

# Avon and Wiltshire Mental Health Partnership NHS Trust

## Inspection report

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Date of inspection visit: 25 February to 25 March 2020  
Date of publication: 22/05/2020

## Ratings

### Overall trust quality rating

Requires improvement 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Requires improvement 

Are services well-led?

Requires improvement 

# Summary of findings

## Our reports

**The ratings in the table above are from our inspection in September 2018. See ‘What we inspected and why’ below.**

We did not change the ratings at trust level at this inspection

This report is a summary of our core services inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

The Evidence appendix appears under the Reports tab on our website here: [www.cqc.org.uk/provider/RVN/reports](http://www.cqc.org.uk/provider/RVN/reports).

## Background to the trust

CQC temporarily suspended all routine inspections on 16 March 2020 to support and reduce the pressure on health and social care services during the COVID-19 pandemic. CQC, as well as providers, want to be able to prioritise keeping people safe during this time.

This inspection was already underway at the time of the suspension and therefore could not be completed in the usual way. This report includes the findings from the completed service level inspections, but the well-led inspection was not completed.

CQC is only able to update findings on well-led at the overall trust level or update the other trust-level ratings when we have inspected the well-led component. As a result, the ratings for the overall trust and five key questions included in this report are from a previous inspection.

## Overall summary

**Our rating of this trust stayed the same since our last inspection. We rated it as **Requires improvement****



## What this trust does

Avon and Wiltshire Mental Health Partnership NHS Trust provides Mental Health services across a catchment area covering Bath and North-East Somerset, Bristol, North Somerset, South Gloucestershire, Swindon and Wiltshire. It also provides services for people with mental health needs relating to drug and alcohol dependency and mental health services for people with learning disabilities. The trust also provides specialist forensic services for a wider catchment extending throughout the south west.

Avon and Wiltshire Mental Health Partnership NHS Trust serves four clinical commissioning groups and six local authorities, NHS England also commission specialist services. It has an annual income of £220 million and employs 3,600 substantive staff. It operates from over 90 sites including eight main inpatient sites and services are delivered by 150 teams. It has a total of 16 locations registered with CQC.

The trust sits within two sustainability and transformation plans (STP). These are:

1. Bristol, South Gloucestershire and North Somerset,
2. Bath and North-East Somerset, Wiltshire and Swindon.

# Summary of findings

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

## What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

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This report includes the findings from the completed service level inspections, but the well-led inspection was not completed. CQC is only able to update findings on well-led at the overall trust level or update the other trust-level ratings when we have inspected the well-led component. As a result, the ratings for the overall trust and five key questions included in this report are from a previous inspection.

## What we found

### Overall trust

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### Are services safe?

We have not updated trust-level ratings following these core service inspections because we were not able to complete the trust-level well-led inspection. This is due to suspension of routine inspections during the COVID-19 pandemic. Refer to the previous inspection report for the detailed findings on which the ratings are based.

### Are services effective?

We have not updated trust-level ratings following these core service inspections because we were not able to complete the trust-level well-led inspection. This is due to suspension of routine inspections during the COVID-19 pandemic. Refer to the previous inspection report for the detailed findings on which the ratings are based.

### Are services caring?

We have not updated trust-level ratings following these core service inspections because we were not able to complete the trust-level well-led inspection. This is due to suspension of routine inspections during the COVID-19 pandemic. Refer to the previous inspection report for the detailed findings on which the ratings are based.

# Summary of findings

## Are services responsive?

We have not updated trust-level ratings following these core service inspections because we were not able to complete the trust-level well-led inspection. This is due to suspension of routine inspections during the COVID-19 pandemic. Refer to the previous inspection report for the detailed findings on which the ratings are based.

## Are services well-led?

We have not updated trust-level ratings following these core service inspections because we were not able to complete the trust-level well-led inspection. This is due to suspension of routine inspections during the COVID-19 pandemic. Refer to the previous inspection report for the detailed findings on which the ratings are based

## Ratings tables

The ratings table below shows that the overall rating for the trust have not changed. The change in ratings for the core services inspected at this inspection are indicated by the arrows in the grid.

## Areas for improvement

We found areas for improvement including three breaches of legal requirements that the trust must put right. We found 15 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

## Action we have taken

We issued requirement notices to the organisation that meant they had to send us a report saying what action it would take to meet these requirements. For more information on action we have taken, see the sections on areas for improvement.

## What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

## Areas for improvement

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

The trust **must** ensure that the use of restraint in prone position is reduced and staff receive training in alternative restraint methods to administer intramuscular rapid tranquilisation.

The trust **must** ensure risk formulations, and interventions to manage current risks are documented within risk management plans and easily accessible to all staff on Elizabeth Casson House and Juniper wards

The trust **must** ensure that all environmental issues identified are acted on. This may involve liaison with other agencies to ensure improvements are made to the physical environments.

The trust **must** ensure that all staff have access to and complete mandatory training, including physical emergency response training and suicide awareness.

The trust **must** ensure that urgent transfer beds are used in line with the standard operating procedures and that patients are only admitted to wards that are the most appropriate clinical setting.

