Avon and Wiltshire Mental Health Partnership NHS Trust

Community-based mental health services of adults of working age

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**

Our findings

Community-based mental health services of adults of working age

Inspected but not rated

We carried out this unannounced focused inspection because we had received information which gave us some concerns about the safety and quality of the Wiltshire, Swindon and perinatal community services. This included information provided to CQC by patients, and details contained within serious incident reports submitted to us by the trust. This information identified potential safety concerns about the assessment and management of risk for patients accessing community mental health services within Wiltshire and Swindon localities. We also received information giving us concerns about the safety and safeguarding processes for patients under the care of the trust's community perinatal teams.

The inspection focused on four community teams and the trust's two specialised perinatal teams. During the inspection we interviewed staff and patients, and reviewed care records for Swindon recovery team, North Wiltshire community mental health team (CMHT), Swindon intensive service and North Wiltshire intensive service. We focussed our inspection on these four services due to serious incident reports received which led us to believe that there might be repeated issues with risk assessment and documentation, completion of crisis and contingency plans, involvement of family and carers, and multiagency working. We also spoke with staff and reviewed safeguarding processes for the Bristol, North Somerset and South Gloucestershire (BNSSG) and Bath, Swindon and Wiltshire (BSW) community perinatal services.

During this inspection we focused on specific aspects of the key question are services safe and inspected across three service types; community based mental health services for adults of working age, mental health crisis services, and specialised community perinatal services. We did not rate these services at this inspection.

We found that:

Staff in all teams worked well with internal and external teams involved in patients' care. There was good multiagency working and multidisciplinary teams worked well together to consider and respond to risk and deterioration in patients' mental health.

The services managed patient safety incidents well. Staff recognised and reported incidents. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. We saw evidence of learning from incidents and associated action plans being implemented within teams.

Staff in the perinatal teams understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The trust had identified previous incidents where opportunities to safeguard patients had been missed, and had implemented an effective action plan to improve safeguarding processes.

The service provided mandatory training in key skills to all staff to ensure they could do their jobs and made sure everyone completed it.

Staff had established effective processes to assess patient risk and ensure effective infection prevention and control processes in response to the COVID19 pandemic. Despite the pandemic impacting negatively on staff availability, the

Our findings

number of face to face appointments, and patient wellbeing, patients told us that the level of support and input from teams had not changed and they were happy with their care. Patients who presented with high risk were seen face to face. There had initially been a reduction in the number of face to face visits offered at the start of the pandemic. However, staff had since increased face to face appointments, and where appropriate, appointments were also offered over video calls.

Staff supported patients during a crisis and ensured easy access to psychiatrists and specialists following deterioration of their mental health or in response to increased risks. Patients and their carers told us that staff took action to respond to their concerns and any deterioration in their mental health.

However:

Staff did not always update risk assessment tools and risk management plans in response to newly identified or changing risks. We reviewed 11 care records that did not include up to date risk assessment and management plan following reference to new risks to self within progress notes. Staff did not always update risk assessments and management plans following patients discharge from inpatient admissions.

There were increasing staff vacancies within the Swindon intensive service, and substantive staff worked extra hours to cover vacancies. Staff in this team did not always have available time to complete risk documentation in patient care records, although risk information was kept up to date in progress notes.

How we carried out the inspection

During this inspection, the inspection team:

- spoke with 20 staff, including managers, psychiatrists, clinicians and allied health professionals
- spoke with 12 patients and two carers
- looked at 25 patient care records
- looked at a range of policies, procedures and other documents relating to the running of the services.

What people who use the service say

Patients told us that staff were respectful and supportive. Patients had not noticed a significant change with the level of support and care they received during the COVID19 pandemic.

Is the service safe?

Inspected but not rated

This was a focused inspection, so we did not rate this key question during our inspection. We found that:

- Staff in all teams knew what incidents to report and how to report them. Staff raised concerns and reported incidents in line with trust policy. Managers investigated incidents and shared lessons learned with the whole team and the

wider service. Staff engaged in regular team meetings and discussed outcomes of incident investigations and lessons learned. The trust had implemented quality improvement projects in response to concerns raised following incident investigations. Improvement areas included, carer involvement, crisis risk management, and a suicide prevention project with access teams.

