# Oxford Health NHS Foundation Trust

## Quality Report

Warneford Hospital Warneford Lane Headington
Oxford OX3 7JX
Tel: 01865 741717
Website: www.oxfordhealth.nhs.uk

Date of inspection visit: 28th September – 2nd October
Date of publication: 15/01/2016

| Core services inspected | CQC registered location | CQC location ID |
|---|---|---|
| Oxford Health NHS Foundation Trust - HQ | 4000 John Smith Drive, Oxford Business Park South, Oxford, OX4 2GX | RNU |
| Buckinghamshire Health and Wellbeing Campus | Bierton Road, Aylesbury, Buckinghamshire, HP20 1EG | RNU09 |
| Cotswold House | Cotswold House, Savernake Hospital, Marlborough, SN8 3HL | RNU05 |
| Fulbrook Centre | Fulbrook Centre, Churchill Hospital Site, Oxford, OX3 7JU | RNU04 |
| Littlemore Mental Health Centre | Littlemore Mental Health Centre, Sandford Road, Littlemore, Oxford, OX4 4XN | RNU30 |
| Marlborough House | Milton Keynes Hospital, Standing Way, Eaglestone, Milton Keynes, MK6 5LD | RNU06 |
| Warneford Hospital | Warneford Lane, Headington, Oxford, OX3 7JX | RNU03 |
| Abingdon Community Hospital | Marcham Road, Abingdon, OX14 1AD | RNUX3 |
| Bicester Community Hospital | Kings End, Bicester, OX26 6DU | RNUCE |
| Didcot Community Hospital | Wantage Road, Didcot, OX11 0AG | RNUCK |
| Townland Community Hospital | York Road,Henley On Thames, Oxfordshire, RG9 2EB | RNU28 |

# Summary of findings

| | | |
|---|---|---|
| Wallingford Community Hospital | Wallingford Community Hospital, Reading Road, Wallingford, OX10 9DU | RNUDJ |
| Wantage Community Hospital | Garston Lane, Wantage, OX12 7AS | RNUDK |
| Witney Community Hospital | Welch Way, Witney, OX28 6JJ | RNUDM |
| Luther Street Medical Centre | Luther Street,PO Box 7, St Aldates, Oxford, Oxfordshire, OX1 1TD | RNUX5 |

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? | **Requires improvement**  |
| Are Services caring? | **Good**  |
| Are Services responsive? | **Good**  |
| Are Services well-led? | **Good**  |

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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

We have rated the trust as requires improvement as in safe and effective. We have rated them as good for caring, responsive and well led.

On the whole services were safe, but the trust received a rating of requires improvement because we found pockets of poor practice. In addition, we found some environments that were outdated for the delivery of modern mental health care and this was of particular concern at the Warneford Hospital. There was poorly recorded risk planning in some areas of children's services in mental health, unidentified ligature points in acute mental health services and a lack of basic life support training for reception and administration staff at the GP practice. These findings have resulted in requirement notices being issued.

Across all services the trust staff were good at recognising safeguarding concerns and reporting incidents. Teams learnt from incidents and complaints and shared learning across services, through regular 'briefing notes'

Staff were compliant with mandatory training and had good induction programmes, as well as opportunities for continuous professional development.

The trust had a strong track record of working in partnership with the independent and voluntary sector using an integrated model to provide services. The trust is clearly committed to services that are multi-agency and multi-disciplinary and this was evident from the range os services on offer. We also observed board discussions about this and staff at the frontline described good multi-agency working.

We found that care plans were not always personalised and did not involve people in their care. In acute mental health inpatient wards this has contributed to a rating of requires improvement. The quality of care plans across the trust was variable and inconsistent. Staff at times were using both paper records and an electronic record system, as the trust moved to a new electronic health record system called Care Notes. This had been placed on the Trust risk register and they acknowledged that there were inherent risks in moving information from one system to another. They were partly mitigating these risks by implementing the new system in a phased way.

In most services, we found that staff were committed, dedicated and passionate about the work they did. Patients and their carers spoke positively about the care they received and felt they were treated with dignity and respect.

There was variability across the trust in their ability to respond to people in a timely way with some areas of outstanding practice and some where there were waiting lists for services. However, waiting lists appeared well managed and the trust were aware of these. They had actions in place to mitigate any risks this may present. There were a number of delayed discharges and bed occupancy levels were high. We found that some patients had been transferred between wards for non-clinical reasons in order to manage beds. The trust did have good systems in place for bed management but it was clear that this was a significant pressure point for the trust. Across most services there was good access to emotional support and the trust considered peoples diverse and individual needs.

Services were well led and staff were positive about local and central leadership. Mangers were visible and accessible and teams and services had the right meetings and handovers in place. Performance was monitored and reviewed. The process for monitoring of risk was robust and the board were clearly sighted on both the corporate and operational risks facing the organisation. These were presented in board meetings via a risk register. Local services also maintained local operational risk registers.

The structure of meetings and committees, which provide the board with assurance, were well embedded. Most had non-executive director oversight. This ensured that the trust have leaders who were well placed to provide the appropriate challenge.

The trust had the right policies in place to support staff in their work. Staff received relevant training and support.

There were some environmental concerns raised, which had not been dealt with in a timely way. For instance, the premises of the child and adolescent mental health services in south Oxford was in a poor condition. A leaky roof had caused substantial water damage which was

# Summary of findings

reportedly highlighted 18 months ago. The smell of sewerage had been reported in a patient's bedroom but this problem continued for over a year without resolution.

The trust achieved ratings of outstanding for 'caring in 'child and adolescent community services' and primary medical services and outstanding for 'responsive' in 'forensic inpatient services' and in primary medical services. It received an overall rating of outstanding for children and young peoples' services. These services were able to demonstrate excellent practice and innovation which went above the standards expected. For instance, in primary medical services the outreach offered to the homeless population was exceptional.

# 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**

**Overall, we rated safe as requires improvement because:**

- Risk assessments varied across the trust and were particularly poor in parts of children and young people and in rehabilitation services. In Melksham children and young people mental health services, 6 records we checked either had no risk assessments completed or were only partially completed.
- There were blanket restrictions in place in some areas, such as acute inpatient wards and rehabilitation wards. These did not have good enough reasons as to why they might exist. For instance, on the rehabilitation wards patients were restricted from using the dining room or taking snacks to their rooms. We concluded that this was not recovery focussed and did not promote independence.
- Staffing levels in some community health services were low and we found services were not adequately staffed at all times because of the increasing demand and increasing complexity of patients
- Some concerns were raised about medicines management where in some places there was insufficient recording and monitoring. For instance, the fridge temperature was not accurately recorded for 3 weeks in the south Buckinghamshire mental health community older people service. Additionally, at one First Aid Unit within the urgent care services, some medicines were found to be out of date and not labelled according to 'medicines and healthcare products regulatory agency guidance.
- It was noted that at some community mental health services, there were no fixed alarm points.
- The buildings in which the acute inpatient wards were situated were outdated for the delivery of modern mental health care. Staff did what they could to manage the risks posed by old buildings such as blind spots and ligature points. The environmental challenges made it very difficult for staff to keep on top of what they needed to do to keep people safe.
- In primary medical services, not all staff had received training in basic life support. We noted that there were occasions when only a GP and member of reception staff were on duty which meant only the GP was trained to deal with emergencies. The practice manager and lead nurse showed us e-mails in which

# Summary of findings

they had requested basic life support training for reception and admin staff but they had been informed that it was trust policy to only offer this training to clinical staff. There was a risk to both the GPs and patients at the practice because administrative and reception staff had not received training in how to deal with medical emergencies

However:

- There was a good track record on safety and staff were aware of how to recognise and report an incident, using the trust's electronic reporting system and staff de-briefs took place following incidents.
- We interviewed staff from the 'safer care team'. We were impressed by the work the team were doing reducing self-harm and preventing people from going absent without leave. It uses the Institute for Healthcare Improvement methodology to improve quality and safety.
- Most medicine charts were legible and completed and patients were well informed of their medication intake and rationale. Medicines were well managed.
- Staff understood the trust's safeguarding policies and procedures and safeguarding training was mandatory.
- Clinic rooms were clean and wards were mostly well maintained. The exception to this was the rehabilitation ward where we found a patient in a room which smelt strongly of sewage.
- Most staffing levels were adequate to meet patient needs.
- 80% of trust staff had completed their mandatory training. The trust target was set at 89%.

**Are services effective?**

**Requires improvement**

Overall, we rated effective as requires improvement because:

- Not all care plans were up to date, sufficient or recovery focused across some parts of the trust. In community health and mental health services there were concerns about the administration and organisation of records. For instance, we looked at 43 sets of care records for patients receiving care and treatment in the acute wards. Patients' needs were being assessed and we observed collaborative interactions with individuals, however, 16 of the care plans we saw were not personalised and did not include patients' views. We found that there was a similar picture on inpatient wards for older adults.

# Summary of findings

- Assessments and records were not easily locatable by staff working in mental health services following migration to a new electronic health record system called Care Notes from RiO. In some areas staff were undertaking double entry in both paper records and electronic notes.
- In community health services, staff did not use tools available to them to address, monitor and review the management of pain. However, patients told us that their pain was managed effectively.
- In rehabilitation services staff were unable to give examples of how the Mental Capacity Act 2005 (MCA) could be used in practice. Additionally, in community health services, although staff had a good understanding of the MCA, the recording of the decisions around end of life care decisions was not always fully documented.

However:

- In primary medical services patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- A range of multi-disciplinary professionals were utilised to improve therapies and outcomes for patients. There was good and effective multi-disciplinary working.
- National Institute for Health and Care Excellence (NICE) guidelines were followed, particularly with patients suffering from schizophrenia and community mental health older people services offering cognitive stimulation therapy groups.
- Forensic services access to 'AptEd', a unit based qualification system in subjects such as mathematics, IT, English, nutrition and sports subjects, helped patients to recover and improve their prospects beyond hospital.
- There were good partnership arrangements in place with local GPs, acute hospitals, local authorities and the voluntary/ independent sector.

