

Inadequate Avon and Wiltshire Mental Health Partnership NHS  
Trust

# Mental health crisis services and health-based places of safety

## Quality Report

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## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RVN2A	Hillview Lodge	Bath and North East Somerset Intensive Team, Hillview Lodge, Royal United Hospital, Combe Park, Bath,	BA1 3NG.
RVN8A	Sandalwood Court	Swindon Intensive Service, Sandalwood Court, Highworth Road, Swindon,	SN3 4WF

# Summary of findings

RVN3Q	Blackberry Hill Hospital	South Gloucestershire Intensive Support Team, Bybrook Lodge, Blackberry Hill Hospital, Manor Road, Fishponds, Bristol,	BS16 2EW.
RVN4B	Longfox Unit	North Somerset Intensive Support Team, Grange Road, Uphill, Weston-Super-Mare,	BS23 4TS.
RVN1H	Trust Headquarters	Central and East Crisis Team Brookland Hall, Conduit Place, St Werburghs, Bristol	RVN3Q
RVN9A	Fountain Way	Wiltshire Intensive South team Wilton Road , Salisbury, Wiltshire,	SP2 7EP
RVN6A	Green Lane Hospital	Wiltshire Intensive north team Marshall Road, Devizes, Wiltshire,	SN10 5DS
RVNEQ	Callington Road Hospital	Bristol Access and Triage team (including the crisis line) Marmalade Lane, Brislington , Bristol,	BS4 5BJ
RVN3N	Southmead AWP	136 Suite - Place of Safety Southmead Road, Westbury-on- Trym , Bristol, Avon,	BS10 5NB
RVN8A	Sandalwood Court	136 Suite – Place of Safety Sandalwood Court, Highworth Road, Swindon,	SN3 4WF
RVN6A	Green Lane Hospital	136 Suite – Place of Safety Marshall Road, Devizes, Wiltshire,	SN10 5DS
RVN9A	Fountain Way	136 Suite – Place of Safety Wilton Road , Salisbury, Wiltshire,	SP2 7FD

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

# Summary of findings

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

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

# Summary of findings

## Ratings

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

### Overall rating for the service

Inadequate



Are services safe?

Requires improvement



Are services effective?

Inadequate



Are services caring?

Good



Are services responsive?

Inadequate



Are services well-led?

Requires improvement



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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

We rated mental health crisis services and health-based places of safety as inadequate because:

- Within the health-based places of safety, the wait for a Mental Health Act assessment was too long. We found evidence that people regularly waited over twelve hours for assessment. People also waited for many hours while found suitable placements for people following an assessment. There were significant challenges in relation to the capacity of places of safety that the trust. We have served a warning notice that requires the trust to take significant action. This will need a multi-agency response. There were many reasons for lack of access to the places of safety, delays in beginning and completing assessments and finding suitable placements for people following an assessment.
- Police regularly took people subject to section 136 to a police station because there was no available space at the places of safety. Police stations can be a place of safety, but should not be seen as an appropriate location for people experiencing a mental health crisis. The Mental Health Act Code of Practice 2015 (paragraph 16.38) states that a police station should be used as a place of safety only on an exceptional basis.
- The trust did not have effective systems in place to monitor the health-based places of safety across the trust and to assess the impact of gaps in service provision. We were concerned that the trust was not able to identify incidents that occurred in the health-based places of safety in Wiltshire as these were recorded as part of the ward incident data. The trust could not provide data for incidents that had occurred within these places of safety. There had been no reviews undertaken into the use of restrictive interventions across any of the places of safety. We found significant problems with the availability and robustness of the data collected to monitor the operation of places of safety in Wiltshire and Swindon. This meant that the trust could not monitor quality and safety effectively. We found issues with the safety and suitability of some of the environments of the places of safety, including ligature points and lack of appropriate furnishing.
- All the teams we met with told us that bed availability caused significant issues and that the delays had a serious impact on staff capacity (taking a clinician a whole shift to locate a bed) and on care for some patients. Staff told us about increased length of time waiting in places of safety, deterioration in mental health in the community and patients being transferred multiple times between hospitals or to locations great distances from their homes.
- The trust intensive teams operated a gate-keeping function for inpatient beds, and all staff spoken with told us that lack of bed availability caused significant issues. We heard from staff that finding a bed took a substantial amount of time. All teams had bed management caseloads, detailing people who needed repatriation to a local bed, which could take up a significant amount of staff time.
- Arrangements for night-time crisis calls varied between the localities. With the exception of Bristol, where there was a dedicated crisis line, calls to most of the intensive teams were taken by a call centre from 5pm until 8am weekdays and at weekends. The call centre was a messaging service and took basic information from the caller but was not staffed by trained mental health clinicians. Teams could not clarify how long it took them to return a call. The South Gloucestershire team operated an on-call system at night, with crisis calls being put through to a ward in the first instance.

However:

- It was to the credit of the local team at the Mason unit that despite significant challenges in relation to managing the health-based place of safety, and a lack of clear planning and direction from the commissioners and trust, morale was good and the team were positive and proud of their work. The team felt valued and well supported by their team manager. The team had developed and maintained excellent working relationships with the police. The ward staff that supported the Wiltshire and Swindon places of safety also demonstrated good understanding of the

# Summary of findings

processes and meeting people's needs. The police were positive partners in working with the trust to meet more effectively the needs of people presenting in mental health crisis.

- The trust intensive teams that formed a core part of the crisis service provision across the whole trust had clear clinical pathways to support effective assessment, management and treatment of clinical needs. The intensive teams and Bristol access and triage team worked effectively and collaboratively with other services to ensure continuity and safety of care across teams, including involvement of external agencies. The teams worked hard to meet the varied demands on the service despite challenges they faced at times with limited resources; for example, lack of in-patient beds.
- We observed that staff in all of the intensive teams were caring, compassionate and kind. People we spoke with were positive about the care and support they received. Staff demonstrated that they knew the needs of the people on their caseloads, and discussions in handovers were patient focussed and respectful.
- The intensive teams had systems and capacity to respond to referrals in a timely manner. The teams were confident that they all worked within the assessment targets agreed by the trust, and data collected by the trust reflected this. We found that there were variations between the localities we visited, in relation to receiving and responding to crisis calls and 'out of hours' contacts. However, from trust data only one person had complained about response times out of hours if they had called any of the teams. People we spoke with told us they could access the teams by telephone easily and got a timely response.
- The intensive teams had meeting structures in place that supported effective local management oversight and development across the whole service; for example, the trust-wide crisis good practice network and locality multi-agency meetings with police, acute hospital and local authority colleagues, mental health liaison and in-patient services. However, crisis concordat meeting minutes from the past 12 months showed that concerns were consistently raised about the capacity of places of safety and the use of police cells and emergency department, with little evidence of a senior management plan to monitor and respond to these concerns.
- We saw good examples of local leadership from the team managers, modern matrons and service managers of the intensive teams. Staff told us that they felt well supported by their team managers and were able to raise concerns and contribute to service development. The service managers and modern matron showed a good understanding of the current challenges for this service and staff.

# Summary of findings

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

### Are services safe?

We rated safe as **requires improvement** because:

- We were concerned that the trust was not able to identify incidents that occurred in the health-based places of safety in Wiltshire as these were recorded as part of the ward incident data. The trust could not provide data for incidents that had occurred within these places of safety. There had been no reviews undertaken into the use of restrictive interventions across any of the places of safety.
- We found issues with the safety and suitability of some of the environments of the places of safety, including ligature points and lack of appropriate furnishing.
- Data about staffing was inconsistent according to where it came from. The data outlining the staffing establishments, varied between information provided by the trust prior to inspection, during inspection and directly from the teams. The trust could not provide data on the use of agency staff as teams had only started using the electronic rostering system in April 2016. Overall, Bath and North East Somerset, North Somerset and Swindon intensive teams reported they had enough staff to safely manage their services. Average shift numbers, rotas and caseload profiles reflected this. However, Bristol central and east team had significant pressures with staffing and were concerned about the frequent use of temporary staff.

However:

- We looked at 96 care records across the intensive teams. Staff identified and managed risks effectively. We found the risk assessments to be consistently of a good standard across all the teams.
- Staff understood how to report incidents. Staff felt confident in raising concerns and knew how to escalate them if necessary. Incidents were a running agenda on team meetings, with information about serious incidents to be shared trust wide. Staff could give examples of learning from serious incidents.

**Requires improvement**



### Are services effective?

We rated effective as **inadequate** because:

- There were clearly significant challenges in relation to the capacity of places of safety that the trust provided in Wiltshire, Avon and Somerset. We served a warning notice that requires the trust to take significant action. We had serious concerns

**Inadequate**





# Summary of findings

with the timeliness of Mental Health Act assessments for people detained in the places of safety. A significant majority of individuals were detained within a trust designated place of safety far exceeding the timescales recommended in the Mental Health Act Code of Practice guidance. There were multiple reasons for lack of access to the places of safety, delays in beginning and completing assessments and finding suitable placements for people following an assessment. People were being taken to police custody and emergency departments to wait for assessment due to lack of space at the places of safety.

However:

- The quality and detail of assessments and care plans in the 96 records we looked at across the crisis teams, overall were up to date and overall consistently of a good standard across most of the teams. Most were holistic, with information regularly reviewed and with up to date risk assessments.
- There were clear clinical pathways to support effective assessment, treatment and management of clinical needs. The intensive teams and Bristol access and triage team worked effectively and collaboratively with other services to ensure continuity and safety of care across teams, including involvement of external agencies.

## Are services caring?

We rated caring as **good** because:

- We observed the staff in all of the teams to be caring, compassionate and kind. People we spoke to were positive about the care and support they received. Staff demonstrated that they knew the needs of their people on their caseload, and discussions in handovers were patient focussed and respectful.

Good



## Are services responsive to people's needs?

We rated responsive as **inadequate** because:

- All the teams we met told us that lack of bed availability caused significant issues and that the delays had a serious impact on staff capacity (taking a clinician a whole shift to locate a bed) and on care for some patients. Staff told us about increased length of time waiting in places of safety, deterioration in mental health in the community and patients being transferred multiple times between hospitals or to locations great distances from their homes.

Inadequate



# Summary of findings

- There were significant issues with the capacity and timeliness of Mental Health Act assessments at the trust designated places of safety.
- The average caseload per intensive team was between 15 and 25 people for home treatment. At the time of inspection, over half of the team caseloads at the north and south Wiltshire intensive teams were people who were ready to be discharged to the community mental health teams. The lack of capacity within those teams meant they were unable to accept additional people.

However:

- The intensive teams and Bristol access and triage team had systems and capacity to respond to urgent and routine referrals in a timely manner. The teams offered a range of interventions which could include support with housing, benefits and employment. The Bristol Central and East team worked with a range of very complex issues and was responsible for all patients in the Bristol area who were of no fixed abode.

## Are services well-led?

We rated well led as **inadequate** because:

- The trust did not have effective systems in place to monitor health-based places of safety and the impact of gaps in service provision. Data showed there were serious issues with service capacity and delivery within the Bristol place of safety, however, the governance structures were not in place within the trust to ensure effective escalation to the executive team.
- An operational policy and audits for the places of safety were not in place in line the Mental Health Act code of practice.
- However: We saw good examples of local leadership from the team managers, modern matrons and service managers we met. Staff told us that they felt well supported by their team managers and were able to raise concerns and contribute to service development, although morale was variable across the teams. The service managers and modern matron showed a good understanding of the current challenges facing the service and its staff.

**Requires improvement**



# Summary of findings

## Information about the service

In February 2014, the publication of the Crisis Care Concordat placed mental health crisis care under the national spotlight. The Concordat committed its signatories to working together to improve the system of care and support, so that people in crisis are kept safe and are helped to find the support they need. AWP have a range of different teams that work together to meet the needs of people who present in crisis; for example, intensive teams, health-based place of safety, street triage, mental health liaison and primary care liaison teams. During this inspection, we focused on the intensive services and the health-based places of safety, although we also describe how these services work with others.

Crisis and home treatment teams within the trust were called “intensive services” in all areas except Bristol. The intensive services teams provide home based interventions to people experiencing a mental health crisis, who may or may not already be working with the mental health services. They are also responsible for gatekeeping of inpatient beds and facilitated early discharge from wards for people over the age of 18. There was no upper age limit, but the service did not cater for people with dementia except in exceptional circumstances. For most patients this was usually up to 4 to 6 weeks.

The trust had seven intensive services:

- The Bristol Crisis and Intensive Home Treatment Service, which was made up of three “spokes” and a “hub”, served Bristol.
- The South Wiltshire Intensive Team serves South Wiltshire
- The North Wiltshire Intensive Team serves North Wiltshire
- The South Gloucestershire Intensive Team serves South Gloucestershire
- The Swindon Intensive Team serves Swindon and agreed North Wiltshire specific area
- The North Somerset Intensive Team serves North Somerset
- The Bath and North East Somerset Intensive Team serves Bath and North East Somerset.

We inspected one of the Bristol spokes (Central and east, serving Bristol city centre), the hub, the

North and South Wiltshire teams, South Gloucestershire, Swindon, North Somerset and the Bath and north east Somerset team

Section 136 of the Mental Health Act allows for someone believed by the police to have a mental disorder, and who may cause harm to themselves or another, to be detained in a public place and taken to a safe place where a mental health assessment can be carried out. Police can also take people who are detained under section 135 to a place of safety. Section 135 can be used by mental health professionals to take someone to a place of safety for a mental health assessment.

A place of safety could be a hospital, care home, or any other suitable place where the occupier is willing to receive the person while the assessment is completed. Police stations should only be used in exceptional circumstances.

Health-based places of safety are most commonly part of a mental health unit on a mental health hospital or acute hospital site, or part of an accident and emergency department in an acute hospital. The trust provides seven health-based place of safety across four locations within its geographical area to adults of all ages with no upper limit.

Wiltshire and Swindon places of safety are based within grounds of mental health hospitals, offering single occupancy at each facility: Fountain Way Hospital, Salisbury, Greenlane Hospital at Devizes and Sandlewood Court at Swindon. Young people under 18 years old can be assessed under a section 136 at the allocated places of safety at Fountain Way Hospital, Salisbury and Sandlewood Court at Swindon. They are served by three clinical commissioning groups (CCGs), North Wiltshire, South Wiltshire and Swindon and Wiltshire police force.

The Mason Unit place of safety in Bristol has capacity for four patients. It covers a wide geographical area commissioned by four clinical commissioning groups (CCGs), covering Bath and North East Somerset, North Somerset, Bristol and South Gloucestershire. It is served

# Summary of findings

by the Avon and Somerset police force. Mason Unit can accept one young person aged 16 and 17 at any time and one under 16 at any one time. If an under 16 year old is detained at the suite, the CCGs have agreed one space will be closed on the unit to ensure a safe environment for the under 16, separated from other adult detainees.

The CQC had concerns in relation to the suitability and safety of the environments of the places of safety at Salisbury and Devizes in the 2014 comprehensive inspection and told the trust they must take action to address these concerns. In our February 2014 inspection of the Mason Unit, Bristol and our trust-wide inspection in May 2014, we told the trust we were concerned that MHA assessments were not being conducted in a timely manner and requested action from the trust. During this inspection we found there were continued concerns with the suitability and safety of some of the environments and also serious concerns with the times people were remaining in the places of safety.

We inspected community based crisis services in June 2014 and were concerned about the use and

management of medicines and staff shortages including medical cover. We told the trust that it must take action to address these issues. During this inspection we found that these issues had been addressed by the trust.

CQC inspected the Bristol crisis and home treatment team in December 2015 as part of an inspection of assessment, recovery and crisis team in the trust, in response to concerns. That inspection resulted in enforcement action. We issued a warning notice to the trust for quality of health care provided by the community teams. We inspected again on 17 February 2016 to check that the actions specified in the warning notice had been completed. We only looked at the specific actions required to be completed by 1 February 2016. We found that there was now an effective system in place to monitor referrals. The trust had revised its governance structure within Bristol to focus on gaining detailed assurance that all teams were delivering safe and effective care in a timely manner. The trust had introduced new governance groups across Bristol.

## Our inspection team

**The Inspection Chair** was Maria Kane, Chief Executive of Barnet, Enfield and Haringey Mental Health NHS Trust.

**The Head of Hospital Inspection** was Karen Bennett-Wilson.

The team that inspected mental health crisis services and health-based places of safety consisted of an inspection

manager, an inspector, two nurses and a social worker with experience of working in adult community mental health. The health-based places of safety were inspected by an inspection manager and a Mental Health Act reviewer.

## Why we carried out this inspection

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

## How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

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

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

# Summary of findings

During the inspection visit, the inspection team:

- visited seven intensive teams and the Bristol triage team (including the crisis line)
- visited all four of the health-based places of safety at the hospital sites, looked at the quality of the environment and observed how staff were caring for patients at each
- spoke with 15 patients who were using the service and 5 carers
- spoke with the 15 managers or acting managers for each of the teams and three service managers
- spoke with 60 other staff members; including doctors, nurses and social workers
- interviewed the divisional director with responsibility for these services
- spoke with three police representatives with mental health lead responsibilities for Avon and Somerset and Wiltshire police forces
- held engagement events that invited key crisis stakeholders to discuss local service provision
- sought feedback from other teams that support the crisis services, for example, mental health liaison teams at the acute hospitals, street triage teams and emergency department staff
- looked at 96 care records
- observed 6 handover meetings, a complex case meeting, the triage morning discussion and a care pathway multi-disciplinary meeting
- carried out specific checks of the medication management at all of the intensive teams, health-based places of safety and the Bristol triage team, including reviewing 10 prescription cards
- looked at a range of policies, procedures and other documents relating to the running of the service.

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

We met with one adult detained on the unit on the day of our visit and they stated that they 'felt safe and was well looked after' at the Mason Unit.

We received very positive feedback from most patients and carers. They told us that staff were supportive, respectful, polite and caring. However, some people felt that they saw too many different people from the team.

## Good practice

- The south Gloucestershire team had employed a peer support worker in research to trial the open dialogue model of care. This member of staff also undertook friends and family questionnaires with discharged patients in order to encourage more detailed and meaningful feedback.
- The Bath and North East Somerset intensive team were using a senior nurse to undertake police liaison work in order to fill an identified gap in service provision due to there not being any funding for street triage. They were able to demonstrate that use of s136 of the Mental Health Act was avoided in 18 cases out of 44 interventions with the police since 31 January 2016
- The Swindon team identified lead roles for all team members, including those without professional qualifications, to encourage staff development and team accountability. This included individual team members taking leads in ensuring the team undertook health care checks, and crisis and contingency planning.
- We saw a very good example of creative and person centred care planning by the Swindon intensive team for a service user with personality disorder. This had resulted in a significant decrease in risk taking behaviours and reduction in hospital admission. The team were due to present their work to other intensive teams to demonstrate good practice.
- Complex care meetings had been established in all localities for people who used a range of services. These involved police, ambulance, mental health

# Summary of findings

liaison, street triage, and the service user to try to establish consistent responses and adherence of treatment plans for people who frequently presented with complex needs and high levels of distress.

## Areas for improvement

### Action the provider **MUST** take to improve

- The trust must review and address the reasons for lack of access to the places of safety, significant delays in beginning and completing Mental Health Act assessments and finding suitable placements for people following an assessment.
- The trust must ensure that people are not detained in police custody other than in exceptional circumstances.
- The trust must ensure that people are not detained longer than the legal maximum time of 72 hours
- The trust must review and ensure that premises and equipment within the health based places of safety are suitable and safe for use, and that effective risk assessments are in place to mitigate identified and known risks
- The trust must ensure that incidents are recorded and governance systems are effective, to allow for review and audit of restrictive interventions used in health based places of safety

- The trust must ensure that governance systems accurately record and report all of the required monitoring data for the health based places of safety and audits are undertaken to identify issues.
- The trust must update the Wiltshire and Swindon health based places of safety operational policy to reflect the changes made to the MHA Code of Practice.

### Action the provider **SHOULD** take to improve

- The trust should review out of hours crisis arrangements to ensure consistency across all the teams and localities
- The trust should ensure good practice is shared more effectively and consistency with use of handover templates and caseload monitoring information such as whiteboards across all teams and localities
- The trust should ensure that governance systems accurately record staffing establishment and use of agency across all teams and localities

## Avon and Wiltshire Mental Health Partnership NHS Trust

# Mental health crisis services and health-based places of safety

### Detailed findings

#### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Bath and North East Somerset Intensive Team, Hillview Lodge, Royal United Hospital, Combe Park, Bath,	Hillview Lodge
Swindon Intensive Service, Sandalwood Court, Highworth Road, Swindon,	Sandalwood court
South Gloucestershire Intensive Support Team, Bybrook Lodge, Blackberry Hill Hospital, Manor Road, Fishponds, Bristol,	Blackberry Hill Hospital
North Somerset Intensive Support Team, Grange Road, Uphill, Weston-Super-Mare,	Juniper Ward
Central and East Crisis Team	Trust HQ

# Detailed findings

Brookland Hall,  
Conduit Place,  
St Werburghs,  
Bristol

Salisbury Intensive Team

Trust HQ

Devizes Intensive team

Trust HQ

Bristol Triage team

Trust HQ

## Mental Health Act responsibilities

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

- None of the intensive or crisis teams that we inspected had patients on their caseloads who were under a community treatment order. All of the intensive teams attended Mental Health Act assessments where possible to help look at alternatives to hospital admission.
- Across the trust, individuals, continued to be regularly conveyed in police vehicles due to lack of availability of ambulances. Once section 136 has been applied, a person should receive transportation to a health-based place of safety via an appropriate vehicle, most likely an NHS ambulance but on occasion private vehicles may have to be commissioned. In exceptional circumstances, conveyance in a police vehicle may be required if other more suitable forms of transport are not available.
- There were clearly significant challenges in relation to the capacity of places of safety in Wiltshire and Avon and Somerset. There were multiple, and often simultaneous, reasons for lack of access to the places of safety, delays in beginning and completing assessments and finding suitable placements for people following an assessment. The CQC raised concerns previously. We served a warning notice against the trust that will require a multi-agency response.
- Police stations can be a place of safety, but it is not seen as an appropriate location for people experiencing a mental health crisis. The MHA Code of Practice 2015 (16.38) states that a police station should be used as a

place of safety only on an exceptional basis, for example where the person's behaviour would pose an unmanageably high risk to other patients, staff or users of a healthcare setting.

- We found that people were regularly being taken to police custody because the places of safety were full. In Bristol, over the past 12 months 267 people had been detained in police cells under section 136. Between March 2014 and April 2015, 182 people were taken to the police cells on a section 136. Most of these people were detained at police cells because the places of safety were full. The Wiltshire police force told us that they have noted an increase in the use of their police cells and reported five detainees in the month prior to inspection.
- We had serious concerns with the timeliness of Mental Health Act assessments for people detained in the places of safety. The MHA Code of Practice refers at paragraph 16.32 to "providing prompt assessment". Paragraph 16.65 says that the local policy should set the expected time limits within which the assessment should commence, and requires relevant NHS bodies and local authorities to review local practice against these targets. The MHA Code of Practice 2015 (16.47) states: 'assessment by the doctor and AMHP should begin as soon as possible after the person arrives at the place of safety. Unless there are clinical grounds for delay, it recommends that joint assessments should begin within three hours.' A significant majority of



# Detailed findings

individuals were detained within a trust designated place of safety far exceeding the timescales recommended within the MHA Code of Practice guidance.

- The length of time to complete an assessment ranged from less than four hours to in excess of 24 hours. Data showed that a significant majority of people were in places of safety for over 12 hours waiting for assessment, and a significant number for 24 to 60 hours. There were multiple, and often simultaneous, reasons for delays in beginning and completing assessments. The main reasons for the delays in the process were recorded as:
  - Awaiting attendance by AMHP
  - Awaiting attendance by section 12 approved doctor
  - Lack of availability of beds
  - Person not medically fit (or intoxicated)
  - Lack of space at the place of safety
- Legally, the maximum amount of time a person can be detained in a place of safety is 72 hours. Trust data showed that there had been eight occasions where people were detained over the legal maximum time of 72 hours between March 2015 and April 2016, and five people between August 2014 and November 2014. There were no overarching guidelines to advise staff on what the process should have been when people remained on the unit for longer than 72 hours and under what legal framework they should have been managed. The incidences where people have remained beyond 72 hours were not been reported as an incident.
- The MHA Code of Practice states that there should be a jointly agreed local policy in place that governs all aspects of the use of sections 135 and 136. This should be maintained by a multi-agency liaison committee. Wiltshire locality did not have a current policy and advised us that the trust and multi-agency committee were reviewing the Wiltshire and Swindon protocol to align with the wider trust 136 policy at the time of inspection. We noted this had also been highlighted in multi-agency minutes in November 2015.
- The Mental Health Act Code of Practice 2015, 14.86 recommends that: 'local recording and reporting mechanisms should be in place to ensure details of any delays in placing patients, and the impact on patients, their carers, provider staff and other professionals are reported to commissioning and local authority leads. These details should be fed into local demand planning.'
- We found significant problems with the availability and robustness of the data collected to monitor the operation of places of safety in Wiltshire and Swindon. The trust was not consistently collecting accurate monitoring data for Wiltshire and Swindon places of safety. The MHA Code of Practice, 16.59, states: "A record of the person's time of arrival must be made immediately when they reach the place of safety. As soon as detention in a place of safety under section 135(1) or 136 ends, the individual must be told that they are free to leave by those who are detaining them. The organisation responsible for the place of safety should ensure that proper records are kept of the end of the person's detention under these sections. In cases where alternative places of safety are used (such as the home of a relative or friend), local policies should define responsibilities to ensure that proper records are kept of the time of arrival, and the time the detention ends." It further states, 16.61: 'When admitted to a place of safety in a hospital, a record of the admission, and of the outcome of the assessment, should be made by the hospital. Where persons who do not work for the hospital undertake the assessment, local procedures should be in place to ensure good record keeping.'
- Some patients had remained in the place of safety for hours, or days, after their Mental Health Act assessment due to the lack of availability of beds to admit people to. Data provided from the trust highlighted that between April 2015 and April 2016, 197 out of the 290 recorded delays post assessment in Bristol place of safety were due to the lack of availability of a suitable bed. We noted from multi-agency meeting minutes May 2015 that lack of availability of beds was raised as having a significant impact on the assessment process and place of safety capacity.
- The trust was not able to provide specific data about incidents, restraint, rapid tranquilisation or seclusion for the Wiltshire and Swindon places of safety. It also could not provide information about those people detained in

# Detailed findings

police cells at the time of an incident, for both Avon and Somerset and Wiltshire. We analysed data provided by the trust in relation to incidents of restraint, seclusion and rapid tranquilisation at the Mason Unit.

- It was not clear from the data provided whether incidents resulting in restraint, seclusion and rapid tranquilisation were attributable to the length of time people were waiting for assessment, waiting for a suitable placement following assessment or due to their presenting condition at the time of admission to the unit. There had been no reviews undertaken into the use of restrictive interventions within the places of safety, even though the Code of Practice states: Places of safety and consent to treatment, 16.72: “Detaining a patient in a place of safety under sections 135 or 136 does not confer any power under the Act to treat them without their consent. In other words, they are in exactly the same position in respect of consent to treatment as patients who are not detained under the Act.’ This means that people cannot be restrained, or given treatment without consent, except in exceptional circumstances.

However, we also found:

- We checked ten patient documents and all s136 documents were in order. Section 132 patient rights were in place.
- We reviewed the trust’s training data and this showed that 100% of staff were up-to-date with mandatory Mental Health Act training.
- All areas’ trust managers, staff and the police reported positive and strong relationships and good attendance at the crisis concordat meetings and multi-agency meetings.
- Street triage services have been piloted in a number of AWP areas from September 2015 – all of which were reported to be having a positive impact and were collecting data and reviewing to apply for permanent funding/commissioning.

## Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act training and Deprivation of Liberty Safeguard training were mandatory. All of the staff working in crisis/intensive team and PoS had completed this training. Staff we spoke with demonstrated a good understanding about obtaining a person’s consent, or if required, relatives and/or their representatives. In the care records, we saw evidence of good practice documented.
- Some staff told us that training was mostly e-learning and that they would prefer some face-to-face learning to improve their knowledge.

# Are services safe?

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

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

## Our findings

### Safe and clean environment

#### Mental health crisis services

- The majority of the crisis/intensive teams' work was carried out in people's own homes, GP surgeries or clinic rooms. Interview rooms in the buildings used by the intensive teams were either fitted with fixed alarms, or portable alarms were used. Staff that used portable alarms were able to show us where these were kept.
- The environments where people were seen were clean and well maintained in all the locations.
- Staff adhered to infection control principles

#### Health-based places of safety

- The current place of safety suite at Devizes opened the week prior to our inspection. This was on the same site as the previous place of safety suite, at Greenlane Hospital, Devizes. At the comprehensive inspection in 2014 we had identified that the place of safety suite was not suitable for use. However, we were informed by staff that this had remained in use until the week before our inspection in May 2016.
- We identified multiple ligature points within the new place of safety. There were two toilet facilities. One had no viewing panel in the toilet, both had multiple ligature points and both were in use at the time of inspection. One toilet was within the en-suite bathroom, which contained multiple ligature risks and only a bath (no shower). This meant that the dignity and privacy of people was compromised by the need to be constantly watched whilst using toilet or bathing facilities in order to mitigate the ligature risks.
- The trust did not have an effective emergency response system in place. For example, in the event of a medical emergency or serious incident. A member of staff from the ward in the next door building would respond if the alarms sounded but would have to go through a number of locked doors, walk outside and go to the next building. There had been no timed drills to ascertain how quickly staff gained access. Staff were not aware that there was a potential second access point through

a garden door if the access via the main door was obstructed. At the time of inspection, the keys for this door were not available on the emergency key ring held by the intensive team. There was no emergency equipment in place, including first aid kit, oxygen or ligature cutters. There was a lack of suitable furnishing and no means of distraction or activities. No risk assessment or plan was in place to manage these risks at the time of inspection. Staff also raised their concerns with us about these risks. On the day of the inspection, we asked the trust to take immediate action to ensure emergency equipment was in place. We visited the following week after initial inspection and found this was in place.

