

Good 

Avon and Wiltshire Mental Health Partnership NHS
Trust

Community-based mental health services for adults of working age

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)
RVN1H	Trust Headquarters	North Somerset recovery team, Weston Super Mare	BS24 7FY
RVN1H	Trust Headquarters	South Gloucester recovery team, (North) Thornbury.	BS35 1DG
RVN1H	Trust Headquarters	South Gloucester recovery team, (South) Fishponds.	BS16 2EW
RVN1H	Trust Headquarters	North Bristol assessment and recovery team.	BS10 5PY

Summary of findings

RVN1H	Trust Headquarters	Central Bristol assessment and recovery team.	BS2 9RU
RVN1H	Trust Headquarters	South Bristol assessment and recovery team.	BS14 9BP
RVN1H	Trust Headquarters	Bath and North East Somerset recovery team, Bath.	BA1 3QE
RVN1H	Trust Headquarters	Swindon recovery team, Swindon.	SN1 4BP
RVN1H	Trust Headquarters	Sarum community mental health team, Salisbury, South Wiltshire.	SP2 7FD
RVN1H	Trust Headquarters	WWYKD (West Wiltshire, Yatton, Keynell and Devises community mental health team, Warminster.	BA12 9AA
RVN1H	Trust Headquarters	North East Wiltshire community mental health team, Chippenham.	SN15 1JW

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.

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

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated community-based mental health services for adults of working age as good because:

- We found very caring, compassionate and motivated staff, and, saw good, professional and respectful interactions between staff and patients during our inspection visit. Patients were extremely complimentary about staff and commented positively about how kind the staff were towards them. We found that staff promoted relationships with patients based on respect and showed empathy consistently. We saw evidence of initiatives implemented to involve patients in their care and treatment. Comprehensive assessments were completed in a timely manner. Most care records showed personalised care which was recovery oriented.
- Following on from the concerns we raised at our December 2015 inspection visit, the Trust had reviewed the skill mix in the Bristol teams and increased the number of registered staff. Staffing levels were safe and recruitment was in progress to fill vacancies. Caseloads were managed and informed by a comprehensive case management tool and re-assessed regularly and were discussed in supervision.

Waiting times from referral to assessment and through to start of treatment were now kept to an absolute minimum. The Trust set targets were being met, with very few exceptions.

- Governance structures had been reviewed and systems put in place, since our inspection visit in December 2015, which meant that managers were now aware of how effectively their teams were performing. Where performance was below the standard expected, managers were alerted in a timely way so that they could plan and take act to correct any poor performance.

However:

- Across all 11 teams, there was no system in place for monitoring uncollected medication from the community team bases, and at the Swindon team base, there was no effective system for monitoring repeat prescriptions.
- Brookland Hall and the Greenway Centre still required full implementation of the premises improvement plans, developed following our concerns raised in December 2015. There were also ongoing concerns about the size and complexities of the recovery navigator caseloads in North Bristol.

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:

- There was no system in place for monitoring uncollected medication from the community team bases.
- At the Swindon team base, there was no effective system for monitoring repeat prescriptions.
- In North Bristol three patients' care records did not have an up to date risk assessment.
- Brookland Hall and the Greenway Centre remain still required full implementation of the premises improvement plans.
- There is no overarching policy for delivering physical healthcare in the community team premises. Not every base had suitable facilities and equipment available.
- There were concerns about the size and complexities of the recovery navigator caseloads in North Bristol.
- The 'step up and step down' escalation policy for recovery navigators was not always used in the North Bristol team.
- The Trust had reviewed the skill mix in the Bristol teams and increased the number of registered staff. Staffing levels were safe and recruitment was in progress to fill vacancies.
- Over 90% of staff were trained in and aware of safeguarding requirements and showed they used the appropriate referral process.
- The teams worked to a lone working practice protocol.
- All areas were clean and well maintained and Infection control information was on display.
- Caseloads were managed and informed by a comprehensive case management tool and re-assessed regularly and were discussed in supervision.
- There was an effective incident reporting system in place and staff knew how to report an incident.
- 82% of staff had received and were up to date with mandatory training.

Requires improvement



Are services effective?