# Summary of findings

Action the provider SHOULD take to improve:

The trust should review access to search training for all staff who may be required to undertake searches

The trust should review the online mental capacity act training for healthcare assistants and ensure this provides them with the knowledge applicable to their role and staff understand the content of this training

The trust should ensure that a staff member is allocated to maintain oversight of incidents and complete incident reviews in the ward managers absence on Silverbirch ward

The trust should ensure that care plans are developed collaboratively with patients, are person centred and meet individual needs

The trust should ensure that safeguarding alerts are documented in full and action plans documented within patient care records

The trust should ensure that any blanket restriction to remove hot drinks and snack access from communal areas is reviewed regularly and access is provided once risk are reduced.

The trust should ensure all young people have access to information about advocacy services.

The trust should ensure it continues to review its use of current premises and should look to ensure clinicians have enough space to treat young people.

The trust should review and address the needs of the 26 young people waiting over 18 weeks for treatment.

The trust should ensure medication records are regularly audited and kept up-to-date.

## Is this organisation well-led?

We did not inspect trust-wide well-led at this inspection. See the section headed 'What we inspected and why for more information.'

## Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

\* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

### Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Dec 2018	Good →← Dec 2018	Good →← Dec 2018	Requires improvement →← Dec 2018	Requires improvement →← Dec 2018	Requires improvement →← Dec 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

## Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ↔ May 2020	Good →↔ May 2020	Good →↔ May 2020	Requires improvement ↓ May 2020	Good ↑ May 2020	Requires improvement ↔ May 2020
Long-stay or rehabilitation mental health wards for working age adults	Requires improvement Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018
Forensic inpatient or secure wards	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017
Child and adolescent mental health wards	Requires improvement Sept 2018	Requires improvement Sept 2018	Requires improvement Sept 2018	Requires improvement Sept 2018	Requires improvement Sept 2018	Requires improvement Sept 2018
Wards for older people with mental health problems	Requires improvement Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017
Wards for people with a learning disability or autism	Good ↑ May 2020	Good ↑↑ May 2020	Good ↑ May 2020	Good ↑↑ May 2020	Good ↑↑ May 2020	Good ↑↑ May 2020
Community-based mental health services for adults of working age	Requires improvement Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017
Mental health crisis services and health-based places of safety	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018
Specialist community mental health services for children and young people	Good ↑ May 2020	Good →↔ May 2020	Good →↔ May 2020	Good ↑ May 2020	Good →↔ May 2020	Good ↑ May 2020
Community-based mental health services for older people	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017
Community mental health services for people with a learning disability or autism	Requires improvement Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017
Substance misuse services	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
<b>Overall</b>	Requires improvement Dec 2018	Good Dec 2018	Good Dec 2018	Requires improvement Dec 2018	Requires improvement Dec 2018	Requires improvement Dec 2018

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

# Specialist community mental health services for children and young people

Good  

## Key facts and figures

The specialist community mental health services for children and young people provided by Avon and Wiltshire Partnership NHS Trust in Bristol and South Gloucestershire are part of the community children's health partnership (CCHP). This includes all community-based children's healthcare services across the area. CCHP was made up of Sirona Care and Health, Bristol Community Health Interest Company, Barnardo's and Avon and Wiltshire Partnership NHS Trust.

Community child and adolescent mental health services (CAMHS) are provided by four locality teams across Bristol and South Gloucestershire. Referrals came through a central outreach, assessment and triage team, which serves as a single point of access to the service which forms part of the getting advice team. The locality teams are based in Kingswood (South Gloucestershire), Barton Hill Settlement (east and central Bristol), Brentry (north Bristol) and Osprey Court and Knowle (south Bristol). These teams deliver assessment and consultation services delivered by multidisciplinary CAMHS teams and early intervention services.

At the last inspection we rated the specialist community mental health services for children and young people as requires improvement overall, with requires improvement in safe and responsive and then good in effective, caring and well led.

We told the trust it must make the following improvements:

- Take all possible steps to reduce the waiting lists across the service to ensure children and young people have timely access to mental health support. (Regulation 12)
- Ensure that risk assessments and care plans are completed in a timely manner, and where no risk is present this needs to be stated with rationale. A copy of the young person's risk assessment completed by the crisis team must be included in their care record. (Regulation 12)

During this current inspection we found the trust had made the required improvements.

At this inspection we rated the specialist community mental health services for children and young people as good overall, with all domains rated as good.

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

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?

During the inspection visit, the inspection team:

- Visited the community teams at South Gloucestershire, Bristol Central and East and Bristol South.

# Specialist community mental health services for children and young people

- Interviewed clinical service managers, team leaders, child and adolescent mental health safeguard lead, nurses, primary mental health specialists, administrative staff, clinical psychologists, doctor, psychotherapists, family therapist and consultant psychiatrists.
- Spoke to nine parents/carers and six young people.
- Observed one team meeting.
- Reviewed 17 care records.
- Observed a therapy session.

## Summary of this service

Our rating of this service improved. We rated it as good because:

- The service was easy to access. Staff assessed and treated young people who required urgent care promptly and those who did not require urgent care did not wait too long to start treatment. The criteria for referral to the service did not exclude children and young people who would have benefitted from care.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that young people had good access to physical healthcare and supported young people to live healthier lives. The service had enough nursing and medical staff, who knew the young people and received basic training to keep young people safe from avoidable harm. Staff used recognised rating scales to assess and record severity and outcomes.
- The teams included or had access to the full range of specialists required to meet the needs of young people. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain young people's rights to them. Staff supported young people to make decisions on their care for themselves proportionate to their competence. Staff assessed and recorded consent and capacity or competence clearly for young people who might have impaired mental capacity or competence.
- The environments were safe, clean, well-furnished and well maintained.
- Staff assessed and managed risks to young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff understood how to protect young people from abuse and the service worked well with other agencies to do so. Managers ensured that where lessons were learnt in relation to incidents, these were shared with staff.
- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for young people and staff. Governance processes operated effectively at all levels and performance and risk were managed well.