- Staff from the perinatal teams understood how to protect patients from abuse and the teams were improving their processes to do this. The perinatal teams were part of a trust quality improvement plan to improve safeguarding. The improvement plan had been implemented following the trust identifying missed opportunities to safeguard patients and children during investigations into serious incidents. The trust had completed a review of safeguarding processes and an action plan was in place and progressing to ensure teams worked well together and were aware of their roles and responsibilities in safeguarding patients and children. Teams had introduced triage meetings with midwives and other agencies to discuss complex cases, including where safeguarding issues had been identified. Managers had introduced a shared safeguarding folder to ensure robust documentation of safeguarding issues and actions. Managers had also increased the focus on safeguarding during case supervision with team members.
- Perinatal team managers were completing regular audits of safeguarding processes and there had been an improvement in the teams understanding of their roles and the documentation in relation to safeguarding. Managers took part in serious case reviews and made changes based on any identified outcomes.
- All staff received training specific for their role on how to recognise and report abuse. Safeguarding training and overall compliance was good for all teams.
- All teams had ensured that patients presenting as high risk were offered face to face appointments. The trust had reviewed the number of face to face visits during the COVID19 pandemic and the number of face to face appointments were increasing. Staff implemented effective processes to ensure patients could access face to face appointments and support in a crisis. The trust had increased the use of 'attend anywhere' appointments and patients could access video call appointments where appropriate.
- The community mental health teams and perinatal teams had enough staff to keep patients safe. Staff vacancies in all teams, except Swindon intensive service, were reducing. North Wiltshire intensive service and the community mental health teams included or had access to the full range of specialists required to meet the needs of the patients.
- Although there had been fluctuating vacancies throughout the previous 12 months in the Bath, Swindon and Wiltshire perinatal team, vacancies were reducing, and staff caseloads were not too high to prevent staff from giving patients the time they needed.
- Staff received and kept up-to-date with their mandatory training. Perinatal team staff received specialised training including, parent interaction training, domestic violence and abuse, and Millwall sleep training.
- All teams worked well with other agencies to share and respond to deterioration in patients' health and increased risks. Perinatal staff reported effective working relationships with external agencies including health visitors and midwives.
- Multidisciplinary teams met at least weekly and discussed patients experiencing a crisis or a deterioration in their mental health. In all teams, patients who presented as ongoing high risk were discussed during every meeting. Patients reported that they felt supported during a crisis, or following deterioration of their mental health, and were able to access their care coordinators or psychiatrist when needed. Carers felt involved and informed with patients care and treatment. We saw evidence of good carer involvement within care records and staff being responsive to concerns or risks raised by carers, family and other health professionals.

However:

Our findings

- Staff in the community and crisis teams did not always update and document changing risks and newly identified risks within risk records. We saw that 11 care records did not contain an updated risk assessment following disclosure of new risk behaviours or following discharge from an acute mental health ward. We also saw that risk management plans were not developed or updated in response to these new or changing risks. It was documented within three of the 11 care records multidisciplinary meeting notes that risk assessment and management plans required updating. However, this action had not been completed.
- Swindon intensive service had experienced increasing staff vacancies since January 2020. Staff reported that the service was regularly understaffed and reliant on locum and agency staff, or substantive staff working extra hours. Staff told us that this had impacted on their perceived ability to engage with patients and manage risk at the start of the pandemic. There had a been period of time when the team did not have a team manager and staff told us that they had not felt supported by senior management during this time. Staff told us that, due to team vacancies, they had less time to document risk assessments and summaries and therefore these were not always up to date within care records. The whole time equivalent vacancies for Swindon intensive service was 9.8 in November 2020 and this had increased over the previous 12 months.

Our findings

Areas for improvement

Action the provider MUST take:

- The trust must ensure that risk assessments and risk management plans are updated in response to new or changing risks.

Action the provider SHOULD take:

- The trust should ensure that initiatives to increase recruitment in teams with vacancies are continued and that there is enough suitably qualified and skilled staff to meet patient needs
- The trust should continue to implement, and monitor progress with, their action to improve safeguarding processes

Our inspection team

The team that inspected the service comprised a CQC lead inspector, an inspection manager, one other CQC inspector, an expert by experience and a specialist advisor who specialised in community mental health services.

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
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment