussed and challenged by board members in relation to their impact on patient care.
- There was a staff recognition scheme and awards available for staff demonstrating good or innovative practise in their teams or service. The trust had recently introduced a peer nominated employee of the quarter for each directorate which carried a prize of £250.
- The trust had invested in number of different training programmes to help staff mange change which included; senior manager's attendance at the Kings Fund (improvement programme) and band seven and eight level staff engaged in management training.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Safe care and treatment:** Care and treatment was not always provided in a safe way. This was because: The trust did not ensure that the high bed occupancy levels on their acute and PICU wards was being managed effectively. The trust did not have local risk registers to record the actions and timescales implemented to manage the risks identified. The trust did not have prompt processes in place to review and approve action plans following serious incidents that require investigations. The trust did not ensure that ligature assessments were carried out for all ward areas. The trust did not ensure that medication cards were accurate and reflected any risks in relation to prescribed medication. The trust did not use a weighting tool to ensure that health visitors deliver an equitable service across geographical locations. The trust did not use robust data collection and collation mechanisms for health visitor service metrics and breastfeeding data at six to eight weeks postnatal. The trust did not complete all initial health assessment within 20 days. The trust did not make arrangements to ensure that all child health clinics were suitably equipped for families and children to ensure their safety.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 12 (1) (2) (a)(b)(d)(e)(h)

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 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Person centred care:** The trust had not provided care and treatment that was appropriate and met the needs of patients. Trust care and treatment plans did not always demonstrate that they were holistic, personalised and person-centred. Care plans were not always completed jointly with the patient. The trust did not comply with all the policy, practice and facilities to meet the requirements set out in the Mental Health Act code of practice. This was a breach of Regulation 9 (1)(3)(a)(f)(g).

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 (RA) Regulations 2014 Dignity and respect **Regulation 10: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Dignity and respect:** Patients were not fully protected against the risks posed to their privacy, dignity and respect. The trust had not taken effective action to reduce the number of same sex accommodation beaches. This was a breach of regulation 10 (1)(2)(b).