- Mason Unit is a four bedded unit within the Southmead acute mental health in-patient facility. It was previously used as a high dependency unit. It opened as a place of safety in 2014. There was an on-going environmental issue with legionella having been identified in the water at the building where the Mason unit was located. The trust was aware and implementing the recommended monitoring and management procedures (including restrictive admissions). The local management team told us that the trust would not remove known ligature risks until this issue had been addressed and they knew the full extent of work required as a result
- The seclusion room did not have full line of sight and the ensuite toilet did not have anti-ligature tap fittings. The mirror could be pulled away from the wall fitting. The door handle from the seclusion room to the ensuite was not of an anti-ligature fitting. The ensuite facilities in the bedrooms were not anti-ligature and the beds could potentially be stood up on their ends therefore could be used to barricade the door or using it as a high ligature point. All of the above was brought to the attention of the modern matron and ward manager on the day of our visit and they confirmed that they were risks already known to the trust. There had been ligature incidents in the past 6 months using all of these identified ligature points. We noted from trust data that there had been 36 recorded ligature incidents between 7 May 2015 – 11 May 2016 at the place of safety.

# Are services safe?

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- At the Swindon place of safety suite the ensuite shower unit was a potential ligature point and the modern matron was made aware of this on the day of our inspection. The lounge area taps /cupboard and door handles were not of an anti-ligature design. We were told that this area was always under staff supervision and patients were either on one to one nursing observations or ten minute close observation. There was no access to outside space.
- We raised concern about the ligature risks, line of sight and access at the place of safety at Salisbury during our inspection in 2014. During this inspection, we found that the trust had made improvements. We found that the door to the bedroom area now opened both ways. There was a mirror system within the room to help with a blind spot. There was a remaining possible ligature point as the TV cable comes out of the TV box and down to a plug. However, patients would be observed at all times
- Within the Wiltshire place of safety documentation there was no recorded evidence that personal searches were conducted on detention by the police. However, all staff we spoke with were assured that police did undertake searches. There was also no process or record that ward staff carry out additional person or personal belonging searches on arrival to the suite.
- An interim protocol from the 1 June 2016 stated that in the event that the Mason unit place of safety was full, adult patients would be taken to Southmead or Bristol Royal Infirmary emergency departments (ED) to wait for assessment. Neither emergency department was a designated place of safety. The emergency staff raised concern about the limited space available in ED and the potential impact on other staff and patients. Routinely using ED was not an appropriate alternative to the lack of a dedicated health-based place of safety. The emergency departments were not a designated place of safety and would not be suitable for vulnerable patients due to the area containing free standing equipment, cords and a number of ligature points. We reviewed crisis concordat meeting minutes over the past 12 months and these showed that the concerns about using the ED facilities had repeatedly been raised.
- Most teams told us that they used bank and agency staff to cover vacancies and sickness. Team managers tried to use regular bank and agency workers whenever possible. Team managers found that weekend shifts and nightshifts were the most difficult to fill and that these were the times that they were more likely to use bank or agency staff. The Bristol central and east crisis team covered 714 shifts by bank and agency in the 12 months prior to inspection, of which 356 shifts were covered by agency workers. The team had three vacant posts which had been filled, although the new staff were not yet in post. Two staff were due to go on maternity leave and there were two band 4 vacancies.
- The trust did not provide consistent data for establishment staffing and levels of bank usage across the intensive teams. The trust advised that prior to April 2016 most intensive teams did not record their agency usage on the trust electronic rostering system. Agency information appeared on the monthly budget reports. Whilst this gave an overview of the amount spent on agency it did not allow us to understand the agency and bank usage in relation to skill mix and shift ratio.
- The staffing information provided by the trust differed to information provided during inspection and directly from the teams. This made it difficult to understand the staffing arrangements of the teams. The data reflected that there were significant numbers of vacancies in some teams. For example, Bath and North East Somerset intensive team's establishment staffing level was 16.9 full time equivalents (FTE) with a vacancy rate of 18%; North Somerset had an establishment of 22.6 FTE and 9.7% vacancies; Swindon had an establishment of 23.6 FTE with 6.6 vacancies (28%); north Wiltshire 21.4 FTE establishment with 18.7% vacancy rate. The teams were actively trying to recruit. South Gloucestershire intensive team had received additional funding for staffing following a period of difficulty due to staff leaving and long term sickness, and had sufficient staff to fill shifts without using agency staff. Staff sickness varied from 3.2% in the Bristol central and east team to 8.6% in the north Somerset team.
- All teams had at least one band 6 member of staff on per shift. With the exception of South Wiltshire, all the teams had a band 7 clinical lead in addition to the band 7 team manager. Bath and North East Somerset, North Somerset and Swindon intensive teams reported they

## Safe staffing

### Mental health crisis services

# Are services safe?

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had enough staff, overall, to safely manage their services. Average shift numbers, rotas and caseload profiles reflected this. However, Bristol central and east team had significant pressures with staffing and were concerned about the frequent use of temporary staff. It was not clear whether the team's staffing levels took sufficient account of the complex nature of the team's workload that included covering a culturally diverse city centre and all patients within Bristol who were of no fixed abode.

- The Wiltshire intensive teams had recently undergone a staffing and resource review, and as a result staffing numbers had been reduced. Staff were not happy about this and reported that they felt there were not always enough staff to safely meet the needs of the service. The north Wiltshire intensive team had been responsible for managing the place of safety until the week prior to our inspection, which had a significant impact on their staffing, at times leaving one or two staff to cover the intensive team function. Staff were confident this would improve now this was being managed by the ward staff. The south Wiltshire team had been short staffed on some shifts due to the number of vacancies they held. They had a 28% vacancy rate in an establishment staffing level of 19.6 full time equivalents. The Wiltshire community service manager confirmed they would continue to monitor and review the adjusted resourcing of the teams to ensure they were staffed safely.
- The Bristol access and triage team, and crisis line team used permanent bank and agency staff, and some of these had recently taken substantive posts within the team. The trust had increased the overall complement of staff of the access and triage team.
- The Bristol Central and east team had a turnover of 50%, although some of this was due to promotion of staff from band 5 to band 6, rather than due to staff leaving. Four qualified members of staff had left the south Wiltshire team in the 12 months prior to our inspection.
- Each team had a psychiatrist as part of the team, and in all teams except Bristol Central and East they were available Monday to Friday in working hours. In Bristol, the team psychiatrist was also the clinical director for the locality, and was available for the crisis team 4 days per week.

- Staff received mandatory training, including resuscitation, risk assessment, safeguarding and medicine management. The compliance rate across the crisis/intensive teams and places of safety was 98%.

## Health based place of safety

- The Mason unit had a dedicated team of staff comprising two qualified nurses and two health care assistants per shift. They also had an additional staffing agreement with the neighbouring acute mental health ward, whereby staff could move between the wards dependent on needs. We were told that approximately 13 to 15 shifts per week were covered by bank staff. The unit reported that agency cover was rarely used, other than to support young people under 18.
- The Wiltshire and Swindon places of safety were staffed by the wards. Each ward had an additional allocation of two staff members within their establishment to ensure there was adequate staff. This was in line with Royal College of Psychiatrists guidance. With the exception of Devizes, staff we spoke with had a good understanding of the process for managing the place of safety. At Devizes the responsibility had changed from the intensive team to the ward staff the week prior to our inspection. There had been little formal planning around this and the ward staff expressed concerns around taking over the management of the place of safety. The intensive staff were supporting them, although this was an informal agreement. Additional staffing requirements on the ward were being addressed and eight agency staff were undertaking their induction at the time of inspection, which included the place of safety.

## Mental health crisis services

### Assessing and managing risk to patients and staff

- We looked at 96 care records across the crisis/intensive teams. Staff identified and managed risks effectively. We found the risk assessments to be of a consistently good standard across all the teams. Swindon and North Somerset's risk assessments, in particular, were all comprehensive and up to date. The Bristol central and east team's risk assessments had improved significantly since the last inspection in December 2015.
- Most teams used a red, amber and green (RAG) rating for their caseloads. Where RAG rating was used, it was usually based on risk. North Somerset intensive team



# Are services safe?

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also held daily multi-disciplinary risk reviews. North Wiltshire RAG rated their caseload according to the number of visits the patients received per day, rather than the specific risks identified. For example, if an individual was having twice daily visits to supervise medication they would be red rated. All teams discussed patient risks daily, and could respond quickly to deterioration. South Gloucestershire intensive team did not RAG rate but discussed risk at handovers.

- Teams used white boards to display information about their caseloads. These were formatted differently in each team. Although all teams used white boards, how these were updated varied. Swindon intensive team's white board separated the caseload according to risk in an immediately identifiable format that was very clear and accessible, and there were criteria for each risk rating alongside the whiteboard. Those used by north and south Wiltshire and Bath and North East Somerset did not provide detailed clear information.
- We attended handover meetings at all intensive teams except south Wiltshire, where we attended a complex case meeting. The staff discussed the risks for each person using the service at the handover meetings. Planning of the team workload took any amended risk into consideration. We observed a very thorough discussion about risk at the Swindon intensive team's handover. However, not all patients in the South Gloucestershire team were discussed, and this meant that risk was not reviewed for every person on the caseload at every handover. The reason given for this was that the members of the team who knew the person were not present for the handover. As this team did not RAG rate the caseload, there was a potential for changes in risk to not be known by all members of the team.
- The intensive teams used a number of systems to allocate and monitor workload and actions required. For example, the South Gloucestershire team used a "to do" list. This was a live document that all the team could access. It was completed after handover and checked twice daily by the shift coordinator.
- There was variation in the quality and detail of crisis and contingency plans. In all the teams we saw excellent crisis and contingency plans but also examples that were of a poor standard. The Swindon team had introduced a local protocol whereby all patients being referred had to have a crisis plan completed, otherwise the admin workers would not complete discharge paperwork. A support worker was doing a weekly audit to check that crisis plans were completed for patients due for discharge. The South Gloucestershire team was not routinely working on crisis and contingency plans with patients.
- Staff had received mandatory training on safeguarding, and knew how and where to report safeguarding concerns. Some teams, such as Swindon and Bristol Central and East, had practitioners who had taken on a role of safeguarding lead and these teams had a particularly strong focus on identifying and managing safeguarding issues. All teams could access the intranet Myspace page that gave clear details of trust safeguarding leads and guidance for staff.
- All teams had good lone working protocols. Shift coordinators took responsibility for contacting staff who were late back from visits. Staff did joint visits if necessary, or would use alternative sites for seeing patients who were considered too high risk to see at home.
- Within the Bristol access and triage team, a qualified practitioner looked at the initial referral and allocated allocated them according to urgency, using a mental health access trigger tool. Where moderate to high risk was identified at the point of triage, a face-to-face assessment would be arranged to complete the risk assessment and formulate a risk management plan. The triage team allocated these referrals to the appropriate crisis team.
- Prescribing of medicines for people using the intensive service was carried out by the team psychiatrist, non-medical prescriber or the person's general practitioner. Most teams had a named member of staff who took a lead role in medicine management. Medication was kept in locked cupboards, and signed for at all teams. Treatments cards were signed and up to date and all medication was in date. Where controlled drugs were being stored, this was done safely. Teams only held small amounts of medication.
- Clozapine is an anti-psychotic medication which requires careful monitoring of physical health when administered due to potentially life threatening side effects. There was no community clozapine titration protocol available, despite at least one team

# Are services safe?

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undertaking clozapine titration at the time of inspection. While the South Wiltshire team appeared to be monitoring and prescribing appropriately, we found that physical observations were recorded in different places – for one individual it was on the electronic care record, and another individual was on paper records.

- The trust's April 2016 pharmacy audit showed that the oversight of clozapine was described as a red risk. The trust advised us that they had re-written the Clozapine procedure and it was due to be ratified at the time of inspection. The trust had also developed a database for the Clozapine patients, but the pharmacy department wasn't due to 'go live' with the database until July 2016. The action plan stated that the rest of the services would have access to the database in October 2016. The database will record blood results, prescriptions, inpatient/outpatient status, and named responsible clinician.

## Health based place of safety

- Staff were well equipped to manage risk and skilled in identifying and mitigating risks.
- At the Mason unit all staff were level 3 trained in safeguarding children, to be able to manage under 16 admissions. On the day of our inspection, there was a 15 year old and a male adult on the unit. We saw that the working arrangement was implemented. This included the closure of one of the three additional beds in order to maintain privacy, safety and dignity for the minor under their care. We were told that there was good communication and support from the child and adolescent services (CAMHS). Under-16 post admission reviews were held and the CAMHS lead completed an outcome form to highlight any service specific delivery issues. However, at the Swindon place of safety the team reported delays in attendance by the CAMHS team (provided by another trust.)
- Anyone detained under Section 136 MHA should be searched by officers at the point of detention, and before being handed over at the place of safety regardless of whether this is a police station or other place. The power to search is based on Section 32(1) of the Police and Criminal Evidence Act (PACE). If the place of safety is a mental health unit police officers should search sufficiently to satisfy themselves that the detainee is not in possession of any implement that could harm them or nursing staff. However, as the police do not have the legal powers to search people detained under section 135, there are risks associated with accepting people without being searched; and there had been occasions when people had brought contraband items onto the Mason unit such as knives, lighters and medication.
- Admission documents at the Mason unit showed that medication reconciliation and patient belongings and searches takes place on admission. At the Wiltshire places of safety, there was no recorded evidence that personal searches were conducted on detention by the police, or any record that ward staff carried out personal belonging searches on arrival to the suite. Staff told us that they were assured that the police undertook the necessary searches. The Wiltshire places of safety did not have access to electronic CAMHS or GP records.
- The Mental Health Act Code of Practice states: Places of safety and consent to treatment, 16.72: "Detaining a patient in a place of safety under sections 135 or 136 does not confer any power under the Act to treat them without their consent. In other words, they are in exactly the same position in respect of consent to treatment as patients who are not detained under the Act."
- The trust could not provide specific incident, restraint, rapid tranquilisation or seclusion data for the Wiltshire and Swindon places of safety; or in Wiltshire and Swindon, or Avon and Somerset for those people detained in the police cells at the time of an incident. We noted from monitoring data that seclusion had been required at the Fountains Way, Salisbury place of safety October 2015, March 2016 and April 2016.
- We analysed data provided by the trust in relation to incidents of restraint, seclusion and rapid tranquilisation at the Mason unit. Between 03 May 2015 and 24 May 2016 there were 124 restraints recorded, nine of which were prone (face down) and seven of these were described as 'planned' restraints. There were 41 episodes of seclusion. Between 30 September 2015 and 16 January 2016, there were four incidents of rapid tranquilisations.
- It was not clear from the data provided whether incidents resulting in restraint, seclusion and/or rapid tranquilisation were attributable to the length of time people were waiting for assessment, waiting for a

# Are services safe?

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suitable placement following assessment or due to their presenting condition at the time of admission to the unit. There had been no reviews undertaken into the use of restrictive interventions within the places of safety.

- In the Swindon place of safety, for those detained under s136 out of hours and requiring medication, a duty pharmacist was called out to obtain medication. This could lead to delays in obtaining the medication in an emergency situation and this included both psychiatric and physical medication. The duty doctor only prescribed on the AWP prescription chart. There was no process for liaising with primary care services (for example, general practitioners) where applicable. The Devizes and Salisbury places of safety could access medication from the wards if required.
- The Mason unit was the only place of safety to have specific guidance on prescribing and administering medication before a Mental Health Act assessment. The Wiltshire and Swindon operational policy required updating to reflect the changes made to the MHA Code of Practice. This states that an individual must be able to give verbal consent to receive oral medication and any other use of medication can only be administered under common law.

## Track record on safety

- There were 11 serious incidents involving the intensive teams and place of safety between 15 March 2015 – 17 March 2016, which involved serious self-harm, unexpected deaths and serious assault. Of these, 8 had ongoing investigations, and the longest investigation had been ongoing since May 2015.
- The trust could not provide data on incidents that had occurred in any of the places of safety, with the exception of the Mason unit in Bristol. However, we were aware that there had been some serious incidents, one of which had resulted in refurbishment work being undertaken in Swindon.

- There had been 62 incidents of attempted and/or actual self-harm recorded and reported at the Mason Unit, including self-harming and ligaturing, between May 2015 and May 2016.

## Reporting incidents and learning from when things go wrong

- Staff in the crisis teams and health-based places of safety understood how to report incidents. They felt confident in raising concerns and knew how to escalate them if necessary. Incidents were a running agenda on team meetings, with trust wide serious incident information disseminated from the trust to teams to discuss. However, team meetings were not always well attended in all of the crisis teams and although team managers told us that it was the responsibility of team members to read minutes for any meetings they had missed, there was potential for this not to happen and therefore staff might miss important updates. The south Gloucestershire team had a file that contained all updates and alerts, which staff were required to sign to show they had read it. The team manager monitored this. The south Wiltshire team manager cascaded information during individual supervision sessions.
- Teams were able to demonstrate learning from incidents. For example, the Swindon intensive team, had introduced a system whereby a senior nurse checked medication at every shift because a medication error had been made by the team. Learning from incidents was discussed at the trust wide “good practice network” meeting. We saw examples in minutes from this meeting relating to contact details of service users and carers being accessible during community visits. This related a recommendation from an investigation into a suspected suicide.
- At the places of safety there had been learning following serious incidents. This included refurbishing the Swindon unit to allow an exit point for staff via the office, and a review of observation processes at Bristol.
- Staff knew about duty of candour and the importance of openness and transparency when things go wrong. Staff reported feeling well supported with access to de-brief through trust psychologists when required.



# Are services effective?

Inadequate 

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

## Our findings

### Assessment of needs and planning of care

#### Mental health crisis services

- We looked at 96 care records across the intensive teams. We found the majority of care plans to be up to date, and the quality and detail of assessments overall to be consistently of a good standard across most of the teams. Most were holistic, with information regularly reviewed and with up to date risk assessments. We saw examples of very good care plans in place at each of the teams. However, at south Wiltshire, seven records out of 27 we looked at did not have care plans, at north Wiltshire three out of seventeen records did not have care plans, and in Bristol two out of 22 care records did not have a care plan.
- The intensive teams had comprehensive daily handover meetings. These meetings were used to discuss and update risks and formulate plans, and included discussion of new referrals. However, we found there wasn't a consistent handover template in use. South and north Wiltshire teams were not using a template at all, which meant that there was no contemporaneous record of handover. Electronic care records were not routinely updated to reflect if plans were changed or why decisions were made in any of the teams.
- It was not always possible to tell if patients had been given a copy of their care plan. Staff told us that they took paper copies out to patients and then brought a signed copy back to the office to be scanned on to the electronic records, but we could not always find signed scanned copies on the electronic records. Consent to treatment was recorded on all the patient notes we looked at in Bath and North East Somerset, Swindon and South Gloucestershire. In the remaining teams, this information was not consistently recorded.
- The north Somerset team had introduced a standardised format for progress notes. This included standard headings, such as new information, intervention, mental state examination, changes in medication, and client/carer view. This made the notes easy to navigate and meant that any member of staff could quickly access current information about a patient.

- All teams operated a shared-caseload model, although teams attempted to ensure that a smaller number of the team worked with individuals, in response to feedback from patients that they felt that they saw too many different people. Some teams operated a keyworker model. The role of the keyworker was to ensure that paperwork was completed.
- The Bristol access and triage service provided a rapid, comprehensive and prioritised specialist mental health triage service. It was open to referrals from GPs, service users known to mental health services, and social care professionals. Its primary aim was to identify appropriate mental health interventions based upon presenting need and signpost as required. This information was used in the on-going assessment and planning of individuals care. Bristol access and triage team had an effective system in place to receive and allocate referrals by locality. Each locality had an administrator who uploaded referral and triage actions, and a band 6 clinician who triaged the information. Discharge summaries were uploaded in clinical documentation and also kept in the shared drive to ensure staff could access information.

#### Health based place of safety

- There were no operational expectations to initiate relevant care plans or risk assessments for those admitted under section 135 or section 136 to the place of safety suites. We found there was little information following detention in the suites at Salisbury and Devizes recorded on the individual electronic records we reviewed. The trust electronic records did not incorporate access to the CAMHS service provided by another trust, or the general practitioner records. The Mason unit had access to electronic patient recording to access patient treatment plans and general practitioner patient summaries available for additional information to aid the assessment process. The street triage team based in police control rooms had access to both the trust electronic patient record system and the police database.
- The crisis care concordat states that significant delays in assessment at a place of safety can impact negatively on the health and wellbeing of people, and possibly increase the likelihood of an inpatient admission. The units we inspected generally try not to use medication which can increase the level of agitation and distress.