# Specialist community mental health services for children and young people

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

However:

- Not all young people found it easy to access advocacy services.
- Not all premises were fit for purpose. Clinicians did not all have enough space in their premises to treat young people or to hold team meetings.

## Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

- All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained.
- The service had enough staff, who knew the young people and received basic training to keep young people safe from avoidable harm. The number of young people on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. At the last inspection some staff reported up to 40 young people on their caseload. At this inspection caseloads had reduced to about 25 young people. Staff spoken with said they felt very busy, but their caseloads were manageable.
- Staff assessed and managed risks to young people and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with young people and their families and carers to develop crisis plans. Staff monitored young people on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- Staff understood how to protect young people 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 provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.
- Staff kept detailed records of young people's care and treatment. Records were clear, up to date and easily available to all staff providing care.
- Staff regularly reviewed the effects of medications on each patient's physical and mental health.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave young people honest information and suitable support.

## Is the service effective?

Good   

# Specialist community mental health services for children and young people

Our rating of effective stayed the same. We rated it as good because:

- Staff assessed the mental health needs of all young people. They worked with young people and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. **The staff teams in all locations have worked hard to ensure all young people had a care plan.**
- Staff provided a range of treatment and care for the young people based on national guidance and best practice. They ensured that young people had good access to physical healthcare and supported young people to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of young people under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided a comprehensive induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit young people. They supported each other to make sure young people had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported young people to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16. Staff assessed and recorded consent and capacity or competence clearly for young people who might have impaired mental capacity or competence.

However:

- Not all paper records were legible so some staff found difficulties in working consistently with young people as it was unclear what actions they should be taking.

## Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Staff treated young people with compassion and kindness. They understood the individual needs of young people and supported young people to understand and manage their care, treatment or condition.
- Staff involved young people in care planning and risk assessment and actively sought their feedback on the quality of care provided. The teams worked closely with Barnardo's (a charity that supports vulnerable children and young people) to make improvements. For example, young people had contributed to the care planning process.
- When appropriate, staff involved families and carers in assessment, treatment and care planning.

# Specialist community mental health services for children and young people

- Young people and parents and carers were involved in the design and delivery of the service. For example, young people were not happy with the naming of the emotional dysregulation pathway, so the service changed its name to the behaviour support pathway. The learning disability team had introduced a bespoke easy read question format young people could use when assisting teams to interview new staff.

However:

- Not all young people had easy access to advocacy services. There was little evidence in the records or from talking to the young people that they were able to access advocacy services.

## Is the service responsive?

**Good** ● ↑

Our rating of responsive improved. We rated it as good because:

- The service was easy to access. Its referral criteria did not exclude young people who would have benefitted from care. Staff assessed and treated young people who required urgent care promptly and young people who did not require urgent care did not wait too long to start treatment. Staff followed up young people who missed appointments. Since the last inspection the trust have reviewed access to the service to help them reduce waiting lists and support young people. In September 2019 they introduced a single point of access team. This team was the first point of contact for all routine and urgent referrals based at Barton Hill settlement. New referrals to the service were triaged by this team and this reduced waiting lists as staff were able to signpost effectively.
- The service ensured that young people, who would benefit from care from another agency, made a smooth transition. This included ensuring that transitions to adult mental health services took place without any disruption to the patient's care.
- The service met the needs of all young people including those with a protected characteristic (the Equality Act covers the same groups that were protected by existing equality legislation. For example, age, disability, gender reassignment, race, religion or belief. These are called protected characteristics). Staff helped young people with communication and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. For example, in South Gloucestershire team they reviewed the way they communicated with parents following a complaint.

However:

- The trust did not ensure premises were fit for purpose. Clinicians did not all have enough space in their premises to treat some young people.
- The south team had 26 young people waiting over 18 weeks to access treatment.

## Is the service well-led?

**Good** ● ↑

Our rating of well-led improved. We rated it as good because:

# Specialist community mental health services for children and young people

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for young people and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect. If staff members completed hand written records that were not legible the managers asked to type them to ensure the records were accessible to all the team.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.
- Managers worked closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) to ensure that there was an integrated local system that met the needs of children and young people living in the area. There were local protocols for joint working between agencies involved in the care of children and young people.

# Wards for people with a learning disability or autism

Good  

## Key facts and figures

The Daisy unit is a purpose-built hospital for adults of a working age with learning disabilities. It opened in January 2017.

The Daisy unit provides five individual living areas known as pods, built around a large communal area. The design of each pod allows it to be a self-contained living environment for the patient.

The pods have their own front doors, doorbells and gardens in addition to a lounge, dining area/kitchenette, bedroom and ensuite bathroom. Each pod had one occupant with two bedrooms, each with an ensuite bathroom.