**Are services caring?**

Good 

Overall, we rated caring as good because:

- Across nearly all services we found good evidence of staff interacting well with service users and demonstrating caring, empathetic and respectful attitudes towards service users.

# Summary of findings

- Patient and carer feedback was largely positive and complimentary about staff and the care they received.
- Most services offered ward handbooks on admission to orientate patients to the service and patients were encouraged to participate in and be heard via meetings and forums.
- In some services caring was rated as outstanding. This was for Luther Street medical practice and community child and adolescent services. These services showed passion, enthusiasm and received overwhelmingly positive feedback. They also demonstrated high levels of patient involvement.

However:

- In community mental health for older people, we did not find evidence that care plans had been given to and signed by service users.
- In acute services care plans did not involve people and did not include the views of patients and their carers.
- In acute services we also found that patients were not always positive about the care they received and were not always treated with dignity and respect.

**Are services responsive to people's needs?**

Good

Overall, we rated responsive as good because:

- There had been a 67% reduction in the use of police custody as a place of safety over the last 12 months and a 50% reduction of those detained by police under the Mental Health Act 1983 as a result of the street triage team.
- Disabled access was good across the trust and there were many instances that the trust was meeting the diverse needs of all service users.
- There were appropriate complaints procedures in place and evidence that staff and patients knew how to raise concern.
- The trust had extremely effective out of hours provision for young people who may be in crisis. This had CAMHS clinicians, psychiatrists and managers all on call.
- Response to people in crisis generally across all services was also good.

# Summary of findings

- We found good examples of emotional support such as bereavement support and counselling services that were on offer. We also found that carers were referred for assessments and support when necessary and in end of life care this was fast tracked for them.

However:

- There were some differences in figures provided by the police and those provided by the trust on the numbers of people taken into police custody on section 136, although any instances of police custody were reported to the multi-agency problems in practice meetings. The reasons for police custody were not recorded in the problems in practice minutes, but we were told by managers and front-line staff that the only reason now for using police custody was because of the risk of violence, and the numbers were now very low.
- There was anecdotal evidence that in order to effectively manage the demand on beds, patients had been moved between wards for non-clinical reasons. We found this on the rehabilitation ward, where patients were regularly transferred to wait for beds elsewhere and on the older peoples' inpatient.
- There were long waiting lists (up to 12 weeks) for specialist services in community health teams from referral to first appointments.

**Are services well-led?**

Good

Overall, we rated well led as good because:

- The visions and values of the trust were transparent across all services and linked well with local objectives. Staff were able to clearly articulate the trust vision and values.
- There were good systems in place to capture information and the trust had the relevant meetings and committees which fed up to the board. Training and performance reviews were documented and the trust had good oversight of the safety, activity, performance and experience of people at the frontline.
- Staff received regular supervision and appraisal. This was evident across the majority of services.
- The board was well governed and in touch with issues affecting the frontline. The chief executive had been effective in driving

# Summary of findings

through significant change. The chief executive was a presence in the working lives of staff and ran a good engagement programme. Staff knew who the board were and the board engaged staff.

- Complaints were logged centrally, responded to appropriately. There was good evidence that learning from complaints was shared across the trust. Learning from informal resolution of complaints should be monitored.
- Morale was generally noted as high with committed, creative and knowledgeable managers in place.
- The trusts was proactive in continuous quality improvement and participated in schemes for accrediting services. There was good rolling programme of both national and local clinical audit.

However:

- In rehabilitation services, a strong smell of sewage was found in one bedroom. This was first highlighted in April 2014 and the trust had been working to resolve this, patients continued to be admitted to that bed. Action was taken at the time of inspection when we raised this with the trust.

# Summary of findings

## Our inspection team

Our inspection team was led by:

Natasha Sloman, head of hospital inspection for the South East region at the Care Quality Commission.

**Chair:** Jonathan Warren, executive director of nursing at East London Foundation Trust.

**Team Leaders:** Serena Allen and Lisa Cook, inspection managers for mental health and community health services in the South East region at the Care Quality Commission.

The team included CQC inspectors, a variety of specialist advisors, mental health act reviewers and experts by experience.

## Why we carried out this inspection

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

## How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

'Before visiting, we reviewed a range of information we hold about Oxford Health NHS Foundation Trust and asked other organisations to share what they knew. We carried out an announced visit between 28th September and 2nd October 2015.

We carried out additional visits to Ruby & Sapphire wards at Whiteleaf Centre (Acute) on 6th October 2015 and Salisbury child and adolescent team 12th October 2015.

During the visit the team;

- Visited over 72 locations.
- Spoke with more than 256 patients and service users.
- Collected feedback from 215 comment cards completed by people using the trust's services.
- Talked to more than 85 carers or family members.
- Spoke to managers of each ward/service.
- Spoke to over 575 other members of staff including doctors, nurses, therapists, clerical, operations, corporate and admin personnel.
- Reviewed over 316 care records.
- Reviewed 276 medication charts.
- Attended seven multi-disciplinary team meetings.
- Held focus groups at each location with different staff groups.
- Liaised with a police inspector with responsibility for mental health.
- Observed duty handovers.
- Attended and observed various treatment or therapy sessions.
- Met with the board and observed a board meeting.
- Met with staff side.
- Met with commissioners and local authorities.
- Reviewed information we had asked the trust to provide.

# Summary of findings

## Information about the provider

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

In Oxfordshire, the trust is the main provider of the majority of non-GP based community health services for the population of Oxfordshire. It delivers these in a range of community and inpatient settings, including eight community hospital sites with ten wards. It also runs GP surgeries. Mental health teams provide a range of specialist healthcare services in community and inpatient settings across the geographic areas of Milton Keynes, Buckinghamshire, Oxfordshire, Wiltshire and BaNES. Additionally, the trust provides forensic mental health and eating disorder services across a wider geographical area including patients in Berkshire, the wider Thames Valley and Wales.

Having been granted foundation trust status in April 2008, the trust operates a total of 562 inpatient beds over 34 locations. It employs a total of 4,822 full time staff members (6,500 headcount). It had a total income for the 2014/15 year which equated to £288.3 million. As a foundation trust it is also regulated by Monitor.

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

Oxford Health NHS Foundation Trust has had six previous inspections at three registered locations (Littlemore mental health centre, Warneford hospital and HMP Huntercombe), At the time of the inspection there were no services that were not compliant with the Health and Social Care Act 2008 (2014)

## What people who use the provider's services say

As part of the inspection, comment cards and sealed boxes were left at various locations across the trust to allow people to tell us about the care they received or witnessed being received. We received 215 comment cards back with 74% of those pertaining to positive comments.

Patients and their carers were mostly complimentary regarding the trust. They commented positively on the professionalism, caring nature and good attitudes of all staff. Patients and carers found staff to be respectful to their needs and wants, whilst open and honest communication was cited between patients and staff.

The comment cards suggested to us that patients and carers were happy with the level of care and treatment they received overall. However, there were some concerns with waiting times, particularly from the Swindon child and adolescent mental health service and Witney hospital.

## Good practice

Community health services for children, young people and families;

- Staff were supported through and valued the safeguarding consultation line
- Young people were supported by the provision of the sexual health service in secondary schools
- The directorate engaged directly with young people through the 'Article 12 group'. Young people had contributed to the development of the children and young person's website and produced videos informing young people about the school health nursing service.

# Summary of findings

Community mental health services for children and young people;

- The trust had introduced apprenticeships for young people who had used services and engaged with their participation programme. This aimed to assist young people to get work experience to aid them in entering the job market following their treatment.
- The trust had extremely effective out of hour's provision for young people who may be in crisis. This had CAMHS clinicians, psychiatrists and managers all on call. Local agencies including emergency departments, local authorities and police had copies of the on call rota. The rota was also available to the 111 telephone service which would contact the clinician on call if they judged someone to be in distress. Young people and their families or carers knew to call the 111 number as part of their crisis plans. The clinicians would initially offer phone consultation and arrange emergency appointments in the two slots held by each tier three team every day, or if necessary would arrange an immediate assessment.
- Managers used routine outcome measures in clinician's caseload supervision to ensure the clinicians were making progress with each case and provide assistance if they were not.
- The trust worked well with other agencies in the youth offending service in Oxfordshire running an innovative cannabis clinic. The police gave warnings on possession and the CAMHS staff triaged young people for developing mental health concerns and provided education on the risk of illicit substance misuse to mental health.

Community health service for adults;

- The home oxygen service had developed a home oxygen risk assessment tool, as no national evidenced based tool was available. The team was working with the research department at the trust to develop an evidence base for this. Staff from the team told us the tool was being used by other home oxygen services nationally in the absence of a national tool. The tool enabled staff to quantify the level of risk, work with patients and their families to mitigate the risk or to provide evidence that the risk was too great to consider oxygen therapy in a patients' home.

Community-based mental health services for older people;

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

Community health emergency and urgent services;

- The virtual fracture clinic at Townlands hospital developed with Berkshire Healthcare Foundation Trust provided a good outcome for patients. A protocol had been developed which identified certain groups of patients with fractures or sprains who were treated and discharged by staff at the units. Patients X-rays were reviewed remotely by a radiologist and decisions made if patients needed to attend fracture clinic. This reduced and minimised unnecessary attendance to fracture clinics the following day.

Community end of life care;

- The community nursing service was skilled at engagement with hard to reach groups such as the traveller community. We observed good engagement and a respect for this group's specific cultural needs from community nurses.

# Summary of findings

- The co-location of multidisciplinary team staff, including social services staff into the integrated locality team hubs has enhanced communication about the needs and priorities of patients at the end of life.

Health-based places of safety;

- The managers of Vaughn Thomas ward had introduced an innovative way of providing training on section 136 throughout the team, using presentations, role play and pocket sized information leaflets. Staff on Vaughn Thomas area were also trained in dual diagnosis and to recognise the signs of alcohol withdrawal.

Child and adolescent mental health wards;

- As a result of learning from incidents, the Highfield ward has developed a self-harm management pathway for managing the needs of young people who were too unwell to go to hospital. Staff have received training from a tissue viability nurse, and an emergency nurse practitioner from the Trust's urgent care service, so that they are better able to assess and treat more minor tissue injuries on the ward.

Forensic inpatient/secure wards;

- The trust were accredited members of the Royal College of Psychiatrists' quality network for forensic mental health services. (For both medium and low secure services).

Luther street medical centre

- There was good provision of volunteer support to patients attending hospital appointments and appointments with other services. This meant patients who might not attend appointments were assisted to do so.
- All patients received a comprehensive health check when they first registered with the practice. Patients' health and social care needs were therefore identified at an early stage and services were established to meet those needs.
- There was visiting of homeless patients in remote locations, which other services would have found difficult to do, to deliver care and treatment.
- The practice involved homeless patients in the delivery of services via an award winning patient participation group and undertook patient surveys. Action was taken adjust service delivery in response to patient feedback.
- Innovative treatment regimes were employed. For example alcohol reduction programmes that did not involve medicines. Research shows this treatment programme to be both effective and reduces risks associated with medicines.
- Daily team meetings took place where all staff were involved in planning care and treatment. This ensured a co-ordinated approach to meeting patients care and treatment needs.

## Areas for improvement

**Action the provider MUST take to improve**

Community end of life care:

- The trust must review their ability to demonstrate how they assess patients' needs and deliver care and treatment in line with evidence based guidance.

Adult community healthcare teams:

- The trust must ensure there are sufficient numbers of suitably qualified staff in all community teams to ensure safe caseload levels and timely access to care and treatment.

Community health inpatient services:

- The trust must ensure emergency equipment is fit for purpose and available in all areas at all times.
- The trust must ensure all staff are trained in basic life support to deal with emergency situations
- The trust must ensure comprehensive and contemporaneous notes are maintained at all times for all patients.
- The trust must ensure the Track and Trigger system is used correctly and that there is early escalation of concerns if a patient's condition deteriorates.

# Summary of findings

- The trust must ensure systems and procedures for the recording and assessing of patients' pain are reviewed.
- The trust must ensure due process is followed regarding Deprivation of liberty
- The trust must ensure there is a clear system for the management and assessment of patients with swallowing difficulties.
- The trust must ensure governance processes across inpatient services are robust, risks are managed effectively and there are arrangements for monitoring and improving safe quality care.

Urgent care:

- The trust must ensure resuscitation trolleys and equipment are checked in line with national guidance and that equipment is available and suitable for the purpose for which it is intended.
- The trust must ensure medicines supplied for patients to take home are appropriately labelled
- The trust must ensure patient Group Directives are written, approved and used in line with national legislation and guidance

Community mental health services for children and young people;

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

Community based mental health services for adults of working age:

- The trust must ensure that staffing levels are continuously reviewed and adapt to respond to changing needs to address staff morale, high turnover and workload to ensure patients' safety.
- The trust must ensure that all staff receive mandatory training and annual appraisals.
- The trust must ensure that all patients have care plans that have clear goals, up to date, person centred, holistic or recovery orientated that address the needs identified in the assessment stage.
- The trust must ensure that patients have access to psychological therapies within a reasonable time frame.

Long stay/rehabilitation mental health wards for working age adults:

- The trust must ensure managers are able to assess the impact on patients moving between acute wards and Opal ward.
- The trust must ensure ward staff are aware of the risks and needs of any patient admitted to the ward, even if this is for a short period and that handovers are timely.
- The trust must ensure when patients are able to express their views on their care and treatment, then care plans reflect the patients' views.
- The trust must ensure maintenance records held by the ward and Estates and Facilities are accurate. Records should reflect work done and any work that remains outstanding.
- The trust must ensure that rooms that are unfit to be occupied are not to be occupied.
- The trust must ensrue blanket restrictions are not in place unless justified on care grounds. When in place they should be reviewed and reflect the changing population of the ward.

  Acute wards for adults of working age and psychiatric intensive care units;
- The trust must review governance systems relating to the assessment and management of ligature risks. The trust must ensure that action is taken to remove identified ligature risks and to mitigate risk of patients harming themselves where they could not be observed.
- The trust must ensure that the care and treatment of patients is appropriate, meets their needs, and reflects their preferences.
- The trust must reduce their use of blanket restrictions in place on some wards. These included access to the gardens, and ability to lock bedrooms.
- The trust must ensure care plans are personalised and include patients' views, are recovery orientated, making use of patients' strengths and goals.

# Summary of findings

- The trust must ensure patients are routinely involved in devising their care plan and receive a copy of their care plan.
- The trust must ensure where systems are in place to identify and manage ligature risks in the patient care areas, all risks are identified relating to ligatures.

Wards for older people with mental health problems;

- The trust must ensure they are compliant with gender separation guidelines

Luther Street Medical Centre;

The trust must ensure all staff are trained in basic life support

**Action the provider SHOULD take to improve**

Community end of life care:

- The trust should ensure that a variety of foods of different textures are available for patients.
- The trust should ensure that staff have been provided with the appropriate education to ensure they have the necessary knowledge and skill to deliver end of life care in line with the 'Five priorities for the care of the dying person'.
- The trust should ensure that advanced decisions; ceilings of treatment and 'do not attempt resuscitation' decisions are discussed with patients and their families and are recorded in such a way as this information is accessible to all the services that the patient may use.
- The trust should improve the collection of information about the dying persons preferred place of care.
- The trust should ensure that there is a consistent approach to advance care planning that occurs across the organisation for patients at end of life.
- The trust should ensure that documents used by clinical staff are appropriately version controlled to ensure that they are using the most up-to-date document.

Adult community healthcare teams:

- The trust should ensure that all patients have appropriate risk assessments completed at their first visit and that risk assessments and care plans are reviewed and updated at regular intervals, in line with guidance.
- The trust should ensure that all clinic rooms are fit for purpose.
- The trust should ensure that all equipment is tested and serviced at regular intervals.
- The trust should ensure that specialist services are involved with patients' care at an appropriate stage.
- The trust should ensure that all staff completes dementia awareness training.
- The trust should ensure that community staff are engaged in developing policies and procedures and in service planning and are fully consulted about changes which affect them.

Community health inpatient services:

- The trust should ensure that equipment servicing and checks are carried out regularly and a record kept that they are safe for use.
- The trust should ensure that service strategies are clear and communicated effectively
- The trust should ensure that discharge planning processes are proactive and well-coordinated with social services to reduce delayed transfers out of hospital.
- The trust should ensure that the effectiveness and purpose of the multidisciplinary team meetings is reviewed.

Urgent care:

- The trust should ensure that all paper copies of expired trust policies, procedures and guidelines are removed from use.
- The trust should ensure that equipment and medicines required in an emergency are tamper evident.
- The trust should improve monitoring systems and take appropriate action to ensure that MIU premises and equipment are clean and infection control processes followed at Witney MIU.

# Summary of findings

- The trust should ensure that staff can access only current approved trust policies, procedures, guidelines and patient group directions.
- The trust should ensure staff supervision programme is developed and staff receive support through supervision and practices are monitored.
- The trust should ensure that the facility for children using MIU and 'first aid units' are fit for purpose and include adequate seating in the waiting area.

Community health services for children, young people and families:

- The trust should ensure that regular infection control audits are carried out in children and young people's services.

Community mental health service for children and young people:

- The trust should ensure that mandatory training should meet its target.
- The trust should ensure that all toys are cleaned regularly and pose no risk to infection control.
- The trust should ensure that the use of care planning is consistent across the services on the electronic records systems.
- The trust should review the recording of capacity and consent and the application the Mental Capacity Act in the care records and staff training for how the act applies to children's services
- The trust should consider a formalised risk assessment for the premises at Melksham considering young people attending the service on their own as it is a shared site with adult services.

Community based mental health services for adults of working age:

- The trust should ensure that the temperature of their medicine fridge and room are recorded consistently to ensure that medicines are stored within the required temperatures at all times.
- The trust should ensure that records are well organised and different team members can have easy access to patient records when needed.
- The trust should ensure that all staff know how to access advocacy services for patients
- The trust should ensure that verbal complaints are recorded so that trends and themes can be analysed.

Community based mental health services for older people:

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

Long stay/rehabilitation mental health wards for working age adults:

- The trust should monitor the use of the female lounge as we observed that only male patients used this lounge during both our visits to the ward.

Forensic inpatient/secure wards:

- The trust should review the use of the Wenric ward seclusion room by women and review the method of transportation for patients from Kestrel ward to Wenric ward
- The trust should ensure that the Wenric ward seclusion room meets all of the standards laid out in the Mental Health Act Code of Practice.
- The trust should ensure that patients receiving high doses of anti-psychotic medication receive three monthly physical health monitoring as per the trust's policy.

# Summary of findings

- The trust should report and track cancellations of planned escorted leave that has been agreed and scheduled with the patient. This will include whether the leave is cancelled due to staffing pressures or due to the risk assessment of the patient leaving the unit.