# Are services effective?

Inadequate 

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

Staff told us that people can become increasingly frustrated with the length of time they are waiting to be seen and a decision made about whether they can go home, also following assessment and waiting for an appropriate bed.

## Best practice in treatment and care

### Mental health crisis services

- National Institute for Health and Care Excellence (NICE) guidance was used for medication and was evidenced in letters to GPs and in individual electronic care records. Consultant psychiatrists and non-medical prescribers were able to explain the use of NICE guidance. A nurse consultant in the Bath and North East Somerset intensive team provided training on NICE guidelines. Discussions were also held as part of the good practice network meeting. Staff at the Swindon intensive team were able to tell us about the use of NICE guidelines for emotionally unstable personality disorder (EUPD), and how they used this in home treatment of people with a diagnosis of EUPD.
- The average length of time that someone would receive home treatment was four to six weeks. Bristol central and east kept cases for the shortest amount of time (an average of 12 days) and south Gloucestershire the longest (31 days) All teams were able to offer at least two visits a day, and three visits per day in some circumstances. However, at the time of inspection, over half of the caseloads at the north and south Wiltshire intensive teams were people who were ready to be discharged to the community mental health teams (CMHTs). The lack of capacity within those CMHTs meant they were unable to accept additional people. The Wiltshire community services manager was aware of these issues and a recent review had been undertaken to develop a service model to address capacity issues.
- With the exception of north Wiltshire intensive team, staff in all teams could access support and guidance from clinical psychologists and could offer short-term psychological therapies. In some teams, band 4 staff had been trained in mindfulness techniques.
- The teams offered a range of interventions which could include support with housing, benefits and employment. The Bristol central and east team worked with a range of very complex issues and was responsible for all patients in the Bristol area who were of no fixed abode.
- Bristol had a male-only crisis house, run by St Mungo's charity, and a female crisis house run by Missing Link, which the crisis team could refer to. The Bristol Sanctuary, run by St Mungo's was also available to people in Bristol in crisis.
- In line with the crisis care concordat, complex care and multi-agency meetings had been established. These involved police, ambulance, mental health liaison, street triage, service user, clinical commissioning group and local authority to try to establish consistent responses and adherence to treatment plans for people who frequently presented with complex needs and high levels of distress.
- Baseline checks for patients on anti-psychotics and lithium took place. However, there was a reliance on GPs for physical health checks in all teams. None of the intensive teams were routinely taking a proactive approach to assessing, monitoring or care planning for general physical health of patients on their caseloads. The Swindon team had identified this as an area for improvement and had a plan in place to improve its approach to physical healthcare. They had bought equipment such as scales in order to undertake routine physical health checks and had identified a lead practitioner for physical health within the team.
- Teams used Health of the Nation Outcome Scales and clustering tools. Other outcome measures were not routinely used to measure the effectiveness of the service.
- Clinical staff in the intensive teams were not routinely taking part in clinical audit other than that required by the trust. All teams undertook monthly care plan audits. Team managers received a list of 5 cases for audit each month from the trust. Some teams were also using peer auditing of case records as a way of encouraging staff to learn good practice from each other.

### Health based place of safety

- The trust was piloting a number of street triage projects across different geographical areas. Mental health professionals provided on the spot advice to police officers who were dealing with people with possible mental health problems. This advice included an opinion on a person's condition, or appropriate information sharing about a person's health history. The aim of street triage is, where possible, to help police officers make appropriate decisions. This should lead to people receiving appropriate care more quickly, leading

# Are services effective?

Inadequate 

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.

to better outcomes and a reduction in the use of section 136. Local universities were reviewing the impact of these services, but informal feedback from staff, police and other stakeholders was very positive.

- The Mental Health Act Code of Practice 2015, 14.86 recommends that: "local recording and reporting mechanisms should be in place to ensure details of any delays in placing patients, and the impact on patients, their carers, provider staff and other professionals are reported to commissioning and local authority leads. These details should be fed into local demand planning". We found significant problems with the availability and robustness of the data collected to monitor the operation of places of safety in Wiltshire and Swindon.
- The trust reported that no audit or review of practice against its own policy had been completed, or was planned for the future. Without this information, the trust could not effectively monitor their operation of places of safety or provide assurance about the care they provide to people subject to section 136. Effective collecting and analysis of this information should also inform needs assessments and highlight shortfalls in the commissioning of services.

## Skilled staff to deliver care

### Mental health crisis services

- All teams had staff from different disciplines, including psychologists, although some teams did not have any occupational therapists. Staff were generally recruited as generic mental health practitioners, but managers had attempted to ensure a good skill mix. All teams had access to pharmacist support. Some teams had non-medical prescribers
- All teams had experienced staff. The Bristol central and East team had successfully recruited newly qualified staff at band 5 who had been able to move on to Band 6 posts within the team after gaining sufficient experience.
- All teams were based close to approved mental health professional (AMHP) hubs and could access advice and support from the AMHP teams.
- Staff underwent the trust's induction and teams had devised their own local inductions
- Data from the trust reflected that team supervision and appraisal rates ranged between 60% and 100% of staff completing. Staff in the intensive teams told us they

were satisfied with the level of support and supervision available. Staff also used handovers as a source of informal supervision and could access reflective supervision from the team psychologists.

- Band 4 health care assistants were eligible to apply for support for their nurse training if they already had a degree in a health or social science subject, although some staff felt it was unfair that they could not access the training if they possessed the required entry qualifications but not a degree. Band 4 staff had opportunities to undertake the care certificate.

### Health based place of safety

- The places of safety and Bristol access and triage team, were staffed by experienced and suitably qualified practitioners. At the Bristol access and triage team, they also supported the healthcare support workers who took initial calls on the crisis line where required. There was effective and skilled administrative staff supporting the team. The Bristol access and triage team offered supervision and support to all its staff, including those on bank or agency contracts.

### Multi-disciplinary and inter-agency team work

#### Mental health crisis services

- The teams worked effectively and collaboratively with other services to ensure continuity and safety of care across teams. This included the involvement of external agencies. Staff reported positive working relationships between various professionals and stakeholders, for example the police and mental health liaison teams. There were locally agreed pathways with the intensive teams that they would accept referrals made by the mental health liaison team who work within the acute hospitals. There were a range of multi-agency meetings in each area to help address complex case discussion and identify quality or safety issues with service delivery.
- We observed a weekly care pathway meeting in North Somerset. The main purpose of this meeting was to manage beds, consider delayed discharges and ensure what needs to be done is being done, covering both wards. This meeting was very well attended and chaired by the service manager. Bath and North East Somerset had implemented a weekly "developing care pathways meeting", that was attended by managers from across the locality to aid communication and ensure shared issues were dealt with, including transfer of cases

# Are services effective?

Inadequate 

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between teams. The team manager of the South Wiltshire team had established multi-agency care planning meetings to promote consistency for people that frequently presented in distress to a number of agencies. This was being adopted by other areas within the trust.

- We attended handover meetings at all the intensive teams that we inspected, with the exception of the South Wiltshire team, where we observed a complex case meeting. Handover meetings varied between teams but all had at least once detailed handover a day. The Bristol access and triage team had a daily meeting to discuss referrals and any issues that required escalating from the dashboard. For example, lack of assessments slots available within the community teams. The Bristol community dashboard provided the daily indicator of the capacity of the Bristol community services. This dashboard was produced daily (Monday to Friday), and circulated to all service/team managers, triumvirate, medical leads and other relevant staff (including commissioners).
- All teams had regular team meetings that followed a standard agenda sent out by the trust. We reviewed a sample of minutes at different teams and saw that the team meetings were not always well attended and didn't take place consistently. Team managers told us that it was difficult to arrange rotas in a way that facilitated staff attendance, but that minutes were available for staff who had not attended.
- In Swindon and the Bristol and access triage team, the bed manager was part of the team, which assisted communication between teams. The primary care liaison services were the single point of access and all initial referrals, other than Bristol, were triaged by them. Teams reported that referrals made to them were appropriate and working relationships were effective.

## Health based place of safety

- Local authorities are responsible for ensuring that there are enough approved mental health practitioners (AMHPs) to meet local need. Prior to our inspection, we held engagement events that invited key crisis stakeholders to discuss local service provision across organisations. Feedback from attendees suggested that there were serious concerns about the availability of AMHPs and S12 doctors to undertake assessments.

AMHPS from the local authority told us that there were delays in doctors attending the places of safety, and in particular a shortage of doctors in the north of Wiltshire. They informed us that they were having issues getting doctors to attend outside of working hours, therefore the person in the place of safety could wait between 12 and 24 hours to be seen, more if it was a weekend or bank holiday. Staff at the places of safety confirmed that this was a significant issue, and data containing information about how long people can wait for assessment further reflected serious capacity issues. A factor highlighted in a recent death of a patient highlighted was that the delays in accessing a S12 doctor led to the Mental Health Act being delayed for two days. The emergency duty team that covered the Mason unit advised us that there were only two AMHPs to cover the whole region for all out of hours requests, including child protection, which meant they therefore had to prioritise. This could mean that a person arriving on a Friday afternoon may not be seen until Sunday or Monday.

- Swindon was still integrated with the local authority and reported less significant delays in both undertaking the Mental Health Act assessment and finding an appropriate bed. The place of safety is on the same site as the AMHP service, the intensive team and the in-patient unit, and all reported working well together to reduce the length of time people were in the place of safety suite. However, we still found unacceptable delays of over 24 hours. There were also delays in the attendance by the CAMHS service (provided by another trust) when there was an admission of a young person. One young person was detained under Section 4 of the Mental Health Act due to the lack of availability of a second doctor to undertake an assessment at the place of safety. Section 4 applies when there is a crisis and someone needs urgent help but there is not enough time to arrange for an admission under Section 2 or Section 3.

## Adherence to the MHA and the MHA Code of Practice

Please see the first part of this report

## Good practice in applying the MCA

Please see the first part of this report.

# Are services caring?

Good 

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

## Our findings

### Kindness, dignity, respect and support

- We observed the staff in all of the teams to be caring, compassionate and kind. Staff demonstrated that they knew the needs of the people on their caseloads, and discussions in handovers were patient focussed and respectful.
- We received very positive feedback from most patients and carers. They told us that staff were supportive, respectful, polite and caring. However, some people felt that they saw too many different people from the team. We observed that some teams had tried to respond to patients' requests to be seen by less members of the team.
- Confidentiality was maintained at all times during our inspection. All staff we spoke with understood the need to maintain confidentiality and to keep information secure

### The involvement of people in the care they receive

- The teams worked flexibly and worked closely with a number of different agencies to meet to meet individuals' needs, and promote community involvement and social inclusion. Care plans were generally person centred and showed involvement of the patient.

- Patients told us that they were given 24/7 contact details and that they were usually able to contact staff easily. This included at night-times.
- Some patients told us that they did not have copies of their care plan, and some carers told us that they had not been offered carers assessment. However they were happy with the care and support they were receiving.
- Some teams had carers "champions" and we observed references to the triangle of care in patients' notes. The triangle of care guide was launched in 2010 as a joint piece of work between the Carers Trust and the National Mental Health Development Unit, emphasising the need for better involvement of carers and families in the care planning and treatment of people with mental ill-health. Staff in Bath and North East Somerset had accessed a carers awareness training video to improve staff understanding of carers' issues. The trust website contained information for carers and teams had carers' packs.
- Staff contacted all patients after they had been discharged to do a 'friends and family' questionnaire. In some teams, this was done by a peer worker; that was, someone who had experience of using mental health services. We observed that when peer workers obtained feedback it tended to be very comprehensive.
- Advocacy was available in all areas.



# Are services responsive to people's needs?

Inadequate



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

## Our findings

### Access and discharge

#### Mental health crisis services

- All the intensive teams had capacity and systems to see people within urgent and routine target times. The intensive teams had criteria for which people would be offered a service. People with mild to moderate mental health needs and people with a primary diagnosis of a mental disorder due to known physiological conditions, such as vascular dementia were excluded from the service. North Somerset had recently received funding for a specialist dementia crisis service; however, there was no out of hours specialist dementia services in South Gloucestershire, Bath and North East Somerset or Swindon. These calls were directed to the crisis team, and they would work with people with functional impairment only. New assessments were undertaken by senior band 6 staff, due to their level of experience. The nature of the service meant that treatment would start immediately, if appropriate to be accepted onto the caseload.
- The average caseload per team was between 15 and 25 people for home treatment. At the time of inspection, over half of the team caseloads at the north and south Wiltshire intensive teams were people who were ready to be discharged to the community mental health teams (CMHTs). The lack of capacity within those CMHTs meant they were unable to accept additional people. The Wiltshire community services manager was aware of these issues and a recent review had been undertaken to develop a service model to address capacity issues. However, the trust was not recording data to monitor this issue. This meant that the trust was not able to analyse capacity issues across the care pathway. Teams also held additional numbers on their caseloads of people who were in out-of-locality and out-of-area inpatient beds who they were trying to repatriate.
- Data provided by the trust showed that 5830 referrals were made to the trust's crisis and intensive services between October 2014 and September 2015. Bristol Central and East had the highest number of referrals (826), and South Wiltshire received the lowest number of referrals (466).
- The Bristol access and triage service were responsible for performing telephone triage to prioritise mental health referrals within Bristol. After telephone triage, they could transfer the referral directly to the crisis service for an emergency (within 4 hours) assessment, or to the assessment and recovery service within the community mental health teams for urgent and routine assessments. GPs retained primary clinical responsibility, unless an individual required treatment within the trust, or was already known to services.
- Bristol had a dedicated crisis line staffed by healthcare support workers, who were always supported by Band 6 clinicians. This provision was staffed 24 hours a day, seven days a week. This was available for anyone, including those already known to mental health services. From January 2016 until 13 May 2016 the crisis line had received 1681 calls.
- Arrangements for night-time calls varied between the localities. Calls to the Bath and North East Somerset, Swindon, North Somerset, South Gloucestershire, north and south Wiltshire intensive teams were taken by a call centre from 5pm until 8am weekdays and at weekends. The call centre was a messaging service and took basic information from the caller, but was not staffed by trained mental health clinicians.
- All teams except south Gloucestershire had one band 6 member of staff available throughout the night to take calls from people in crisis and undertake urgent assessments. South Gloucestershire's on-call worker was a lone worker, and would arrange to do night-time assessments with the on-call doctor. Staff in the intensive teams were unable to tell us how long it took, on average, for someone who had called the call centre to be contacted by the intensive team. Sometimes, if they were undertaking an assessment they were not available to call back until they had completed it.
- The call centre put calls to south Gloucestershire through to the intensive team until 9.30pm and to the inpatient ward after that. This was because the south Gloucestershire team, unlike all the other teams, operated an on-call system for assessments at night. The trust advised that this service was commissioned this way as there had been insufficient demand for a night-time crisis shift. However, over the six months prior to our inspection, 487 calls had been put through to the ward. Of these, the ward had needed to contact

# Are services responsive to people's needs?

Inadequate 

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

other services on 105 occasions, including contacting the police or ambulance, medics such as the out of hours GP on call SHO, the on-call manager, emergency duty team and other intensive teams or the on-call south Gloucestershire intensive team member. We reported our concerns about access to night time intensive team support in south Gloucestershire to the trust. We were told subsequently that the ward was continuing to manage the intensive team calls, but that this was under review; that staffing had been increased until midnight, and the IST manager would support the staff via supervision and training to ensure capability of staff working out of hours.

- We looked at call logs for transfer of calls from the call centre to the North Somerset team over a 3 night period. Calls took from one minute to 50 minutes for contact to be made with the intensive team. The trust-wide switchboard intensive procedure stated that the intensive team had a four hour window in which to return calls to the patient, although guidance states that patients should not be advised that it may take up to four hours.
- During daytime hours, all teams took calls directly from service users on their caseload. Patients who were not on the caseload were triaged by the primary care liaison teams, or if the callers lived in Bristol, the Bristol access and triage team. The teams had a shift co-ordinator role in all teams, who had responsibility for taking calls about new referrals and co-ordinating assessments or signposting to other services.
- Patients that we spoke with told us that they could usually get through to speak to someone on the phone without unreasonable delay. When we reviewed complaints data provided by the trust, only one related to timeliness of speaking with a member of the crisis services out of hours.
- The crisis and home treatment teams facilitated early discharge from the wards where possible, although this was not taking place effectively within either of the Wiltshire teams. Both teams advised us that they recognised this was a gap and were recruiting to fulfil this role.
- Staff told us they would attempt to engage service users who did not respond to contact, or were hard to engage. This included contacting next of kin, cold

calling, and requesting police welfare checks. However, this was not discussed with patients when they showed signs of disengaging and was not routinely discussed with all patients. We observed discussions in a handover in Swindon where the team discussed and agreed the steps to take for a patient who was hard to contact. However, in the south Gloucestershire handover, a patient was discussed for whom the plan was to continue to try to contact, but there was no discussion about how long this should be attempted for or what to do if contact was not made.

- The Bristol access and triage provided mental health triage services for the adult population, (17 and half years and older). The route of referral was via fax, telephone, letter, and email. Where risk and urgency was evident, a telephone referral would supplement any written information. An electronic referral route from primary care was being developed and was expected to be live from 1 April 2016. Although this was not fully embedded at the time of inspection, this method of referral would then become the main referral route. Referrals for people aged 16 – 18 would usually be passed onto child and adolescent mental health services (CAMHS). There was clear guidance and administrative support in place for practitioners on the referral and allocation stages to ensure that referrals were not lost or not addressed in a timely manner.
- There was an escalation plan in place to enable the Bristol local delivery unit (covering all the aspects of community mental health care, including the crisis and access and triage teams) to be alerted to fluctuations in demand and capacity across community services..
- Staff at the places of safety, intensive teams and AMHPs reported significant issues accessing beds, particularly a lack of beds for informal admissions. Therefore, to gain admission, patients needed to deteriorate to point of needing detention under the Mental Health Act before getting a bed. Mental Health Act assessments were reported as being frequently rolled over to the next working day due to the lack of beds, and patients could be transferred to out of area beds a significant distance from their local area. Crisis concordat meeting minutes for both Avon and Somerset and Wiltshire, showed that some delays in Mental Health Act assessments were due to lack of bed availability. Therefore, AMHPs prioritised other assessments until a bed could be located. There had also been instances when Mental Health Act

# Are services responsive to people's needs?

Inadequate 

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assessments had to be re-done due to lack of bed availability. In December 2015 the emergency duty team from a local authority reported to the multi-agency meeting that 57% of its assessments that led to section 2 recommendations required another subsequent assessment to make the application. This was due to the identification of a suitable bed taking too long and therefore the AMHP involved in the first assessment had finished their shift.

- All teams operated a gate-keeping function for inpatient beds and we heard from staff that this took a substantial amount of time. Band 6 staff attended most Mental Health Act assessments to assess whether home treatment could be offered as an alternative to admission. All teams had bed management caseloads, which detailed people who needed repatriation to a local bed, and which could take up a significant amount of staff time. Bed management meetings took place daily, which the team managers attended. Swindon intensive team had not placed been anyone in an out of area acute care beds for the past year. Every team highlighted that bed management was one of the main challenges that they faced, and which could take up significant amounts of a clinicians time. We were told that staff could spend a whole shift trying to locate a bed and then have to hand it over to the next shift to continue the search.

## Health based place of safety

- Some patients remained in the place of safety for hours, or days, after their Mental Health Act assessment due to the lack of availability of beds to admit people to. Data provided from the trust highlighted that between April 2015 and April 2016, 197 out of the 290 recorded delays post assessment in Bristol place of safety were due to the lack of availability of a suitable bed. We noted in multi-agency meeting minutes from May 2015 that the lack of availability of beds was raised as having a significant impact on the assessment process and place of safety capacity.
- There were 1035 admissions to the Mason unit between 01 April 2015 - 31 March 2016, and 413 instances recorded from 03 April 2015 – 11 May 2016 across the three Wiltshire places of safety. Referrals for admissions were taken directly from the police by staff managing the place of safety. Medical cover was provided from the adjoining wards if required.
- We had serious concerns with the timeliness of Mental Health Act assessments for people detained in the places of safety. There are clearly significant challenges in relation to the capacity and timeliness of Mental Health Act assessments in the place of safety in Wiltshire and Avon and Somerset. These issues are complex and a multi-agency response will be required. The significant number of individuals who were detained in a place of safety far exceeded the recommended timescales in the MHA CoP guidance. The length of time to complete a Mental Health Act assessment ranged from less than four hours to in excess of 24 hours. Data showed that a significant number of people were in places of safety for over 12 hours waiting for assessment, and many for two or three days. There were eight occasions between March 2015 and April 2016 where people were there beyond the legal limit of 72 hours. There were many reasons for delays in beginning and completing assessments. The main reasons for the delays in the process were recorded as:
  - Awaiting attendance by AMHP
  - Awaiting attendance by section 12 approved doctor
  - Lack of availability of beds
  - Person not medically fit (or intoxicated)
  - Lack of space at the place of safety
- The capacity of the Mason unit to accept adult patients was reduced by the admission of person under the age of 18. Aftercare arrangements for children and young people were complex and could involve multiple agencies. This had resulted in some children and young people spending longer in the place of safety. In a report to the board December 2015, it was highlighted that 75% of children and young people remained in the place of safety over twelve hours, citing 57% of these delays were due to risks, complexity and other teams. The report reflected that only 12.5% required hospital admission.
- It was concerning that police and staff confirmed that people were regularly unable to access the places of safety because they were already occupied. In addition, the place of safety at Swindon had been closed to admissions due to maintenance issues five times between November 2015 and February 2016, the Salisbury place of safety was closed for four days and



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the place of safety at Devizes was closed on two occasions due to lack of staff. The trust was unable to provide dates that these closures occurred, which also reflected that they had not been recorded and reported as incidents.

## The facilities promote recovery, comfort, dignity and confidentiality

### Mental health crisis services

- The intensive teams mostly saw people at home, or in a place of their choice. Assessment rooms that were used were clean and comfortable.
- The Crisis Care Concordat states that police vehicles should only be used in exceptional circumstances to transport people who are subject to section 136 of the MHA. A significant number of patients continued to be transported by the police. This appeared to be an issue in relation to the capacity of the ambulance service to meet demands. A private ambulance company was also used at times to try to meet the demand.
- We were told that patients were often admitted to beds a long outside of their own area (for example, to Yorkshire), despite family members raising concerns. In addition, we were given examples of people returning to an AWP bed from an out of area hospital at very short notice and at unacceptable times of day. For example, one patient was transferred to a hospital in Bradford from Wiltshire. They arrived at the hospital at about 5pm. At midnight, another ambulance crew arrived to bring the patient back down to Wiltshire, where he arrived at 5am.

### Health based place of safety

- Welcome packs were available for patients on admission to the place of safety suites.. Patients were allowed access to their mobile phones dependent on risk assessment. Staff could meet personal and gender specific needs including toiletries. All suites had facilities to provide snacks and hot meals.
- The place of safety suite at Swindon was approximately six years old. Mason unit was a four-bedded unit within the Southmead adult mental health in-patient facility, previously used as a high dependency unit. The suites were spacious with separate lounge areas, and bedrooms had en-suite facilities. The Mason unit had a large enclosed garden. The Swindon suite did not have

access to a garden area. The Mason unit design and layout meant that there was no potential physical or visual cross over or interaction between adults and young people. The Mason Unit could facilitate visitors. There were activities available for young people. The Salisbury suite had a bedroom with an outside window and a television but the other part of the suite had no window and it was quite dark. People would need to access the garden facilities on the ward, therefore would only be able to do this if it was appropriate for them to leave the suite. Whilst there was no landline, staff had a designated mobile. This telephone could also be used by the person detained to speak to friends and family. The newly allocated place of safety at Devizes was a stand-alone unit, part of an unused ward. It was spacious, with separate lounge and bedroom areas. However, due to poor planning when moving the suite from the previous location the week prior to our inspection, there was a lack of suitable furnishing and no equipment for activities or means of distraction.

### Meeting the needs of all people who use the service

- Staff were able to download leaflets in different languages from the intranet. Interpreters could be accessed easily through the trust. Bath and North East Somerset had a social worker who was due to start training in sign language, so they could improve the service for deaf people..

### Listening to and learning from concerns and complaints

- The trust's complaints records showed that there had been 36 complaints across the intensive teams between 1 February 2015 – 31 January 2016. Of these complaints 12 had been upheld, 18 partially upheld, and three had been referred to the ombudsman. We saw examples of how complaints had been responded to. For example, the Bristol crisis service manager had engaged service users to help develop guidance for effective management of crisis calls.
- There was a complaints procedure, although in the first instance people were encouraged to speak with a member of staff involved in providing the care. Patients and carers told us that they felt able to raise concern or make a complaint although most of the patients and carers we spoke to told us that they had not been given information on how to make a complaint.

# Are services well-led?

**Requires improvement** 

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

## Our findings

### Vision and values

- Most staff we spoke with were aware of the trust vision and values and who the most senior managers were in the trust, although did not necessarily feel connected with them. All staff were aware of the triumvirate management system that the trust had in place.

### Good governance

- The intensive teams and the Mason unit had access to effective trust governance systems that enabled them to manage their teams. The information generated through those systems was accessed by the senior managers in the trust. The governance systems at the other places of safety were managed by the wards they were attached to as they were not stand-alone units.
- The trust provided a random selection of 5 case notes per month to team managers, to be audited. All team managers were aware of this and said they undertook the audit. Some teams had introduced additional peer review of case notes, so that team members could learn good practice from each other.
- Local managers had ensured that their staff had completed or were booked onto mandatory training received supervision and appraisals. Managers were supportive and encouraging of their teams' development. Staff we spoke with told us they felt respected and valued by their team managers.
- During an inspection of the Bristol community service in December 2015, we identified a number of serious concerns in relation to capacity within the community teams to undertake the volume of assessments, governance and senior oversight. This was having a serious impact on the safety and capacity of the triage and access team to manage the referrals and ensure people had a timely assessment. This inspection demonstrated governance systems in place to monitor and address issues were more effective. The Bristol triage and access team produced a weekly report using information from the electronic record system, and this covered access, assessment, treatment and discharge within the whole Bristol community pathway. A newly implemented `dashboard` was the main information source for the escalation of any issues with capacity or

service delivery. The service manager reported this information daily to the Bristol triumvirate senior management team, with a clear escalation process in place if required.

- There were significant problems with the availability and robustness of the data collected to monitor the operation of places of safety in Wiltshire and Swindon. Comprehensive data would ensure the commissioners' awareness of key issues that could inform their commissioning decisions, specifically in relation to the proposed new model of one four bedded place of safety to serve Wiltshire and Swindon.
- Data showed there were serious issues with the capacity and service delivery within the Bristol place of safety; however, the governance structures were not in place within the trust to ensure effective escalation to the executive team. Figures for the number of people being held, potentially inappropriately, on the caseload of the intensive teams, due to capacity issues within the community mental health teams, was not monitored by the trust.

### Leadership and morale

- A team of three senior clinicians, called the triumvirate led the services at locality level, staff reported varying levels of engagement from this management system. We saw good examples of local leadership from the team managers we met. Staff told us that they felt well supported by their team managers and were able to raise concerns and contribute to service development. The service managers and modern matrons we met across the trust showed a good understanding of the current challenges for both the individual teams and the wider trust.
- The Bristol central and east team's morale was good overall, although the current cramped working environment did not support the team's productivity. Staff continued to struggle to find space and access to computers. This team also covered the most complex demographic of all the intensive teams we visited, and this was not reflected in the team skill mix and numbers. This team had made a number of improvements, although staff felt that the senior management team did not always listen to their concerns about workload and staffing.

# Are services well-led?

Requires improvement 

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- Morale was poor at south Wiltshire intensive team due to on-going difficulties in team dynamics. We asked the trust to increase the support they had in place for this team. Morale at the North Wiltshire team was variable. Some staff reported feeling well supported by their local management team and were positive about changes being implemented, but some staff felt less supported and were unhappy with the on-going problems with finding beds and low staffing levels.
- Overall, the other teams we visited were well-supported by their local managers and good morale was observed and reported. The Bristol access and triage team's morale had improved significantly since a previous inspection in December 2015. They reported feeling much more valued and supported by the trust's senior team. The Bristol triage team were, without exception, proud of what they did and felt engaged and valued by their team members and local management team. Additional resources and systems put in place by the trust had made an improvement to workload and risk management.
- It was to the credit of the local team at the Mason unit that despite significant challenges in relation to managing the place of safety, and a lack of clear planning and direction from the commissioners and trust to address the serious issues identified, morale was good and the team were positive and proud of their work. The team felt valued and well supported by their team manager. The team had developed and maintained excellent working relationships with the police.

## Commitment to quality improvement and innovation

- There were no "CQUIN" (commissioning for quality and innovation) targets for the crisis/intensive teams.
- All intensive and crisis teams had taken part in the CORE (Crisis resolution team Optimisation and RElapse prevention) research study, carried out by University College London. The study ran from 2011-2016, and its aim was to improve the standard of support offered to users of Crisis Resolution Teams. The Swindon Intensive Service was identified as the most improved crisis team out of 140 teams in the study, and the team had developed a plan to continue to improve further areas that were identified in the study.
- The south Gloucestershire intensive team was part of a national pilot project trialling the use of the Open Dialogue model with patients and included a peer support worker in the team involved in the trial. Open Dialogue is a model of mental health care pioneered in Finland that involves a consistent family and social network approach, and all healthcare staff involved receive training in family therapy and related psychological skills.
- North Somerset intensive team was informally piloting a study looking at anticipated discharge date due to anecdotal evidence that had suggested that the capacity of the teams, rather than clinical need, reflects acceptance of referrals and subsequent home treatment.
- Bristol and south Gloucestershire crisis/intensive teams were accredited by the Home Treatment Accreditation Scheme (HTAS) until January 2017. The Swindon intensive service was in the review stage of accreditation.

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  Treatment of disease, disorder or injury	<p>Section 29A HSCA Warning notice: quality of health care <b>We served a warning notice under Section 29A of the Health and Social Care Act 2008</b></p> <p>the trust has failed to ensure that systems and processes are operated effectively to:</p> <ul style="list-style-type: none"><li>• monitor and improve the quality and safety of services and</li><li>• assess, monitor and mitigate risks relating to the quality and safety of service users and others</li><li>• provide care and treatment in a safe way for service users</li></ul> <p>In all health based places of safety within the trust.</p>