The Daisy unit aims to offer a placement that could help the patient to learn the skills needed within the community whilst having the safety offered by a hospital. This means that patients detained under the Mental Health Act due to their behavioural difficulties, can develop the independent living skills needed for discharge, and have the independence offered by a supported living placement.

All patients at the Daisy unit have individual care packages. To ensure that staff give individualised care, each patient has an allocated staff team for each shift. The Daisy unit agree the number of allocated staff working with each patient prior to admission. In addition, to the patients' core staff teams, there are floating staff who can give additional support.

The Daisy unit provides long-term placement, with funding agreed for each patient for at least six months.

The inspection was announced to ensure the patients knew we were visiting and the staff we needed to speak to were available.

At our previous inspection in September 2018 we rated the service inadequate. We rated the service inadequate for effective, responsive and well-led domains, and requires improvement in the caring and safe domain.

We issued the service nine requirement notices and told it to make improvements to leadership and governance, record keeping, staffing, training, restrictive interventions, and patient involvement in the service and their care.

We found the service had taken necessary and significant action to meet the concerns raised from the September 2018 inspection, particularly in establishing a strong leadership team with a clear model of care and robust support and guidance in reducing restrictive interventions.

During the inspection visit, the inspection team:

- interviewed three nurses and two healthcare assistants
- interviewed the speech and language therapist
- interviewed the modern matron, operational manager and deputy manager
- spoke with three patients and one family member
- interviewed the consultant psychiatrist and assistant psychologist
- we reviewed the clinic room and toured the ward environment
- reviewed all five medication charts
- reviewed all five sets of notes.

# Wards for people with a learning disability or autism

## Summary of this service

Our rating of this service improved. We rated it as good because:

- There was a strong, visible person-centred culture. Staff treated patients with respect and built open relationships so that patients felt able to discuss their needs and raise concerns. The unit would invite families and advocates to be involved in meetings about the patients.
- The service provided safe care. The ward environment was safe and clean. The ward had enough nurses and doctors. Managers ensured that staffing levels were adjusted to reflect the fluctuating needs of patients and the risk levels present at that time. Any potential impact of staffing vacancies was mitigated by the use of bank and agency staff familiar with the ward and its patients.
- Staff assessed and managed risk well, followed good practice with respect to safeguarding and minimised the use of restrictive practices. Staff had the skills required to develop and implement good positive behaviour support plans to enable them to work with patients who displayed behaviour that staff found challenging.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a ward for people with a learning disability and autism and engaged in clinical audits to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- There were high levels of satisfaction within the staff groups. There was strong collaboration and team-working and a common focus on improving the quality and sustainability of care and people's experiences. Quality improvement methodology was embedded on the ward. Staff were empowered to lead and deliver change.
- The service participated in the trust's restrictive interventions reduction programme, which met best practice standards. The service had appointed a reducing restrictive practice lead and had embedded a Positive Behaviour Support model of care, this had been effective in significantly reducing the number of restrictive interventions.
- Governance arrangements were robust, and incidents and risks were reported, analysed and shared. Leaders had high quality management information, which showed trends and risks in the service. They were able to use this information to manage risks and improve the service.

However,

- Medication records had a number of missing signatures and review dates. We raised this at the time of inspection and the manager agreed to follow up.

## Is the service safe?

**Good**  

Our rating of safe improved. We rated it as good because:

# Wards for people with a learning disability or autism

- The Daisy unit was purpose built and offered ample space and good lines of sight to allow observation of the ward environment. The service provided safe care. The ward environment was safe, clean, and had ample staff for the number of patients.
- Staff assessed and managed risk well and followed good practice with respect to safeguarding. Staff demonstrated knowledge of risks to each patient and acted to prevent or reduce risks. Staff used Positive Behaviour Support (PBS) methods to identify patient triggers and minimise the opportunities for challenging behaviour to occur. Staff had the training and skills required to develop and implement good PBS plans to enable them to work with patients.
- The service had significantly reduced the use of restriction interventions since our last inspection. The Daisy unit participated in the provider's restrictive interventions reduction programme, which met best practice standards. The service had appointed a reducing restrictive practice lead and a quality improvement lead to focus on reducing incidences of restraint.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a ward for people with a learning disability (and/or autism) and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- Staff access to essential information had improved since our last inspection. Clinical records were stored securely, patient notes were comprehensive, and staff said they could access the records they needed quickly on the electronic recording system.
- The ward had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. At the time of our inspection, improving incident reporting was a quality improvement project and had resulted in improvements to the quality of incident reports. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff had monthly incident focus groups attended by a range of staff to analyse incidents, discuss learning, and how to improve patients' care to reduce incidents. When things went wrong, staff apologised and gave patients honest information and suitable support.

However,

- We reviewed all five medication records and found some minor errors in documentation. Records had incomplete dates and signatures. For example, some review dates were expired or had no date, which meant that we could not be assured that patients' medicines were being regularly reviewed.

## Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. The service had improved care plans significantly since our last inspection. Care plans reflected the assessed needs, were personalised, holistic and strengths based, and were reviewed regularly through multidisciplinary discussions and updated as needed. They worked with patients and with families and carers to develop individual care and support plans.

# Wards for people with a learning disability or autism

- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to psychological therapies, support for patients to self-care and develop everyday living skills and to undertake or progress to undertake meaningful occupation. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Since the previous inspection, the service had introduced and embedded the use of recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early on in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity. The speech and language therapist had been training staff in communication to support staff in their MCA responsibilities.

## Is the service caring?

**Good** ● ↑

Our rating of caring improved. We rated it as good because:

- Staff treated patients with compassion and kindness. We saw staff interact with patients in a way that showed they were dedicated to protecting patients' dignity as well as keeping them safe. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Patients' individual preferences and needs were always reflected in how care was delivered. Patients' emotional and social needs were seen as being as important as their physical and mental health needs. Staff developed social stories with patients prior to an activity. Social stories help autistic people with short and/ or pictorial descriptions of an event or activity, which include specific information about what to expect in that situation. The staff assisted families by compiling positive behaviour support plans to help to support families and carers to understand how to reduce challenging behaviour when visiting the ward and when on section 17 leave.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Easy read care plans were given to all patients and every effort was made to help patients participate in and understand the care they received. They ensured that patients had easy access to independent advocates.

# Wards for people with a learning disability or autism

- Staff encouraged patients to have a voice and be actively involved in decisions about their care. The core team encouraged patients to take a central role in their ward round, listened to their views and took these into account when reviewing changes in care and treatment.
- Staff informed and involved families and carers appropriately.

## Is the service responsive?

Good  

Our rating of responsive improved. We rated it as good because:

- Discharge planning had improved considerably since our last inspection. Discharge planning began from the point of admission and staff managed discharge well. Staff liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. Staff made every effort to ensure the success of discharges, for example staying overnight with patients in the community prior to discharge to support patients.
- The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own apartments with a living room, kitchen and bath. Patients could keep their personal belongings safe. Patients were able to personalise their own apartments, even picking out paint colours prior to their admission on the ward.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The ward met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support. The ward had notice boards displaying information on a wide variety of topics in easy-read format and had a wide range of information leaflets also in easy read formats.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

## Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- Leaders demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. They were visible in the service and approachable for patients and staff. Leaders had a deep understanding of issues, challenges and priorities in their service.
- Since our last inspection managers had embedded a robust model of care into the service that centred on Positive Behaviour Support, based on National Institute for Health and Care Excellence (NICE) best practice guidance.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff were proud of the ward and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns.

# Wards for people with a learning disability or autism

- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Governance arrangements were robust, and incidents and risks were reported, analysed and shared. Leaders had high quality management information, which showed trends and risks in the service. They were able to use this information to manage risks and improve the service.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff engaged actively in local and national quality improvement activities.

## Areas for improvement

Our rating of well-led improved. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for young people and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect. If staff members completed hand written records that were not legible the managers asked to type them to ensure the records were accessible to all the team.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.
- Managers worked closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) to ensure that there was an integrated local system that met the needs of children and young people living in the area. There were local protocols for joint working between agencies involved in the care of children and young people.

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

Requires improvement   

## Key facts and figures

Avon and Wiltshire Mental Health Partnership NHS Trust provides mental health services across Bath and North East Somerset, Bristol, North Somerset, South Gloucestershire, Swindon and Wiltshire.

The service has 11 acute wards and three psychiatric intensive care units (PICU) for adults of working age. The wards are based across seven locations throughout Avon and Wiltshire.

- Callington Road in Bristol has two acute wards; Lime unit, which is male only and Silverbirch ward, which is female-only. There are also two PICU's; Hazel which is male-only and Elizabeth Casson House, which is female-only.
- Fountain Way, in Salisbury, has an acute ward; Beechlydene, which is mixed sex and a PICU; Ashdown, which is male-only.
- Green Lane Hospital, in Devizes has an acute ward; Poppy which is mixed sex.
- Sandalwood Court, in Swindon, has an acute ward; Applewood, which is mixed sex.
- Hillview Lodge, in Bath, has an acute ward; Sycamore which is mixed sex
- Southmead Hospital, in Bristol, has an acute ward; Oakwood, which is mixed sex.
- Long Fox unit, in Weston-Super-Mare has an acute ward; Juniper, which is mixed sex.

The previous comprehensive inspection of this service took place in September 2018. Following that inspection we rated this service as requires improvement overall, with a rating of requires improvement in safe, responsive and well-led domains. We rated caring and effective domains as good. During that inspection we identified four actions that the trust must take.

- The trust must ensure that all wards have robust plans in place to ensure risks presented by ligatures are managed robustly, including removing ligature points as appropriate. (Regulation 12)
- The trust must reduce the number of prone restraints and ensure staff are trained appropriately and consistently in undertaking restraint. (Regulation 12)
- The trust must address the issues caused by the seclusion of male patients on the Elizabeth Casson ward (female PICU). (Regulation 12)
- The trust must ensure that it addresses the risks posed by the low fence and low roof on Oakwood ward. (Regulation 12)

This inspection was undertaken as part of our comprehensive programme of inspections. Based on a review of data available and risks identified elsewhere in the service, prior to the inspection, we did not visit Ashdown psychiatric intensive care unit in Salisbury or Lime unit, Callington Road, Bristol.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

We found that the trust had met three of the four actions that we told the trust is must take following the previous inspection. The trust had not fully met the action to reduce the number of prone restraints; the proportion of restraints in the prone position had increased over the most recent 12 months. However, the trust had ensured that staff were trained appropriately and consistently in undertaking restraint.

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

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.

During the inspection, the inspection team:

- visited nine wards across all eight sites, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 60 patients who were using the service
- spoke with three carers of patients who were using the service
- spoke with the managers or acting managers for each of the wards
- interviewed 52 staff including, consultant psychiatrists, nurses, healthcare assistants, psychologists, occupational therapists, activity coordinators, and pharmacists
- reviewed 68 care records for patients
- reviewed 113 patient medication charts
- reviewed five seclusion records
- attended 13 various ward activities including handover meetings, clinical review meetings, patient activity groups and care programme approach meetings
- carried out a specific check of medication management and clinic rooms on all the wards and,
- looked at policies, procedures and other documents relating to the running of the service.

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Staff did not always manage risk in a way that ensured the safety of patients and staff. The service had not reduced the use of prone restraint (face down position) as identified as an improvement the trust must make following our last inspection in September 2018. The number of prone restraint incidents had increased and the percentage of all restraint incident types that involved prone position had increased from 24% to 26%. Patients had been admitted to wards out of hours despite ward staff identifying that their risks or needs could not be managed on the ward. These patients had required more restrictive interventions to manage their risks and, in two cases, had been transferred to psychiatric intensive care units, soon after admission.

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

- Managers had not ensured that staff received mandatory physical health response training (PERT). Staff told us it was difficult to reserve a place on PERT courses and these were often cancelled or held outside of their locality. Training compliance with this course was below 75% across the service and 50% on Juniper ward.
- There was not always a bed available within the trust wards for a person who would benefit from admission. Bed occupancy was generally between 95% and 100% for the previous 12 months. There had been 382 patients admitted to out of area beds due to capacity issues in the previous 12 months. The trust had identified three urgent transfer beds on Oakwood and Poppy ward which were used for patients who had been at the place of safety longer than 24 hours. Managers told us that these beds were not always used in line with the standard operating procedures and were not always reserved primarily for people from the place of safety. Staff told us they experienced increased pressure due to the quick transfer of patients into and out of the urgent transfer beds and the extra work this created from admission, assessment and risk management processes. The manager on Oakwood ward had raised these concerns with the trust and the use of these beds and impact had been added to the wards risk register.
- Six of the nine wards we visited required environmental works to ensure they were safe and therapeutic spaces. Environmental changes were required to the layout of seclusion rooms on Elizabeth Casson House, Oakwood and Juniper ward, to ensure that patients who were high risk could safely access en-suite facilities. Some seclusion rooms also had blind spots despite the presence of CCTV. The trust had undertaken a seclusion room review and had identified these issues and particular safety risks within Juniper seclusion room. The review had concluded that work on Juniper ward should be prioritised and a further full review of seclusion rooms should be completed. The doors on Oakwood and Silverbirch ward were identified on the ward risk registers following an increase in detained patients going absent without leave (AWOL) from these wards. Silverbirch ward did not secure shut automatically and Oakwood ward's main door opened out to the hospital grounds, and was controlled from the nursing office, therefore patients had been able to leave these wards as staff entered. Elizabeth Casson House and Oakwood ward layouts did now allow for space for female patients to access quiet and private space other than their bedrooms.

However:

- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. This included, psychologists, nursing staff, medical staff and occupational therapists. Managers ensured that these staff received regular supervision and appraisal. Ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff completed comprehensive assessments of the physical and mental health of all patients and reviewed patient needs, and progress, regularly through multidisciplinary discussion. On Beechlydene, Sycamore, Oakwood, and Poppy wards staff developed individual care plans, which reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions through one to one sessions, ward reviews and care programme approach meetings,
- Staff told us that there had been a recent improvement in engagement with staff by senior managers on design of the service and management of ongoing local risks. Staff praised their ward managers and multidisciplinary team relationships and said that morale had improved on all wards.

## Is the service safe?

**Requires improvement**   

Our rating of safe stayed the same. We rated it as requires improvement because:

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

- Across the whole service, the percentage of restraints that were prone position had increased from 24% at the last inspection to 26% between November 2018 and October 2019. The number of incidences of prone restraint, across all wards (272), had also increased from the previous 12-month period (268). The number of incidences of restraint had increased on Elizabeth Casson House PICU, and Lime, Silverbirch and Sycamore acute wards. Although the trust had increased prevention and management of violence and aggression (PMVA) training compliance, only staff on Poppy, Applewood, and Beechlydene wards were aware of alternative restraint and injection techniques that avoided use of prone restraint.
- There were significant vacancies throughout the service and there were 31 registered nurse vacancies across Silverbirch, Elizabeth Casson House, Beechlydene, Hazel and Applewood ward. Applewood ward also had eight healthcare assistant vacancies. Elizabeth Casson House and Silverbirch ward had high sickness and turnover in the previous 12 months. Sickness rates for Elizabeth Casson House were above 7% for four of the months and up to 9.0% for two of these. Silverbirch had increasing turnover from August 2019 which had risen from 27% to 32%. The turnover on Elizabeth Casson House had been between 39% and 52% throughout February 2019 to January 2020. There had been recent ward manager absences and vacancies on these two wards and senior nurse vacancies across other wards. Staff told us that due to these vacancies and time spent without senior nurse or ward manager support they had received less supervision and guidance while on shift and when managing challenging cases. Staff on Elizabeth Casson House told us that high turnover, and regular use of locum staff had prevented the team from remaining consistent and cohesive.
- The trust had not completed environmental works, identified on ward risk registers, to improve the safety of the environment on some of the wards. There were blind spots within seclusion rooms on Elizabeth Casson House, Oakwood and Applewood ward. These were on the ward risk registers and staff mitigated risk by shutting off the toilet facilities that had blind spots. On Juniper ward the seclusion toilet facilities were locked off for patients presenting with high risk due to risk of the door being used to hit against the sink and cause damage. The front doors of Oakwood ward and Silverbirch ward were on the wards risk registers due to increase incidents of detained patients absconding from the ward via these. Oakwood ward door was controlled from a panel inside the nursing office and opened out from the ward communal area into the hospital grounds. The lock on Silverbirch door did not always close securely and did not lock automatically. Elizabeth Casson House seclusion did not have a de-escalation area and staff told us the seclusion was too small to aid de-escalation of patients once in the seclusion area. The trust had completed a review of seclusion environments following previous concerns being raised by care quality commission but were unable to provide a timeline for planned remedial works.
- Senior managers for Silverbirch ward had not ensured there was full oversight of incidents during the previous ward managers absence. There was a backlog of incidents waiting to be reviewed by the new ward manager which dated back to July 2019. These incident reports had not been reviewed and signed off to ensure staff had received debriefs and investigations had taken place as appropriate.
- Patients had been admitted to wards out of hours, when the ward team had assessed that their risks and needs could not be met due to them requiring psychiatric intensive care or less restrictive environments. Staff told us that on-call managers often overruled clinical decisions not to admit referred patients which staff had assessed were unsuitable for the ward. Staff identified a lack of clear communication between ward teams, on call managers and bed gate-keeping teams as a factor in these incidents. We reviewed three incidents of patients being admitted to wards that had been identified as unsuitable for their needs. These patients had required more restrictive interventions, soon after admission, to manage risk; including use of physical restraint, seclusion and increased observations. A staff member on an acute ward had also been seriously injured during a restraint of a patient whose risk assessment indicated the need for admission to a psychiatric intensive care unit. The trust did not supply the incident investigation report.

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

- The trust did not provide search training to all staff. There was not always a member of staff trained to carry out searches of patients on each shift and, on Juniper ward, none of the staff had completed search training. Staff told us that when a search trained staff member was not available, staff relied on patients confirming whether they had any contraband on their person and agreeing to hand this in.
- Managers had not ensured staff had remained up to date with training in suicide awareness and physical emergency response training (PERT). The training compliance for PERT training was below 75% for Sycamore, Oakwood, Elizabeth Cassons House, Beechlydene and Juniper. Only 50% of staff had completed PERT training on Juniper ward and on the same ward only 41% of staff had completed mandatory suicide awareness training. Managers told us that PERT courses booked up early, were often cancelled and staff could not free up time from the wards to travel across localities to attend training.
- On Juniper ward and Elizabeth Casson House psychiatric intensive care unit (PICU) staff had not documented risk formulations, and planned interventions to manage risk, onto risk management plans in 11 out of 13 care records. This information was recorded within ward reviews and handover records but had not been transferred onto risk management plans that were easily accessible to staff caring for patients.

However:

- Staff on Poppy, Beechlydene, Oakwood, Sycamore and Hazel wards developed risk management plans based on risks identified during assessment and reviews. Staff on all wards discussed risk behaviours and incidents during daily handovers and ward reviews and documented outcomes and actions within patient progress notes. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- The trust monitored safer staffing numbers and recently completed a staff skill mix review. The outcome of the review had not yet been reported. Managers were involved in recruitment activities and had held recruitment days and linked in with local job centres. Where possible, managers used agency and bank staff who were familiar with the ward to improve consistency for patients. Oakwood, Sycamore and Poppy wards had low or reducing vacancies for registered nurses and healthcare assistants.
- The trust had made progress with refurbishments on the wards and had installed anti-ligature furniture, and anti-climb fixtures in the garden spaces.
- All mixed sex wards ensured patients were kept safe and provided female-only spaces. Beechlydene ward was part of a sexual safety working group, along with external organisations, that were improving sexual safety on inpatient wards.

## Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. On Beechlydene, Sycamore, Oakwood, and Poppy wards staff developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. These care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

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

- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included psychotherapies, such as art and drama therapy, and medication, and psychoeducation. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales, to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills to provide high quality care. They supported staff with regular appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

However:

- Care plans on the PICUs, Juniper and Silverbirch wards, did not document that patients had been involved in developing them, and the identified needs, interventions and goals were generic across all care plans. Staff did not ensure that care plans on these wards were person-centred and some patient's with specific needs such as physical health conditions, or self-neglecting, did not have this care planned individually and therefore staff could not review and monitor progress towards goals. PICU managers expectations were for nursing staff to develop positive behavioural support plans with patients to ensure personalisation of the treatment plan, but these plans had not been completed for the current patients on the wards.
- The Mental Capacity Act training for healthcare assistants was provided at induction through an online learning module, whereas registered nurses completed face to face training. Healthcare assistants told us that they were unsure whether they had received training and that they were not confident in identifying the principles and application of the MCA in relation to their role.
- Staff did not receive training to provide care for patients with learning disabilities or autism. Managers and ward staff on the psychiatric intensive care units (PICU), and Juniper and Beechlydene wards, told us that the number of patients being admitted with specialist needs in relation to learning disabilities or autism were increasing and they did not always have the necessary skills to plan and deliver their care. Staff were unaware of any specialist training that they could access.

## Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition, through 1:1 sessions and ward reviews.
- Most patients on all wards told us they felt involved in their care and treatment planning and decisions. Staff involved patients in ward reviews and care program approach meetings. We saw evidence of collaborative care planning and decision-making between patients and staff in progress notes within care records. Staff actively sought patient feedback on the quality of care provided and ensured that patients had easy access to independent advocates.

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

- Staff informed and involved families and carers appropriately. All wards used the triangle of care model, which aims to increase collaboration between staff, patients and their family or carers. The service provided at least monthly forums for carers to receive and provide feedback. On Applewood ward this included a weekly meeting where carers could meet with the ward psychologist and psychiatrist.

However:

- Staff had not ensured that all patients were involved in developing their care plans. It was not always clear within care plans whether patients had received copies of these. On Elizabeth Casson House ward four out of five patients we spoke with said they didn't always feel involved in their care. Five out of 13 patients across Applewood, Oakwood, and Juniper wards told us that they didn't feel involved with reviewing their care plans and were unsure whether they had received their own copies.

## Is the service responsive?

**Requires improvement**  

Our rating of responsive went down. We rated it as requires improvement because:

- On average, bed occupancy on all wards was generally between 90% and 100%. Between 2018 and 2019 there had been 382 patients admitted to out of area beds due to bed capacity issues.
- The trust had identified three urgent transfer beds for patients who had been at the place of safety longer than 24 hours. These beds were on Poppy and Oakwood ward and staff told us that these beds were not always used in line with the standard operating procedures. Staff told us the beds were not always reserved primarily for people from the place of safety and were used inappropriately by emergency departments for patients waiting for admission to psychiatric wards. Staff also raised concerns that patients were transferred into these beds, without a clinical reason, during a time when they were acutely unwell and could become further unsettled by being moved within a short period of time to a different bed once this had been identified. Patient's using an urgent transfer bed on Poppy ward had previously been transferred during the night, rather than within working hours.
- Between February 2019 and 2020 urgent transfer beds had been used for 314 patients. Staff working on Poppy and Oakwood wards told us they experienced more pressure and stress due to the fast turnover of these beds and having to complete admission processes, assessments, manage risks and provide support to these patients, while also providing ongoing care and treatment to other patients on the ward.
- The design, layout and furnishings of Elizabeth Casson House and Oakwood ward did not fully support patients' treatment, privacy and dignity. Staff, patients and managers at Elizabeth Casson House told us that the environment was not therapeutic or supportive of recovery due to a lack of open space, natural light, quiet areas and privacy. The ward rooms were based along one corridor and therefore incidents were often managed within the corridor. Patients could not access private and quiet space other than within their bedrooms. The female corridor on Oakwood ward was a thoroughway to meeting rooms and therefore did not provide any quiet areas for patients to relax.
- Due to previous incidents with access to hot water, patients on Juniper, Elizabeth Casson House and Hazel wards told us that they were dependent on staff to make hot drinks for them. The ward teams were implementing this as a blanket restriction and had not reviewed whether these restrictions remained necessary for the current patients on the wards.

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

- The environment and furnishings on Juniper, Poppy, Applewood, Silverbirch and Oakwood wards were tired and some areas required maintenance and refurbishment. On Elizabeth Casson House ward the environment walls were bare and rooms hadn't been maintained. On Applewood, Juniper, Oakwood and Poppy ward some furnishings had been marked, scuffed and torn. Staff told us that improvements to the ward environments were ongoing but were progressing slowly.

However:

- The trust had made improvements to some ward environments and facilities. This included an extension to Poppy ward, a new seclusion room on Hazel ward and refurbishments to Applewood ward. The trust had also submitted a bid for funding to improve the environment at Elizabeth Casson House.
- Staff on Juniper ward and Beechlydene ward had organised fundraisers to raise money to improve the ward environments for patients. This included a local artist coming to Juniper ward to paint a large mural on the garden fence and make the outside space more welcoming. On Beechlydene ward staff had completed a charity obstacle course to raise money for a 'calming lounge' on the ward.
- The service monitored delayed discharges and worked well with community teams to remove barriers to discharge. Patients were supported to work towards recovery and discharge and discharge planning meetings were collaborative with input from community teams, carers, patients and the multidisciplinary ward team.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service

## Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Staff acknowledged a recent improvement in the visibility of senior team members and engagement with staff when developing the vision and strategy for the trust.
- Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

However:

- Staff expressed that they did not always feel supported and respected by out of hours senior managers when escalating refusal of patient referrals. Staff escalated referrals to senior managers if there was a clinical rationale to refuse admission of a patient. Out of hour managers making decisions regarding admission were not always clinically trained. Staff told us that this was not an issue in usual working hours when escalating to locality managers.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

**Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website [www.cqc.org.uk](http://www.cqc.org.uk))

**This guidance** (see [goo.gl/Y1dLhz](https://goo.gl/Y1dLhz)) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

## Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

# Our inspection team

The inspection team included 11 inspectors, five specialist advisers, and four experts by experience.

Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.