Child and adolescent mental health wards:

- The trust should ensure that checks of resuscitation equipment are carried out regularly in line with trust policy, recorded on appropriate forms and that records are kept in line with policy.
- The trust should continue with its review of the admissions policy of the Highfield unit to ensure that only patients who are suitable to be treated on a general child and adolescent mental health ward are admitted.
- The trust should ensure all equipment that requires PAT testing is tested regularly in accordance with legislation.
- The trust should ensure that all scales used to weight patients are re-calibrated when necessary.
- The trust should ensure that staff understand how to use the Mental Capacity Act.
- The trust should review the use of seclusion and long term segregation in the Highfield unit to ensure they fit the definitions of the Mental Health Act code of practice. This should take place before the unit re-opens.
- The trust should review the availability of the advocacy service at Marlborough House to understand why advocates did not visit proactively and if this is sufficient for the needs of the patients.
- The trust should review the activities available to patients at weekends.
- The trust should review its communication with parents and carers of young people at the Highfield unit to ensure that parent and carers are updated promptly of incidents and concerns relating to their children and to ensure that messages from parents and carers are passed on to the young people on the ward.

Wards for older people with mental health problems;

- The trust should continue to review the management of environmental risks, particularly on Cherwell and Sandown wards.
- The trust should ensure that the prescribing and use of as necessary medication is routinely reviewed.
- The trust should ensure care records are recovery or outcome orientated, and include patients and carers' views.
- The trust should ensure its staff are familiar with the revised Mental Health Act code of practice.
- The trust should review the impact of moving patients between wards during their admission to hospital.

Health based places of safety:

- The trust should be consistent and comprehensive in its reporting of delays before and after Mental Health Act assessment.
- The trust should ensure that any disagreements between nursing staff and police officers are reported and reviewed and that joint action plans are developed which build on the existing programme of shared events and training.

Acute wards for adults of working age and psychiatric intensive care units;

- The trust should review governance systems in relation to the way information is gathered from the electronic incident recording system, particularly in relation to prone restraint.

Luther street medical centre.

- The trust should promote the availability of the chaperone service.
- The trust should risk assess the range of emergency medicines held.
- The trust should ensure that nurses who administer medicines included in patient group directions receive updated training in the administration of these medicines. (Patient group directions are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment)

# Oxford Health NHS Foundation Trust

**Detailed findings**

## Mental Health Act responsibilities

Overall the application and management of the Mental Health Act 1983 was good. This was overseen by a senior team which included the head of information governance and a non-executive director. The 'effectiveness committee' monitored the 'act'. This took place every quarter and there was a legislation group which met monthly to discuss operational issues.

The trust worked well with other agencies such as police, social care and ambulance services. Concerns affecting people subject to detention was discussed at the problems in practice group and there was evidence of learning being shared across all partners from this group.

All new staff received training on the MHA on induction and then received refresher training every three years. Since the introduction of the new Code of Practice (which

accompanies the Mental Health Act) in April 2015, the refresher training had focussed on the changes in the new code. However, despite this training we did find that on four of the wards that we visited, staff had poor awareness of the new code.

The trust also provided training to section 12 doctors and approved clinicians and appraisals of doctors included knowledge and skills of using the MHA.

The new code required the review of a number of policies. The trust had either reviewed or was in the process of reviewing all policies affected.

The operation of the MHA was supported by a team which provided reminder systems to clinical staff, scrutinised documents and organised of tribunals and hearings. The MHA team provided weekly data on the operation of the act to senior medical staff to enable them to discuss how the Act was being used. There were

Work streams in place which reviewed the use section 17 leave, community treatment orders and consent to treatment. These reported into the 'effectiveness committee'.

The trust had recently changed to a new electronic patient recording system and this had created some challenges for clinical staff. We heard how the MHA team had supported clinicians during this change and about the benefits that the new system would bring when implemented. This included better monitoring of the Mental Health Act, for instance, the system would be able to generate reminders of when further assessments were needed.

During the inspection we carried out a full Mental Health Act review on six wards in a range of core services and visited the section 136 suites. We also carried out a documentation review on four other wards. Detention papers were available for review and were in good order. On two wards we found that some reports from the approved mental health professionals involved in the detention were missing. Patients had their rights explained to them, but on five wards this was not always repeated following a significant change in their treatment. Information regarding the right to independent mental health advocacy was not always available.

On one ward we found that the involvement of patients in their care was excellent. This was on Chaffron at Marlborough House. This ward operated in a way that was

Requires improvement

# Are services safe?

least restrictive and engaged patients in how the ward ran. However, on five other wards there was little evidence of patients jointly developing their care plans or their views being recorded. Some care plans were out of date and were not linked to the risk assessments. On one ward there were blanket restrictions regarding patients accessing their rooms and the garden, and use of mobile phones which were not consistent with the purpose of the ward.

Capacity to consent to treatment was well documented on two wards but was inconsistent on the four others visited. One patient was prescribed medication which was both over the second opinion appointed doctor authorisation and over the British National Formulary limit. We found five other smaller examples of medication not being correctly documented, but the majority of medication given was authorised.

Section 17 leave was authorised through a standardised system and was generally well managed. On two wards we were unable to find evidence that patients were fully informed about their leave entitlements. We reviewed the forms of 13 patients on section 3, but being cared for in the community. Some of these patients had been on section 17 leave for some months and one for more than three years. If leave was authorised for more than seven days, the authorisation form required the responsible clinician to record why section 17 leave was being used instead of a community treatment order. In all cases we found that this had been completed although the reasons given were not detailed.

## Mental Capacity Act and Deprivation of Liberty Safeguards

Overall there was good understanding of the Mental Capacity Act 2005, with some exceptions. The trust had delivered training to most staff on the application of the MCA and we found this had been effective. In acute services the care records we viewed showed that patients' mental capacity to consent to their care and treatment was regularly assessed on their admission.

In primary medical services patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of the MCA.

In rehabilitation services staff we spoke with had poor working knowledge of the MCA. The principles of the MCA were on display around the ward and staff could quote these. However, we found that staff were not able to describe examples of how they would use the MCA in practice, for example in creating a discharge plan with a patient.

In community health services, although staff had a good understanding of MCA, the recording of the decisions around end of life care decisions was not always fully documented.

There were 73 DoLS applications at the trust in the past year. Of these, 37 (50.7%) were not granted.

Eight out of ten DoLS applications at Abingdon Community Hospital had not been granted.

Amber Ward had the highest number of DoLS applications with 30 (41%)

Requires improvement

# Are services safe?

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

Requires improvement

# Are services safe?

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

## Summary of findings

## Our findings

**Track record on safety**

A total of 3,254 incidents were reported by the trust to the National Reporting and Learning System (NRLS) between 1st July 2014 and 30th June 2015, of which 19 were deaths. The majority resulted in no harm (72%) or low harm (24%). 3% of incidents resulted in moderate harm and 0.4% in severe harm. The trust took an average of 36 days to report issues.

Sixty two incidents were reported to the 'strategic executive information system between the 1st July 2014 and 3rd August 2015. The 25 deaths reported accounted for 40% of incidents, but no 'never events' were reported.

The most recent NHS staff survey revealed that 12% of all staff had witnessed potentially harmful errors, near misses or incidents in the last month and was in the lowest 20% of trusts nationally for this.

There were 894 uses of restraint in the past six months, of which 131 (15%) were in the prone position. Of these restraints 51 (39%) resulted in rapid tranquilisation.

- The child and adolescent wards at Highfield had the highest number of prone restraints at 34 (26% of prone restraints).
- Kestrel Ward had the highest number of rapid tranquilisation at 14 (28%).
- Ashurst Ward reported the highest number of incidents of seclusion at 49 (22%)

The department of health guidelines (Positive and Proactive Care, reducing the need for restrictive interventions.) states that prone restraint should not be used. When it is used it should be for the least time possible and it should not involve the application of pain.

Ashurst Ward reported the highest number of incidents of seclusion at 49 (22%) CAMHS Highgfield reported 83 incidents of seclusion, Kestrel Ward reported 70 incidents of seclusion and Kingfisher Ward reported 35 incidents of seclusion.

**Safe staffing**

The following inpatient wards reported staffing levels of 80% and less for the period February – April 2015:

- Bicester (February – April 2015) with a figure of 50% in April 2015;
- Wenric (February – April 2015) with a figure of 50% in February 2015 and 52% in March 2015.
- Abingdon Wards 1 & 2 in older people's services had staff turnovers of 23% and 32% respectively in the last 12 months. Abingdon Ward 2 had a bank and agency usage of 31%.
- District Nurses in the South West locality had a staff turnover of 30% for the last year and a vacancy rate of 23%.
- District Nurses in the South East and West had turnover rates of 17% and 17% respectively.
- Physiotherapy had a turnover rate of 17% for the last year.
- City hospital ward nursing staff had a bank and agency usage of 22% in the past year.
- Out of hours GPs had a vacancy rate of 49%.

In between the 2nd of February and 3rd of May 2015, community health services had a total of 911 number of shifts filled by agency staff to cover sickness, absence or vacancies.

In the same period GP services and out of hours services had no shifts filled by agency staff to cover sickness, absence or vacancies.

In mental health services there was a total of 1,878 number of shifts filled by agency staff to cover sickness, absence or vacancies (2nd Feb-3rd May)'

Overall the trust reported a 3.6% sickness rate, which is below the England average.

**Learning from incidents**

Across the trust there was strong evidence that staff knew how to recognise and report incidents using the trust's electronic reporting system. This system ensured senior management within the trust were alerted to incidents in a timely manner.

Staff told us de-brief sessions were routinely held following incidents for both staff and patients and that appropriate

amounts of support was offered post incident. Staff reported that the trust worked to a 'no blame culture' to encourage people to report incidents and learn from mistakes.

Incidents were investigated and learning was fed back and shared to the front line via team meetings. The trust had also implemented briefing notes which were sent to all staff to capture learning from incidents and share this information across the organisation. Across all services, staff described a culture of learning and said they felt supported when things did go wrong. We found good evidence where learning from mistakes had prompted changes in practice. For instance, changing lone working procedures. This meant that future risk of the same mistake happening again was reduced. Another example of change following an incident was in urgent and emergency care, where as a result of an incident, where a fracture had not been diagnosed, a learning programme had been developed to help staff identify a hard to diagnose fracture, that is not always picked up on X-rays.

**Safeguarding**

Across most services there was good understanding of safeguarding. Staff knew how to report abuse and there were policies in place to support staff. Staff had been trained in safeguarding and there were safeguarding leads within the trust to offer support and advice. The trust had both a named doctor and named nurse for safeguarding both adults and children. The safeguarding committee fed directly to the trust board and the trust was represented on the local safeguarding local authority boards.

Safeguarding issues were observed to be shared between staff at staff meetings, handovers and emails. There appeared to be sufficient information readily available on wards and in community teams regarding safeguarding and good links with the local safeguarding teams were noted. In urgent and emergency care there was a lack of focus and understanding on domestic violence and the impact and risk this posed to individuals.

The trust also complied with best practice in relation to gender segregation, across all inpatient services, with the exception of older people's inpatient services, where we found men and women sleeping in the same corridors in order to manage beds. Staff did increase their levels of observations to try and manage this.

**Assessing and monitoring safety and risk.**

Overall, there was some evidence of good assessment of risk. This was well managed for the most part. We reviewed over 316 care plans and risk assessments. We found that risk assessment had mostly been completed, was up to date and contained sufficient, relevant information to ensure that people were appropriately managed.

However, the exception was in community mental health services for children and young people, where we reviewed six records in Melksham. We found that all had either no or only partially completed risk assessments. Similarly, the same service in Oxford central and Swindon demonstrated poor risk assessments and this has resulted in a requirement notice being issued. Upon raising these concerns the trust undertook an audit which 'confirmed the variability of risk assessment entries' and an action plan was put in place to address these issues. In rehabilitation services, risk assessment was poor, with staff describing a recognised risk assessment tool but having no evidence of its use within patient notes. During handovers, patient risks were also not fully explored and discussed. This was also evident in the community health services of the trust.

We found blanket restrictions in place across, rehabilitation services, acute and child and adolescent mental health services. For instance, on rehabilitation wards patient's bedrooms were locked during the day. This did not allow free access for patient's to seek privacy and patients would have to be escorted to collect something from their room. We were advised by staff that, as of yet, no review of these practices had taken place to assess its effectiveness.

Medicine charts were found to be fully completed and patients were well informed about their medication intake and rationale for this. However, medicines management varied across all services. For example, both the north and south Buckinghamshire community mental health service for older people kept medicines in a locked cupboard and refrigerated medication in a locked refrigerator. The north Buckinghamshire team recorded fridge temperatures daily and when the room was too hot, opened a window to mitigate. The south Buckinghamshire team though had not recorded fridge temperature for nearly 3 weeks. In community services, we found that some medicine items were out of date whilst medicines provided to take home from MIU and first aid units were not correctly labelled in accordance with Medicines and Healthcare Products Regulatory Agency (MHRA) guidance.

Requires improvement

# Are services safe?

Additionally, on the forensic services at Marlborough House, seven out of eight patients receiving high dose antipsychotic medication and had not received a three monthly physical health check monitoring as advised in the trust's policy. The trust responded immediately to this concern.

Potential risks

Our intelligent monitoring flagged suicide as an area of risk for the trust in relation to those people detained under the Mental Health act 1983. Regarding this, the trust has developed some key actions:

- To develop suicide awareness and prevention strategies, in teams across the trust and review the impact on practice.
- Carry out benchmarking against other providers for common indicators.
- Implement recommendations and share learning with safeguarding children's boards from Oxford Foundation Trust internal report into children's and young people's suicides.

Key measures have been introduced, such as:

- measuring days between probable suicides in individual adult mental health teams (target 300 days)
- measuring days between probable suicides in inpatient services (target 300 days)

Ten teams were to receive suicide awareness/prevention training in line with the interpersonal theory of suicide.

The trust was in the bottom 20% of trusts for seven key findings, including work pressures felt by staff, staff working extra hours and feeling satisfied with the quality of care they provide to patients'. Action had been taken by the trust to work to reduce the pressure on staff, including the closing of some of the community beds and changing the working hours of the district nurse team.

Overall we found that teams and wards were well maintained, clean and well-equipped. Cleaning rotas were fully completed across the board and good infection control processes were place. The most recent patient led assessment of the environment scored the trust as above the England national average of 98% and 91% for both 'cleanliness' and 'condition, appearance and maintenance' with 99% and 95% respectively.

In community teams, interview rooms were clean and well maintained and most staff had access to personal alarms for in the event of an emergency. However, we also noted that some areas had no fixed alarm points, which may present a risk to patients and staff should they not be able to alert help when required. There were no alarms in the Bath and North East Somerset base in Keynsham, nor the Salisbury, Witney or Swindon base but personal alarms were available in all but the Witney base.

Clinic rooms across the trust had the necessary emergency equipment available such as automated external defibrillators and oxygen. There was good evidence of these being regularly monitored and maintained to be fit for purpose with the exception of community health services whereby some items were missing.

In the South Oxford child and adolescent mental health service, the premises were in a poor condition with a leaky roof that caused substantial water damage. The trust had this on their local risk register and the scaffolding surrounding the building suggested action was being taken, however the service manager advised it was first reported 18 months ago.

In acute and intensive care inpatient wards we were concerned about the management of ligatures. Not all ligatures had been identified and therefore were not being mitigated. Ligature points can pose a risk to patients who may use ligature points to harm themselves.

In primary medical services Luther street practice held a risk register which was reviewed at the monthly team meeting. Any significant risks and safeguarding concerns were discussed at the daily meeting and actions agreed to reduce or mitigate risks. For example, we saw that when patients posed a risk to others they were issued with three warnings before they were referred to the difficult to place patients register and/or the police. CCTV had also been installed in the practice to reduce the risk to both patients and staff.

The trust had completed all mandatory training at 80%, including safeguarding training. The trust target was to complete to 89%.

**Duty of Candour**

The trust was meeting their responsibilities under duty of candour and was open and honest when things went wrong. We saw evidence that the trust had a duty of

Requires improvement

# Are services safe?

candour policy and saw examples of letters sent to patients and relatives post a serious incident. The trust kept a spread sheet so it could monitor that they were completing to timescale and had taken all necessary action.

Requires improvement

# 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

## Our findings

**Assessment and delivery of care and treatment**

In community mental health services, the City and North East assessment function team had assessments and care plans which were in date, however some of the plans were not detailed enough and none were adequately person centred with clear goals. In the Aylesbury team care plans were not detailed enough and did not give clear guidance on how staff could support patient needs identified at assessment. They were not person centred and did not contain clear recovery focused goals. We found that care notes were disorganised with different team members unable to access patient notes when needed.

In primary medical services the practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines and a range of other guidelines from various bodies. For example, guidelines for the care of patients with mental health issues.

We commonly found that the trust's migrating onto a new electronic health record system called Care Notes from RiO caused staff difficulties in identifying where care plans, assessments and records were located. However, this transition was still in its infancy, having been implemented for mental health services 6 months prior to inspection. Community health services were due to go live with the new information in October 2015.

In community mental health services for children and young people, the new system of care notes required staff to use pre populated diagnosis codes within the system. This led to staff reluctantly using the diagnosis terms of 'mental retardation' in the learning disability teams. Staff in those services attempted to put more respectful formulations and diagnoses of the children in the free text boxes, but staff were very unhappy at using the pre-determined term in the young person's records.

In all other services, we found that comprehensive, holistic assessments were completed with attempts to involve the patients and reflect their views where possible. It was noted in the forensic services that either 'my shared pathways' or 'recovery star' were implemented in care plans; both designed to focus on a patient's strengths and goals.

**Outcomes for people using services**

A range of psychological therapies were utilised across services and were individually tailored to meet the needs of different patient groups. These included multi-family therapy, cognitive behaviour therapy, dialectical behaviour therapy, anxiety management and psychodynamic psychotherapy. These were delivered by multi-disciplinary teams consisting of psychologists, occupational therapists and activity therapists.

In community health services, national guidelines and best practice were used to provide evidence-based care and treatment across all their services. However, there was a variation in how patient's pain was managed and inconsistency in the use of pain assessment tools to assess pain and monitor the effectiveness of pain control measures.

We found that psychological therapies were clearly in line with National Institute for health and Care Excellence (NICE) guidelines, particularly for patients with schizophrenia. We attended a 'hearing voices group', the content of which was closely related to NICE guidelines.

In community based mental health services for older people, we observed a cognitive stimulation therapy group, a treatment recommended by NICE as evidence based focus for dementia. Staff used a range of outcome measures, including health of the nation outcome scale. Overall of the 2689 patients subject to the 'care programme

approach', 1798 had a completed HoNOS reported for the last 12 months. This is roughly 67%. Different outcome measures were used for each patient group appropriately and well.

An area of good practice was in the forensic services where patients had access to 'AptEd' – a unit based qualification system in subjects such as mathematics, IT, English, nutrition and sports subjects. This qualification is regulated by Ofqual, offering patients opportunities to gain national qualifications to aid their recovery and future prospects.

There was good use of local clinical audits across services which informed practice as well as participation in a number of national audit programmes including contributing to the national confidential enquiry into suicides and homicides. The clinical audit programme was strong and covered most clinical areas. There was also a good programme of financial audits in place.

The trust had a recovery college; this was launched in September 2015. The recovery college manager and coordinator employed to run the college had lived experiences of a mental health illness. Peer support workers run every class offered at the recovery college. All the courses had been designed and will be attended by people who use mental health services, their families, carers as well as staff and volunteers

**Staff skill**

Across all services there was good input by different professional groups who all contributed to the multi-disciplinary team. This proved positive for the delivery of care. An exception to this was in community mental health services where we found that the lack of psychologists hampered the delivery of psychological therapies.

The trust utilised a range of staff from a variety of backgrounds to deliver treatment. They were all fully integrated into the service to provide good multi-disciplinary input, with the community mental health service giving staff a 3 week induction and withholding caseloads until fully inducted.

Staff received appropriate mandatory and specialist training and supervision. This included 1:1 supervision, group supervision and good opportunities for reflective practice.

We found that most staff had received appraisals. However, in the City and North East community mental health team, only 50% of staff had, had an appraisal.

The trust offered additional training, for instance, with courses on dementia, psychological therapies, nurse prescribing and dual diagnosis. The trust also offered a comprehensive induction programme on joining.

In urgent and emergency care we found that not all staff received regular 1-1 supervision.

**Multi-disciplinary working**

We found strong evidence of regular, effective and fully inclusive multi-disciplinary meetings taking place throughout all services. Handovers and team meetings happened frequently and good working relationships were noted between partners. They shared information effectively about patients likely to move between services - for example inpatient wards, street triage, psychiatric liaison teams and the emergency departments.

Partnership arrangement with GPs, acute hospitals, local authorities and independent organisations were good. Additionally, we found partnership working a real strength of this particular trust and this can be found in their commitment to working with joint management arrangements with the independent sector. The street triage service had shown to effectively reduce the numbers of section 136 patients being detained.

**Information and Records Systems**

The trust was in the process of transitioning its patient information system from RiO to a new electronic health record system called Care Notes. Mental health services had switched in March 2015 and community health services in October 2015 (just post our inspection.) There were numerous examples from across the trust that there had been some risks associated with this. For example, some staff found it difficult to easily locate care plans and assessments. Not all records had been migrated. The trust had identified this as a risk and it was on the corporate risk register. They planned to roll out 'care notes' in a staged way in order to manage some of these risks. We found that there were connectivity issues across the trust and that this could sometimes hamper inputting of information. The trust was aware of this problem and this was also on the risk register.

Requires improvement

# Are services effective?

Staff raised concerns and frustration around multiple records being in use and not all staff being able to access each system. We found in some areas that patients' medical and nursing records were difficult to track as information was not clearly documented in one place.

**Consent to care and treatment**

Consent to care and treatment was not consistent across all wards and Mental Health Act reviewers found on four of the mental health wards they visited, that the documentation of this was poor.

However, in primary medical services patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. They described having access to immediate advice from the specialist mental health worker when they had any concerns relating to patients who may not have the capacity to make decisions about proposed care and treatment.

In acute mental health services, the care records we viewed showed that patients' mental capacity to consent to their care and treatment was always assessed on their admission or an on-going basis. There was good documentation of the assessment of mental capacity in all care records.

For children under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke to in children and young people's services were conversant with the principles of Gillick and used this to include the patients where possible in the decision making regarding their care.

In rehabilitation services and older peoples services consent to treatment provision on the ward was found to be good. All patients were assessed as to their ability to consent to treatment at the first administration of a medicine**.**

**Assessment and treatment in line with Mental Health Act 1983 (amended in 2007)**

There was good adherence to the Mental Health Act (MHA) code of practice and documents were generally in order. We found good evidence in the care records and observations that most patients' were given an explanation of the MHA and had their rights given to them. The trust provided training on induction to all staff training on the MHA and refresher training required every 3 years. Capacity to consent appeared to be well documented.

Good

# Are services caring?

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

## Summary of findings

## Our findings

**Dignity, respect and compassion**

In two of the core services we visited, Luther Street medical practice and child and adolescent community mental health services, we rated them as outstanding for caring. In every other service, with the exception of acute mental health inpatient wards we have rated caring as good.

Across all services, feedback from service users, carers and family members were largely positive, noting the compassionate, kind, honest and respectful attitudes of all staff members. We observed many occasions whereby interactions between staff and patients was positive and supportive of patient needs.

Staff were additionally attentive to the warning signs of particularly agitated patients and demonstrated good understanding of everybody's individual needs based upon their individual situation.

In primary medical services patients said they felt the Luther street practice, offered an excellent service and staff were helpful, caring and treated them with dignity and respect. A survey carried out by the surgery showed that:

- 97% said the GP put them at ease.
- 100% said the practice nurses gave them enough time.
- 98% said the practice nurses listened carefully to what they said.
- 91% said the care they received was either good or excellent.

In community health services staff provided compassionate care and ensured that patients were treated with dignity and respect. We observed that patients' privacy and dignity were maintained at all times. Patients were complimentary and expressed satisfaction with the care they had received and people we spoke with felt active partners in their care.

They had a clear understanding of their condition, care plan and treatment goals. Staff spent time talking to patients, ensuring the information was presented in a way the patient could understand.

In relation to patient led assessments of the care environment (PLACE) scores for dignity, privacy and respect the trust scored 85% satisfaction, 2% below the England national average.

The friends and family test highlighted that 56% of staff were either 'extremely likely' or 'likely' to recommend the trust as a place to work and 73% as a place to receive care, both below the national average of 62% and 76%.

**Involvement of people using services**

The trust was committed to involving people in the design and delivery of services at a strategic level. For instance, people who use service's had been involved in the recent changes, for instance :

- There were nine dedicated sessions were ran for service users and carers who helped to develop the new service model.
- Helping to redesign the physiotherapy service.
- The development of a dedicated children and young people website.
- Carers had supported the application to achieve the 'triangle of care' accreditation and other external accreditations (such as the 'accreditation for inpatient mental health services and quality network for inpatient CAMHS')

Most services offered introductory handbooks on admission to inpatient wards containing relevant information on the patients' health needs, care and treatment options.

Patients were encouraged to attend community meetings with patient and carer forums also taking place across all services. The community mental health services for children and young people facilitated a particularly novel joint group named 'Article 12 council' based upon article 12 of the United Nations Convention on the Rights of the Child to promote fair discussion and views from its service users.

Good

# Are services caring?

Whilst in the most part advocacy services were accessible to all patients, information on this was limited in the south Oxfordshire and Aylesbury community mental health teams.

In forensic services and community child and adolescent services there was a strong culture of involving people at both a strategic level and in involving people in care planning.

In primary medical services 100% of patients surveyed, said that the last GP they saw, and explained tests and treatments either to some extent or completely. 97% said the last GP they saw was good at involving them in decisions about their care and treatment. They also said that the practice nurses were good at involving them in decisions about their care and treatment.

However, in community based mental health services for older people and working age adults, staff were unable to provide sufficient evidence that care plans had been offered to or signed and agreed by patients. This was echoed by the rehabilitation services with little evidence of patient involvement. These patients were also unhappy with the amount of 1-1 time they spent with staff.

**Emotional support for people.**

There was good emotional support for people. The chaplaincy service was strong and visible force across many of the services, offering spiritual guidance and support to people of all faiths. This service also offered support to staff, if they wanted this, for instance, post a serious untoward incident.

The needs of the families and carers of end of life patients were always considered. This included fast tracking carers for assessments and support when needed, especially where they were managing high care needs.

Parents told us they felt supported by their health visitors and were very satisfied with the relationships they had.

There was bereavement support and counselling services available for families.

During a clinic parent and child group, we observed the therapist was very skilful in engaging with the parent and identifying what potentially could be worrying the mother. This resulted in the therapist proposing strategies to support the parent and child.

In primary medical services the patients who took part in the practice survey were positive about receiving emotional support from practice staff and we saw that patients could bring a friend or carer to their appointments to support them.

The physical disability physiotherapy service and the pulmonary rehabilitation service ran group exercise sessions, which enabled patients and carers to offer support to each other. Patients at a pulmonary rehabilitation class told us they felt encouraged, well supported by the group and could see improvement in their overall wellbeing.

The integrated locality teams and the reablement service worked with voluntary organisations to provide support to patients. This included a welcome home package for patients who had been discharged from hospital and a project to support people to be involved with activities in their local community, to reduce isolation and loneliness and build relationships.

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

## Our findings

**Planning and delivery of services**

In community mental health services, access arrangements ensured that people were seen quickly within 48 hours with the services hitting this 100% over the last 3 months. Following triage, referrals were prioritised by risk and identified needs. In adult services, emergencies or those requiring crisis care were to be seen within 4 hours. The services met this target 100% of the time over the preceding three months. Urgent cases were seen within 7 days and routine cases were seen within 28 days. The teams responded on time and effectively when patients required crisis care.

Teams worked from 7am to 9pm every day and had night staff that worked from 9pm to 7am who were responsible to responding to all out of hours calls.

In child and adolescent mental health services they aimed for emergency referrals to be seen within 24 hours, with different targets for urgent and routine referrals dependant on where they were commissioned. Waiting times for non-urgent referrals into children and adolescent mental health services were variable and dependant on the area within which a person resided. For instance, in north Buckinghamshire the trust gave a 2 week wait for Tier 3 services compared to Salisbury where there was a 16 week wait. Additionally, on inspection, the Salisbury children and adolescent mental health team reported an actual waiting list of 24 weeks.

The musculoskeletal physiotherapy service waiting times position paper (September 2015), reported that from April to July 2015, the trust target of 95% of patients being seen for their first appointment within 12 weeks was not met. The average was 82% of patients were seen within 12 weeks. The service was rated high risk on the directorate risk register, with additional funding provided by Oxfordshire CCG, who acknowledged the service was underfunded. Locum staff were being recruited to manage the immediate waiting list backlog, with on-going work to standardise the service to reduce inefficiencies and inconsistencies. A proposal had been submitted and agreed in principle with stakeholders to redesign the patient pathway for this service.

Staff from the physical disability physiotherapy service described a patient who had developed a lesion on their hand, which was initially missed by care staff. They felt delay in access to their service had contributed to this incident, which was reported and investigated. They told us the waiting time for a first appointment was 16 weeks. Their aim was to see all new patients within six weeks; the trust had not set a waiting time target for this service. They told us they were funded for 620 patients, but last year saw just over 1000 patients. Data from the trust showed that for September 2014 to August 2015, an average of 70% of patients were seen within 12 weeks for this service.

We received differing figures from the police and the trust regarding the numbers of people taken into police custody on section 136. However, any instances of police custody were reported to the multi-agency problems in practice meetings. The reasons for police custody were not recorded in the problems in practice minutes, but we were told by managers and front-line staff that the only reason now for using police custody was because of the risk of violence, and the numbers were now very low.

Positively, we were informed by police figures, that there had been a 67% reduction in the use of police custody over the last 12 months due to the health based place of safety, with the number of people detained on section 136 also reducing more than 50% as a result of the street triage team.

We found some instances of delayed transfers of patients through services in forensic services, child and adolescent services, rehabilitation services and community health services. At Highfield child and adolescent services, one patient was found to be on an inappropriate clinical placement as there was no alternative unit available in the whole country. Despite the challenge of this, the trust were managing this situation and was in contact with commissioners.

Good

# Are services responsive to people's needs?

In rehabilitation services, some new patients were being admitted on long-term bases to beds still allocated to patients on extended leave. Patient's fed back that this left them unsettled with the way their personal possessions were managed; particularly should they have had to return early.

The trust's bed occupancy rates have been consistently above the national average over the last 12 months with all but four sites well above 85% bed occupancy rates. The trust flags as a 'high risk' via the Care Quality Commission intelligent monitoring indicators for average bed occupancy rates. For instance, in rehabilitation services senior hospital staff told us that beds on the ward were used for acute patients when rehabilitation patients were away from the ward on overnight leave. This enabled the acute bed to be made available for an admission. Hospital staff told us they tried to minimise this and ensure that acute patients return to the appropriate ward as soon as possible. However, we found that in 25 out of 26 of the week's up to and including the inspection, there was at least one such admission per week. This meant that ward occupancy was frequently over 100% and if patients had to return early from leave, then a bed would not be available.

The children and adolescent mental health services in Swindon and Highfield had the lowest bed occupancy rate at 64% and 66% respectively and are commissioned by NHS England to meet full capacity and staffed to do so.

High bed occupancy was noted to impact upon care in the community health services with patients experiencing long lengths and stays and not being discharged in a timely way. Additionally, there were waiting times from referrals to first appointments of 12 weeks and waiting lists for specialist therapy services.

**Diversity of needs**

Disabled access was good across the Trust with adaptation made in some areas, for instance in rehabilitation services where some bedrooms had been designed for wheelchair access.

A range of information leaflets were available for people across all services detailing in other languages on the back for alternative languages to be requested if needed.

Staff had good access to interpreters when required, and local faith representatives visited the wards and held services of worship on site and could be contacted to request a visit. We interviewed the chaplain for Oxford Health Foundation Trust and noted that there was good involvement and understanding of spirituality and that chaplains were regular visitors to the ward. Chaplains' also provided support to staff if required, for instance, following a serious untoward incident.

The health based place of safety service in Aylesbury recently developed a scheme in which regular visitors of the service, street triage and/or A&E department were offered further support from a third sector organisation to give advice on matters of housing, finances, welfare and substances should they feel it necessary.

**Right care at the right time**

Accessing services was good despite waiting lists, urgent and emergencies cases were prioritised appropriately. The trust understood their 'hot spots' and worked with commissioners to respond to changing need. There were challenges though and on many mental health wards, staff told us there was a high rate of delayed discharges. This was due to difficulties in finding appropriate accommodation. Our data supported this and showed that there were 2,128 days where discharge was delayed. Some of these delays were attributed to:

- 577 days due to lack of housing
- 611,awaiting further NHS placement in acute care
- 169 awaiting nursing home placement
- 136 awaiting care packages

Despite these delayed discharges this was an improving situation. We were told that the trust had initiated working with the private and voluntary sector to move people back in to the community. Social workers regularly visited the ward rounds and supported with the challenges faced by the wards in relation to finding appropriate "move on" services.

In community health services we found that the trust offered a universal health visiting service which provided additional support as needed. Health visitors informed parents at new birth visit of access to for example, drop in clinics and children's centre.

The health visiting service was slightly below the 95% target for new birth visits at 10 to 14 days, at 89.5% for the first quarter of 2015/16. The trust had a target of 95% for recording breast feeding status at the six to eight week check; we saw evidence the trust was exceeding this target

Good

# Are services responsive to people's needs?

at 100%. Another target was to encourage parents to continue to breast feed from two weeks to six to eight weeks. The target was 60% and the trust was exceeding this target at 61%.

School health nurses described difficulty in supporting young people with mental health issues. A primary children and adolescent mental health service (PCAMHS) worker was available at the school half a day per and staff had access to the PCAMHS consultation line where they could obtain advice. We reviewed the waiting times for the PCAMHS service which had reduced from 29 weeks in May 2015 to six weeks in September 2015 due to measures put in place to meet demand

**Learning from concerns and complaints**

We found copies of the complaints process displayed in the wards and information leaflets for patients explaining how to make a complaint on all wards. Most patients we spoke to told us they knew how to complain both formally and informally.

Welcome packs provided information on how to make a complaint. Patients felt that changes were made as a result of their complaints and we saw evidence of 'have your say' meetings whereby patients could raise concerns.

Trust bulletins were sent to staff which shared learning from incidents and complaints from across the whole trust. The patient and advice liaison service visited each ward weekly and met with patients. Feedback on the issues they had raised was given at subsequent meetings with patients.

The trust submitted data to say they received 65 complaints over the 12 months prior to 31st March 2015 with 16 of these being upheld. This was a drop in complaints when compared to the previous year (2013/14) of 225 and 76 upheld.

In community services, patients knew how to raise concerns and make complaints and felt confident that staff would listen to their concerns. Staff were aware of the formal complaints process. Good analysis of complaints received was processed and discussed in their team meetings.

Good

# 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

## Our findings

**Vision, values and strategy**

The vision of the trust is 'outstanding care delivered by outstanding people' underpinning this are the trust values of:

Caring

- Privacy and dignity are at the heart of care. Treating people with respect and compassion and listening to what people say and acting upon this.

Safe

- Services are to be delivered to the highest standards of safety and in an environment that is safe and ensuring that there are effective systems and processes in place.

Excellent

- They aspire to be excellent and innovate in everything they do and continually improve recognising those who deliver excellent care.

The aims of their strategic plan are:

- To continuously improve.
- To work in partnership.
- To fully involve patients and carers.
- Translating innovation and putting technology into practice.

The achievements of these aims are set out in a wheel which describes how the organisation will meet its objectives.

Across all teams and services, staff were able to articulate the vision and values of the organisation. They told us that these values were linked to local objectives.

A key driver for the trust was a focus on maintaining quality for patients. This required significant investment in order to redesign and remodel services. The aim of this remodelling was to develop care pathways which ensured that services for both physical and mental health care were wrapped around an individual. This investment had increased the risk associated with the cost improvement programme and the new approach resulted in a deficit of 3.5m. As a result of this Monitor were investigating the trust finances and have a number of actions in place for the trust. These include:

- Providing monthly assurance to Monitor that it is achieving key milestones and develop a two-year financial plan for the period 2016/17 to 2017/18
- Ensure that Monitor receive latest trust board finance and cost improvement papers every month.
- The trust has to continue to engage with commissioners and other stakeholders effectively on the development and agreement of the financial plan and any transformation plans within it.

The board were of the view that the redesign would be effective at producing greater efficiency.

**Good governance**

At local level across all teams and services, we found good systems which provided assurance that relevant meetings were taking place. These meetings reviewed quality, safety, performance and finance. Meetings with key stakeholders were also in place and the trust had a good structure of committees which reported directly to the board. Training had been completed, supervision and appraisals were happening. We found that risk was being adequately managed. Services had local risk registers that were reviewed and kept up to date. There was a corporate risk register and the board were sighted on both.

There was good recording of serious incidents, monitoring and reviewing incidents and associated action plans put in place. Performance of teams was monitored at regular performance meetings. Where performance did not meet the expected standard, actions plans were put in place.

Whilst complaints were logged and learning from complaints was gained, we saw little evidence of monitoring informal complaints at a local level.

Good

# Are services well-led?

### Leadership and culture

Across the trust staff described a positive culture, staff felt free to talk and raise concerns. They said that there was a desire to learn from when things went wrong and a no blame culture. Clinical commissioning groups were overall positive about the trust. They believe there was openness and transparency.

Managers were visible and proactive, with many staff commenting that the senior leadership team visited services. The chief executive has a rolling programme of visits and staff engagement meeting called 'talk to Stuart'. Notably, the response from the trust to difficult circumstance at their Swindon community mental health services for children and young people was exemplary.

The NHS staff survey in 2014 demonstrated that 79% of staff at the trust worked more than their contracted hours and feedback from some staff suggested this increased the pressure on their workload and sometimes demoralised and lowered staff morale.

However, morale of staff was generally noted as good across the trust and staff spoke positively about its leadership. We found mangers within the trust to be committed, creative, knowledgeable and enthusiastic about their work.

Most staff described the trust as being a positive place to work. However, The trust was not in the top 20% of trusts in England for any key findings. The trust was in the bottom 20% of all trusts for the following key findings:

- The percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver.
- Pressure of work felt by staff.
- The percentage % of staff working extra hours.
- The percentage % of staff appraised in last 12 months.
- The percentage of staff witnessing potentially harmful errors, near misses or incidents in last 12 months.
- The percentage of staff reporting errors, near misses or incidents in last 12 months.
- The percentage of staff experiencing harassment, bullying or abuse in last 12 months.

### Fit and Proper Person Requirement

The trust is meeting the fit and proper person requirement. They have a comprehensive policy in place and all staffed are check using the barring and disclosure service (DBS) The trust policy sets out best practice in regards the requirements of directors to meet this duty. Staff had undergone recent DBS checks. We looked at records kept by human resources department which also confirmed this.

### Engaging with the public and with people who use services

The trust has a communications team and a 5 year communication strategy in place as well as a media policy. Currently it engages the public through a variety of mediums such as :

- The Oxford Health website.
- The Oxford Health intranet for staff. A weekly e-bulletin for staff.
- A quarterly Insight magazine for public, members and staff, with a monthly e-supplement featuring the latest developments.
- A suite of literature for internal and external audiences, including service leaflets.
- Media releases to print, radio, television and trade publications.
- Social media engagement through Twitter, YouTube and Facebook.

### Quality improvement, innovation and sustainability

The trust has joined many accreditation schemes including:

- Inpatient mental health services and psychiatric intensive care units.
- Inpatient mental health services for older people.
- Eating disorder units.
- Inpatient rehabilitation units.
- Electroconvulsive therapy service.

Memory assessment clinics have also recently been awarded accreditation with the memory service national accreditation programme.

The trust has also introduced apprentices for young people who had used services and who had engaged with their participation program. This aimed to gain work experience to assist the patient to enter the job market following their treatment.

The trust had a recovery college; this was launched in September 2015. The recovery college manager and coordinator employed to run the college had lived experiences of a mental health illness. Peer support

Good

# Are services well-led?

workers run every class offered at the recovery college. All the courses had been designed and will be attended by people who use mental health services, their families, carers as well as staff and volunteers.

The trust was one of the first pilot sites for street triage services and this had seen significant improvement in the response to those people subject to detention under S136 of the Mental Health Act 1983.

In urgent care services the virtual fracture clinic at Townlands hospital developed with Berkshire Healthcare Foundation Trust provided good outcomes for patients. A protocol had been developed which identified certain groups of patients with fractures or sprains who were treated and discharged by staff at the units. Patients X-rays were reviewed remotely by a radiologist and decisions made if patients needed to attend fracture clinic. This reduced and minimised unnecessary attendance to fracture clinics the following day.

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<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**Regulation 12 (2) (a)**<br>In community mental health services for children and young people;<br>Assessing the risks to the health and safety of service users of receiving the care or treatment<br>The provider must address the variable quality of risk assessments to ensure that all risks to young people are properly recorded and managed. |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**Regulation 17 (2) (b)**<br>In community mental health services for children and young people;<br>Providers must have systems and processes that enable them to identify and assess risks to the health, safety, and/or welfare of people who use the service.<br>The provider must review the caseloads in the Tier 3 CAMHS teams and the impact on safe patient care. |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**Regulation 12 (2)(b)**<br><br>In forensic inpatient/secure wards;<br><br>The trust should be doing all that is reasonably practicable to mitigate any such risks.<br><br>At Marlborough House seven out of eight patients receiving high dosages of antipsychotic medication had not received a three monthly physical health monitoring check as per the trusts policy.<br><br>This was a breach of regulation 12(2)(b) |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**Regulation 17**<br><br>In long stay/rehabilitation mental health wards for working age adults;<br><br>The trust did not take action to access, monitor and mitigate the risks relating to the health, safety and welfare of service users when moving patients between wards to create beds for other users.<br><br>The trust did not ensure that sufficient information about these patients was handed over between staff after they moved wards.<br><br>This is a breach of regulation 17 |

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises<br>**Regulation 15**<br>In long stay/rehabilitation mental health wards for working age adults;<br>The trust did not keep accurate records of maintenance issues and did not maintain the premises to an appropriate standard of hygiene for the purpose required.<br>This led to service users staying in bedrooms that were not fit for use due to the smell of sewage from blocked drains and a leaking roof.<br>This is a breach of regulation 15 |

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines<br>**Regulation 13 (4) (b) (c)**<br>In long stay/rehabilitation mental health wards for working age adults;<br>Blanket restrictions were in place on the ward in relation to access to rooms and access to food and drink. This resulted in service users sitting on the floor outside the dining room waiting for mealtimes.<br>The restrictions were not proportionate to the risk of harm posed to the service users and were degrading for the service users.<br>This is a breach of regulation 13:4 b and c |

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**Regulation 12 (1) (2) (g)**<br><br>In Urgent Care;<br><br>People who use services and others were not protected against the risks associated with unsafe care or treatment because. The provider did not protect service users against the risks associated with the proper and safe management of medicines. |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br>**Regulation 15 1 (f)**<br><br>In Urgent care;<br><br>The provider did not provide adequate seating and waiting place to meet the needs of children using the service.<br><br>The provider had not ensured resuscitation equipment available in all clinical areas at all times. |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment<br>**Regulation 18** |

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br>**Regulation 9(3)(b)**<br><br>In community based mental health services for adults of working age;<br><br>Person-centred care<br><br>The care and treatment of patients must be appropriate and meet their needs. The Aylesbury and City and North East teams did not have care plans that had clear goals, up to date, person centred, holistic or recovery orientated that addressed needs identified in the assessment stage. |
| | In community based mental health services for adults of working age;<br><br>Sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed and receive appropriate training and appraisal.<br><br>The trust did not have adequate staffing levels in the City and North East team so that staff could cope with the workload to ensure patients safety.<br><br>Not all staff had received mandatory training and appraisals.<br><br>Patients could not receive psychological therapies on time.<br><br>This was a breach of regulation 18(1)(2)(a) |

This section is primarily information for the provider

# Requirement notices

This was a breach of Regulation 9(3)(b)

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br>Regulation 9 (1) (b), (3) (a)<br><br>In community health inpatient services;<br><br>Person-centred care.<br><br>People's pain was not assessed and monitored. Regulation |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br>Regulation 13 (5)<br><br>In community health inpatient services;<br><br>Safeguarding service users from abuse and improper treatment.<br><br>Service users were deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 13 (5). |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Requirement notices

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|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs<br>**Regulation 14 (2) (b)**<br><br>In community health inpatient services;<br><br>Meeting Nutritional and hydration needs.<br><br>The nutritional and hydration needs of service users not being met because Assessment and Management of swallowing was not in the service user's best interests |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**Regulation 17 (2) (a) (b), (c)**<br><br>In community health inpatient services;<br><br>Good governance<br><br>How the regulation was not being met: Accurate, complete and contemporaneous records were not maintained.<br><br>Governance processes across inpatient services were not robust, and risks were not managed effectively and that there were not robust arrangements for improving the quality of care. |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures | Regulation 17 HSCA (RA) Regulations 2014 Good governance |

This section is primarily information for the provider

# Requirement notices

| | |
|---|---|
| Treatment of disease, disorder or injury | Regulation 17 (2) (a)<br><br>In community end of life care;<br><br>Good governance<br><br>Systems and processes were not in place to ensure that the quality and safety of services was monitored and feedback received to ensure quality improvement could take place. |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>Regulation 12 (1), (2) (a), (b),(c)<br><br>In Luther Street Medical Centre<br><br>Safe care and treatment<br><br>12.—(1) Care and treatment must be provided in a safe way for service users.<br><br>(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—<br><br>(a) assessing the risks to the health and safety of service users of receiving the care or<br><br>treatment;<br><br>(b) doing all that is reasonably practicable to mitigate any such risks; |

This section is primarily information for the provider

# Requirement notices

(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;

- Non clinical staff had not been trained in basic life support (BLS).
- A risk assessment to determine the need for non-clinical staff to be trained in BLS had not been undertaken.
- A risk assessment of the emergency medicines required had not been completed.

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br>**Regulation 9 (1) (a), (c)**<br><br>In acute wards for adults of working ages and psychiatric intensive care units;<br><br>Person-centred care.<br><br>The trust is not effectively ensuring that the care and treatment of patients is appropriate, meets their needs, and reflects their preferences.<br><br>There were blanket restrictions in place on some wards. These included access to the gardens, and ability to lock bedrooms. |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures | Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services |

This section is primarily information for the provider

# Requirement notices

| | |
|---|---|
| Treatment of disease, disorder or injury | Regulation 9(1)(a)(c), 9(3)(a)(b)(d)(f)<br><br>In acute wards for adults of working ages and psychiatric intensive care units;<br><br>The trust are not effectively ensuring that the care and treatment of patients is appropriate, meets their needs, and reflects their preferences.<br><br>Care plans were not personalised and did not include patients' views, nor were they recovery orientated, for example, they did not include the patients' strengths and goals.<br><br>Patients were not routinely involved in devising their care plan and had not received a copy of their care plan. |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>Regulation 17(1), 17(2)(a)(b)(f)<br><br>In acute wards for adults of working ages and psychiatric intensive care units;<br><br>The systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients who may be at risk which arise from the carrying on of the regulated activity, and systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services), are not operating effectively. |

This section is primarily information for the provider

# Requirement notices

Systems were in place to check the quality of the care plans, for example, we saw evidence of care plan audits. However, such systems did not identify and remedy the limitations in the quality of the care plans.

Systems were in place to identify and manage ligature risks in the patient care areas, for example, we saw evidence of ligature risk assessments and action plans. However, such systems were generic and did not identify specific management strategies relating to ligatures.

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**Regulation 18 (1)(a)**<br><br>In acute wards for adults of working ages and psychiatric intensive care units;<br><br>For September 2015: 67 out of 184 staff had a supervision recorded. This meant that people employed were not receiving appropriate supervision. |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**Regulation 18(1)**<br><br>In community health services for adults;<br><br>Staffing<br><br>There were not sufficient numbers of staff in some community teams, to meet the requirements set out in the fundamental standards. |