We rated effective as good because:

Good



Summary of findings

- Comprehensive assessments were completed in a timely manner. Most care records showed personalised care which was recovery oriented.
- Staff were aware of and we saw evidence that they followed followed National Institute of Care Excellence guidance.
- A variety of therapy and treatment options were available and patients had access to psychological therapy, family interventions and appropriate medication management.
- The teams were multi-disciplinary and consisted of psychiatrists, psychologists, nurses, social workers, occupational therapists, recovery navigators and support workers. There was effective working with other agencies and services.

However:

- There was a large amount of uncatalogued patient paper records stored in two rooms in Warminster.

Are services caring?

We rated caring as good because:

- We found very caring, compassionate and motivated staff, and, saw good, professional and respectful interactions between staff and patients during our inspection visit.
- Patients were extremely complimentary about staff and commented positively about how kind the staff were towards them. We found that staff promoted relationships with patients based on respect and showed empathy consistently. We saw evidence of initiatives implemented to involve patients in their care and treatment.
- Involvement coordinators in each area worked with clinicians to deliver a high level of patient engagement especially in Bath and North East Somerset and South Gloucestershire.
- People with lived experience of mental health conditions delivered a series of educational and skills based workshops and programmes, in partnership with staff.

Good



Are services responsive to people's needs?

We rated responsive as good because:

- Waiting times from referral to assessment and through to start of treatment were kept to an absolute minimum. The Trust set targets were being met, with very few exceptions.

Good



Summary of findings

- Staff were flexible about timing of appointments to meet the needs of patients referred.
- The specific needs of patients referred were considered, for example cultural and disability needs. There was access to interpretation services when required.
- Teams responded to, and learned from complaints, local resolution was tried wherever possible.
- There was access a psychiatrist when required. There was joint working with all services, such as primary care, crisis and inpatient care when required.

Are services well-led?

We rated well-led as good because:

- Governance structures had been reviewed and systems put in place which meant that managers were now aware of how effectively their teams were performing. Where performance was below the standard expected, managers were alerted in a timely way so that they could plan and take act to correct any poor performance.
- Most staff were aware of the Trust's vision and values and could describe them. Most staff knew who the senior managers and executive directors were.
- All staff said they could raise issues with their manager if required and action would be taken. Clinical and managerial supervision was taking place.
- Sickness rates were low, poor attendance was addressed using the relevant policies and managers said they had received advice and support from human resources. Teams could raise items for the risk register when necessary.

However:

- We were concerned by issues in the leadership of North Bristol, and WWYKD (West Wiltshire, Yatton, Keynell and Devizes) community mental health teams. There was poor morale in both teams.

Good



Summary of findings

Information about the service

Avon and Wiltshire Partnership NHS Trust manages 11 community teams across six localities. These were:

- the North Bristol assessment and recovery team,
- the Central Bristol assessment and recovery team,
- the South Bristol assessment and recovery team,
- the South Gloucester assessment and recovery teams, one based in the North and one in the South,
- the North Somerset assessment and recovery team based in Weston Super Mare,
- the Bath and North East Somerset recovery team based in Bath,
- the Swindon assessment and recovery team based in Swindon,
- the Sarum community mental health team based in Salisbury,
- the WWYKD (West Wiltshire Yatton Keynell and Devizes) community mental health team based in Warminster and Trowbridge, and
- the North East Wiltshire community mental health team based in Chippenham.

In Bristol, the Trust was successful in securing the tender for community-based mental health services as part of a wider consortium called, Bristol Mental Health. From October 2014, Bristol Mental Health was launched and delivers mental health services across North, Central and South Bristol by a mix of 18 public and voluntary sector organisations, including the Trust.

In Wiltshire there had been a reorganisation of community services in 2014 and locality structures were reorganised to fit with clinical commissioning areas. Wiltshire merged its specialist older people mental health services to become an ageless service to better meet the needs of people by not having to move to a different team as they became older, unless their needs changed.

The community based services offer people with identified mental health needs a range of assessments, community based treatments, psychological support and interventions, medication and advice across the six localities. The community services we inspected were based in a variety of urban and rural settings, within a wide geographical area. The population served was diverse and included significant areas of deprivation. In addition to the services we inspected, the Trust also provided a wide range of other community based services including crisis services, older people's services and children's mental health services.

We have inspected these services previously from 10-12 June 2014 and the 8th and 9th December 2015. Following our last inspection of these services we issued a Section 29a warning notice, of the Health and Social Care Act 2008, on 31st December 2015.

- We had concerns that care and treatment was not always provided in a timely way.
- There was a lack of safe care and treatment.
- There was a lack of governance systems in place to manage the quality and effectiveness of the service.
- Staff providing care to patients did not always have the competence or experience to provide care safely.
- Staff did not always take steps to safeguard patients from abuse.
- The premises and equipment were not suitable at Brookland Hall and the Greenway Centre.

We returned to these services on 17 February 2016 to check that the actions specified in the section 29a warning notice had been completed, and we found that they had. During this inspection visit, we checked that any further outstanding action had been completed.

Our inspection team

Our inspection team was led by:

Summary of findings

Chair: Maria Kane, Chief Executive of Barnet, Enfield and Haringey Mental Health NHS Trust.

Team Leader: Karen Bennett-Wilson, Head of Hospital inspection (mental health) CQC

The team that inspected the community-based mental health services for adults of working age consisted of 11 people, divided into three smaller teams which included: three inspectors, one inspection manager, three nurses, three social workers and one psychiatrist.

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 we held about these services, asked a range of other organisations for information and sought feedback from people using the services and staff at focus groups.

During the inspection visit, the inspection team:

- Visited 11 community-based mental health services, across 17 different sites. We looked at the quality of the environments and observed how staff were caring for people.
- Spoke with 56 patients who were using the service, 14 in their own homes.

- Spoke with 12 carers of people using the service.
- Spoke with the team managers.
- Spoke with 168 staff members including doctors, nurses, social workers, occupational therapists, psychologists, support workers, recovery navigators, occupational therapists, administrative staff and student nurses.
- Interviewed the senior management team with responsibility for these services, including two service managers.
- Attended and observed 15 multi-disciplinary clinical meetings.
- Looked at 127 treatment records of patients, including records specifically for Mental Health Act documentation and medication administration charts.
- 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 spoke with patients, their carers, families and friends who were very positive and complimentary about their experiences of care from the community mental health services available for adults of working age. They told us that staff were caring, kind, professional and supportive towards them. They told us that care and treatment

interventions were highly effective in achieving recovery goals. Everyone we spoke with felt that staff actively involved them when making choices about their care and treatment. Patients said that staff were particularly motivated, compassionate, and skilled and developed good relationships with them to support recovery.

Summary of findings

Good practice

- Staff were available in all teams to ensure patients were supported to remain in employment. For example, staff told us about the, 'work matters' clinics in the South Gloucester teams which supported patients with job retention, facilitated meetings with employers and their occupational health staff. These staff also provided mental health awareness training to employers and maintained contact with patients to ensure they remained well and were able to cope well in their return to work plan. The community teams had achieved a 12% success rate in patients finding employment, compared to the National average of 6.7%.
- The Trust ran a confidentiality conference in Bath with workshops facilitated by a triad of a patient, clinician and carer. The conference worked with third sector providers and helped all parties to think about what each other wanted to share and know. It was described as a positive learning experience for all. Recommendations from this were being rolled out to the teams.

Areas for improvement

Action the provider **MUST** take to improve

- The Trust must have a system in place for monitoring uncollected medication from the community team bases.

Action the provider **SHOULD** take to improve

- The Trust should ensure that all patients in the North Bristol assessment and recovery service have an up to date risk assessment.
- The Trust should continue with the action plan to move the Central Bristol team out of Brookland Hall. In addition the Trust should continue with the premises improvement plan at the Greenway Centre.
- The Trust should review the policy for delivering physical healthcare in the community team premises. Suitable facilities and equipment will need to be reviewed and provided where required.
- The Trust should review the frequency within which sharps boxes are collected and removed from the premises.
- The Trust should review the complexities of the recovery navigator caseloads in North Bristol.
- The 'step up and step down' escalation policy for recovery navigators should be used regularly in the North Bristol team.
- The Trust should continue with the increased staffing levels of registered posts to further consolidate progress made and to ensure further improvements to service delivery.
- The Trust should develop an effective system for monitoring repeat prescriptions.
- The Trust should review the system for requesting Mental Health Act tribunal reports from community staff. This should include how staff are approached and ensuring reasonable timescales with regards to clinician's capacity.
- The Trust should address the storage of historical paper records at Warminster.
- The Trust should address the morale of staff and management issues in North Bristol and WWYKD (West Wiltshire, Yatton, Keynell and Devizes) community mental health teams.

Avon and Wiltshire Mental Health Partnership NHS Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
North Somerset recovery team, Weston Super Mare.	Trust Headquarters
South Gloucester recovery team, (North) Thornbury.	Trust Headquarters
South Gloucester recovery team, (South) Fishponds.	Trust Headquarters
North Bristol assessment and recovery team.	Trust Headquarters
Central Bristol assessment and recovery team.	Trust Headquarters
South Bristol assessment and recovery team.	Trust Headquarters
Bath and North East Somerset recovery team, Bath.	Trust Headquarters
Swindon recovery team, Swindon.	Trust Headquarters
Sarum community mental health team, Salisbury, South Wiltshire.	Trust Headquarters
WWYKD (West Wiltshire, Yatton, Keynell and Devizes community mental health team, Warminster.	Trust Headquarters
North East Wiltshire community mental health team, Chippenham.	Trust Headquarters

Detailed findings

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.

- 84% of staff had received training in the Mental Health Act.
- We reviewed a sample of care records specifically in relation to the Mental Health Act. We reviewed all of these records, including those patients receiving services who were subject to community treatment orders. The documentation was found to be in order and up to date. Staff we spoke with providing care and treatment to these patients subject to a community treatment order were aware of the conditions stipulated within the order. They were also aware of the statutory requirements of the Mental Health Act.
- All of the teams had approved mental health professionals either integrated within the teams or accessible to the teams. The duty staff members coordinated and arranged any Mental Health Act

assessments required. Staff said there were no specific delays in carrying out the assessments but that there were sometimes delays in accessing a local bed should admission to hospital be required.

- Staff told us that they did not receive much notice for the writing of tribunal reports from the central Mental Health Act office. For example, one member of staff was given 1.5 days to prepare a report with no consideration for their workload or booked appointments. Several staff said the timescales meant that they had to work evenings to complete them as they could not cancel their planned appointments. Concern was expressed that this affected the quality of the tribunal reports and they felt uncomfortable producing reports that were not the best they could do for the patient. Staff found the wording of the requests with the timescales intimidating. The emails informing them they had to complete a report cut and pasted the wording from the statutory documentation. This stated that “failure to comply with this legal deadline will result in you being issued with directions from the first-tier tribunal service”. Some staff described this as a bullying approach coupled with the unrealistic timescales.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were familiar with obtaining a person’s consent, although they commented that patients using community services had a high degree of autonomy to determine many aspects of their daily lives, including contributing to their risk assessments and care plans.
- Staff were able to explain the process to follow should they have to make a decision about or on behalf of a

person lacking mental capacity to consent to proposed decisions, in accordance with the Mental Capacity Act. Patients had access to independent mental capacity advocates if required.

- 75% of staff were up to date with refresher training in the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

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

- In December 2015 when we issued a Section 29a warning notice, of the Health and Social Care Act 2008, the premises and equipment at Brookland Hall and the Greenway Centre were not suitable. During this visit we found improvements had been made. The premises at Brookland Hall, the base for the Central Bristol recovery team were still too small to comfortably accommodate the team. However, as an interim solution, an additional team base had been acquired for a third of the team to use. We visited this base, at Stokes Croft and saw that staff were using the facility safely and effectively. We looked at the action plan developed by the Trust to address our concerns and saw that the longer term aim was to move the Central Bristol team into one appropriate, alternative base. Scoping for this objective had begun. There were some inconsistencies in the quality of environments across the 11 team sites with Brookland Hall, the base for the Central Bristol team requiring some general improvements to decoration. An estates plan had been developed to address a number of concerns with the Greenways Centre which included, providing a separate and dedicated waiting room for patients visiting for appointments and to increase the availability of office space. This and other concerns had been raised in our previous inspection visit to Greenways in December 2015. The action plan laid out plans to increase the space available to the assessment and recovery team and to ensure that these areas were quiet and conducive spaces to work in and receive treatment. Access to the other mental health centres for appointments and clinics were through staffed reception areas with comfortable waiting areas. We saw that the environments were safe, clean and well maintained.
- Call alarms were available to all staff within the team bases, either wall mounted or mobile, however, none were available to staff to use on home visits.
- In Warminster, key coded doors separated patient areas with staff offices. However, there was a newly opened office with three administrative staff next to the patient toilets. This was also next to a large open stationary cupboard and isolated from other staff areas. Patients were not supervised if they used the toilets during sessions, and there was no alarm system in the office for the administrative staff to summon assistance. This had not been recognised on any environmental risk assessment until our inspector brought it to the manager's attention. The manager assured us an alarm system would be installed.
- Not every centre was equipped with a clinic room where the necessary equipment to carry out physical examinations was available. The South Gloucester teams, North and South teams had no clinic room at all, just locked cabinets in a room for storing medicines. There were some inconsistencies across the eleven sites with the availability of medical equipment and the procedures for the checking of medical equipment. In both the Central Bristol and North Somerset, Weston Super Mare recovery teams there were many sharps boxes awaiting collection.
- In Warminster, the clinic room was hot with the temperature being recorded consistently above the Trust recommended maximum temperature of 25 degrees. The majority of entries recorded were 26-27 degrees. The fridge temperatures in the clinic room were 0.5 degrees which had been consistently recorded since May 2015. The trust recording chart that the temperatures were on stated that the fridge should be between 2-8 degrees. There were 15 boxes of Risperidol Consta in the fridge which the manufacturers guidance said should be stored between 2-8 degrees. Despite the advice on the recording sheets and medication staff had taken no action other than continue to record the temperatures. The temperature record sheets were sent routinely to the Trust pharmacy department and staff thought they would address this. However, the lead pharmacist said these would not be reviewed due to capacity of the pharmacists and would be filed without review.
- Clear information on good infection control protocols was evident in all team bases.

Are services safe?

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

Safe staffing

- In December 2015, when we issued a Section 29a warning notice of the Health and Social Care Act 2008, we had concerns about safe staffing across the three Bristol teams. During this inspection visit we found that considerable improvements had been made.
- A service manager had been appointed to cover the three Bristol teams and we found their contribution to date and leadership skills were considerable.
- In addition, all three teams had a manager in place, although the Central Bristol team manager had only been in post two weeks.
- Staff commented positively about improvements in staffing levels and although many felt these improvements were quite new and tentative, they were able to recognise that the Trust had responded swiftly to the Care Quality Commission concerns raised in December 2015.
- We found that the new model was working particularly well in the Central and South Bristol teams. We had some concerns about the North Bristol team, particularly in regards to the use of the recovery navigators and the size and complexity of their caseloads.
- Staffing figures across all community teams were 800 whole time equivalent posts.
- Community staff vacancies for those staff employed by Avon and Wiltshire Partnership NHS Trust were low at 1.8%. In Bristol, the recovery navigator vacancies, employed by different, non-statutory organisations were higher at 25-30 % At no time since the service was established in 2014 had the 25 recovery navigator posts in each recovery team been completely filled. As a result the posts were frozen and a skill mix review had been completed to increase the registered posts. Each Bristol recovery team was due to recruit a further two Band 6 posts as well as an additional Band 7 senior practitioner to the North Bristol team. Additional administrative posts had also been agreed. These posts were being actively recruited into at the time of our inspection visit. Staff commented positively about the skill mix review and agreement had been reached with Bristol Mental Health that the arrangements were permanent.
- The staffing skill mix across the remaining eight teams was to use less non registered staff and there were minimal staff vacancies in these teams.
- There had been a high turnover of psychologists across the teams in Wiltshire.
- Caseload numbers had been decided on by using a caseload management tool and using service mapping to assess and reflect the daily operations and future activity projections of all of the community teams. All teams were going through the process of mapping by an outside agency. Process mapping is an exercise which provides a map of a patient journey and this is presented visually. The map shows how things are and what happens, rather than what should happen. This then helps to identify any problems and identify areas for improvement. Staff had found this process challenging and some teams felt that it had not captured a true reflection of their work, telling us it had not captured report writing, teleconferences or informal case discussions. In Sarum, staff in the primary care liaison and memory service were concerned that the review stated they were over staffed by one clinician despite them marginally breaching the current target by a few days with the existing staff complement who were already completing the two assessments a day that the review recommended.
- Caseload numbers for care co-ordinators ranged from low, under 10 through to 35 and numbers were monitored in team meetings and supervision. Staff told us that their caseloads were being actively scrutinised with a view to reducing the size. However these were higher in Warminster following staff leaving the team following a major change in the service. The caseload management tool was populated from the electronic care record and staff diary system. Red, amber and green, 'RAG' ratings were flagged for due dates or care programme approach reviews, crisis plans required, risk summaries available, care plans, review dates and face to face contacts. The caseload management tool calculated a caseload weighting score, taking into account other responsibilities such as therapy groups, training, supervision, clinical hours, admin, management and travelling. All staff maintained a clinical activities log. Any score above 120 flagged to team managers as red and requiring attention.

Are services safe?

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- Sickness absence rates for the year to February 2015 across the Trust were 4.5%. Sickness absence rates for the year to February 2015 for the community teams were at the same level as the trust average at 4.5%.
- Agency staff were used appropriately in all of the teams and they were primarily carrying out assessments in the three Bristol teams.
- 82% of staff in the community teams had received and were up to date with mandatory training. We saw there had been an increase in training provided to the recovery navigators, covering topics such as care planning and risk management, for example.
- All 11 teams had access to a consultant psychiatrist and approved mental health professional when required and in an emergency. However there was some delay accessing a psychiatrist in a timely manner in the South Bristol recovery service where locum staff were covering one longer term absence.
- However we found a variable quality of risk assessments for patients in the North Bristol team. For example, at the North Bristol team we found that three out of nine risk assessments were overdue a review. We escalated four concerns we had about risk to the service manager on the day of our visit to the North Bristol team which were dealt with immediately. At the Central Bristol team we escalated one concern to the service manager which, again was dealt with immediately.
- Staff across all teams told us that they discussed case load management in both group and individual supervision and that this included strategies for managing risk. The caseload management tool was used as the overarching system for monitoring all staff caseloads.
- We had concerns in the North Bristol team about the expectations put on the recovery navigator posts, particularly the number of patients within their caseloads with a high level of complexity. The recovery navigators in this team told us they found this, “overwhelming”. We saw, in one clinical meeting that a recovery navigator had raised concerns about one person who had experienced a deteriorated mental state. The escalation policy was not activated, as should have happened. We raised our concerns with the service manager, who took immediate action to ensure a registered staff member assist the recovery navigator in managing this case safely.

Assessing and managing risk to patients and staff

- In December 2015, when we issued a Section 29a warning notice of the Health and Social Care Act 2008, we had concerns across the three Bristol teams that not all patients had an up to date risk assessment. During this inspection visit improvements had been made although we still had concerns about the North Bristol assessment and recovery service where we found three risk assessments out of nine were not up to date.
- We looked at 127 care records during our visit.
- Initial assessments were undertaken by either the primary care liaison teams or via the triage function of the community teams Risk assessments were carried out at this point.
- In the community teams, comprehensive risk assessments were completed and reviewed regularly which included at the majority of the multidisciplinary team meetings we observed. The assessments used the care programme approach template, and followed a zoning or, ‘RAG (red, amber, green) rating’ system to make the level of risk clearly identifiable. The level of risk was then reviewed regularly, and adjusted as necessary. Each person was discussed at the regular staff handovers, and their level of risk and care plan reviewed.
- Joint visits between staff were undertaken at times and other precautions were undertaken by staff when required which were supported by risk assessments and reviewed regularly.
- Staff were clear about appropriate procedures to follow if patients did not attend their appointments. These included telephone contact, making home visits and sending letters. Contingency plans were in place and staff were aware of these.
- In December 2015 when we issued a Section 29a warning notice, of the Health and Social Care Act 2008, we had concerns across the three Bristol teams that there were failures to use safeguarding procedures. During this inspection visit we found that improvements had been made.
- The trust had a safeguarding policy, which followed the county-wide multi-agency policies. Over 90% of

Are services safe?

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

community team staff had completed safeguarding training, and those we spoke with demonstrated that they could identify safeguarding concerns, and knew what action to take in response. All teams had appointed a safeguarding champion. A new safeguarding tracking system had been introduced following an audit of safeguarding procedures. There were safeguarding leads within or accessible by the teams, and staff knew who they were and how to contact them for advice. We observed a discussion about an existing safeguarding investigation underway, at one team, and saw that additional safeguarding concerns were highlighted. The local authority was contacted to discuss further action to be taken to protect patients using services. Safeguarding was a standard item on team meetings and staff were able to discuss procedures and how to escalate concerns. Staff said that support was available swiftly from managers. We saw particularly strong joint working in the North Somerset recovery team where all safeguarding alerts were reviewed jointly between the Trust and the Local Authority to ensure the policy was being accurately followed, that all paperwork was in place and that patients were being protected from abuse.

- The Trust had a lone working policy. The staff we spoke with were familiar with this, and confidently gave examples of what they did to keep one another safe. For example, if they had particular concerns about a person using services they may visit in pairs or arrange for the patient to be seen at the office. In Bristol, we heard about a positive initiative where the teams operated a “safe call” system, run by the local authority. This system required staff to log into a computer system at the start and end times of all visits. At any point, should staff fail to do this, an escalation process was followed by the staff managing the system to locate the staff member and check on their welfare. However in Wiltshire, some community staff did not have mobile phones and had to share or use their own. The trust resolved this issue as soon as we raised it.
- Staff who were pregnant had a comprehensive risk management plans developed with their manager that included a review of their caseload and locations they could see patients in. Staff told us they felt supported in this process.
- Admin staff in the services felt safe and supported by clinical colleagues with risks about visiting patients being appropriately shared. Clinicians felt supported by admin colleagues where they administered the lone working calling in procedures.
- All of the community teams had at least one qualified nurse prescriber or more in training. However, there was frustration amongst some of them that there was lack of a clearly defined role with the same size caseloads as other staff, with no protected time for assessments or reviews.
- We carried out a specific and detailed check of medicines management at the Swindon recovery team base at Chatsworth House and looked at arrangements for the safe management of medicines across all of the community teams.
- We found concerns across all of the community teams about dispensed medicines waiting for collection by patients. All of the medicines were stored in locked cupboards in the clinic rooms however the cupboards were very full. Staff did not routinely monitor or audit uncollected medicines, meaning that the care coordinators and doctors were not always aware if patients had not collected their medicines. For example at the Swindon recovery team, we saw uncollected medicines from February, March and April 2016. In the Sarum base in Salisbury there were three uncollected medications for patients that were dispensed in February 2016, December 2015 and one for August 2015, nine months prior to our visit.
- All teams managed a large amount of repeat medicines. A number of General Practitioners across the Trust’s service would not take over prescribing responsibilities. The teams did not always have an effective system to monitor the repeat prescriptions and at the Swindon recovery team, for example, we were told that pharmacy frequently chased for new prescriptions. The chief pharmacist recognised that the system was flawed and a review of community repeat prescribing was on the pharmacy action plan, however, the current system poses some risks in that the service could not be assured that patients received medicines as intended.
- We saw a protracted supply process for medicines at the Swindon recovery team. For example, doctor prescribed,

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person attended a clinic or had a home visit for blood test, bloods sent to Great Western Hospital, pharmacy in Calne supplied medicine (delivered to patients home or Chatsworth House), person collected medicine.

- The locality pharmacist said that they did not have time to talk to patients about their medicines, despite this being an important part of pharmacy support to patients. The pharmacist did not conduct staff training or work closely with doctors. The pharmacist visited the Swindon recovery team for a maximum of one hour each week and used the majority of this time to look at the depot prescription cards. Six out of nine prescription cards looked at did not have allergy status recorded.
- However there was good practice in the community team in Bath and North East Somerset which had a locally created audit system with a weekly stock check of meds. If it is noted a patient has not come to collect their medication, this results in an email to the care coordinator

Track record on safety

- There were 33 serious incidents requiring investigation, across nine of the eleven community services, within the previous year to May 2016, all apart from five were unexpected deaths. There were a total of 122 serious incidents requiring investigation across the Trust during the same period of time. Following one serious incident we saw that a review of security had been undertaken at the South Gloucester team base in Thornbury.

Reporting incidents and learning from when things go wrong

- In December 2015 when we issued a Section 29a warning notice, of the Health and Social Care Act 2008, we had concerns across the three Bristol teams that there were failures to make improvements to care planning and risk assessing which were clearly identified areas of lessons learnt from incidents. During this inspection visit we found that improvements had been made.
- Staff we spoke with knew how to recognise and report incidents on the Trust's electronic recording system. All incidents were reviewed by the manager, given a risk grading and forwarded to senior managers and the Trust's patient safety team for further review. The system ensured that senior managers within the Trust were

alerted to incidents in a timely manner and could monitor the investigation and response to these. The action taken by the team manager was also recorded on the electronic system.

- Staff told us about the critical incident overview group which took place every month to monitor serious incident investigations and develop action plans to ensure that any lessons are learnt to prevent re-occurrence.
- The Trust circulated a monthly safety matters briefing to alert staff of any safety issues and /or themes arising from incidents or complaints to do with safety. However although staff were aware of incident learning locally, staff were not aware of incidents in other areas. For example the Bristol teams were aware of incidents that had occurred elsewhere in Bristol, but not in Wiltshire. The Wiltshire teams did not know if issues had occurred in Bristol but were able to tell us of incidents in other local teams. This meant there was no shared learning across the Trust.
- Staff told us that the annual suicide prevention report was due to be published and that they discussed any lessons to be learnt in their team meetings and individual and group supervision.
- Where serious incidents had occurred within the teams, serious incident investigations had been completed and dated action plans implemented locally. In North Somerset, for example, one of the consultant psychiatrists ran mindfulness education slots for staff to attend to think specifically about learning from root cause analysis investigations following serious incidents. Significant incidents were discussed in staff meetings and handovers. Staff were always offered debriefing sessions following serious incidents. In Bristol, the care pathway for pregnant patients had changed following a significant incident. This included learning from the inquest as well as internal learning process with the clinical teams reflecting on their caseloads.
- Recovery support workers in Bristol, who were part of the service but worked for other third sector providers, had to complete multiple incident forms. For example a recovery worker employed by 2nd Step completed a form for his employer and one for AWP. They reported a

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positive response from AWP managers and occupational health but no response from 2nd Step. They found having to complete multiple incident forms impacted on their time to deliver care.

Are services effective?

Good 

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

- In December 2015 when we issued a Section 29a warning notice, of the Health and Social Care Act 2008, we had concerns across the three Bristol teams that care and treatment was not always provided in a timely way. During this inspection visit we found improvements had been made.
- We looked at 127 care records across the 11 community teams on our inspection visit.
- Patients' needs were assessed and care was delivered in line with their individual care plans. We did note however that there was a variable standard of care records. We found some care plans in all of the teams that were basic and not always personalised or recovery focussed. We found some care records across all teams which were more detailed and the entries into the daily records were completed to a high standard. Managers told us that they recognised that there were inconsistencies with the variable standard of the written care plans. A training programme had commenced across all teams and extra vigilance was made towards examining the quality of care plans in supervision. In addition every manager and senior practitioner across all teams audited the quality of five care plans every week to address the variations in quality.
- All of the teams held a daily meeting to look at all the referrals and assessments held. For example, in the South Bristol team the quality of the assessments carried out were checked to ensure the assessment had been carried out to the required standard. All referrals and assessments across all teams were tracked and updated on the electronic care record system to prevent any omissions and to ensure waiting times were within the Trust waiting time targets.
- In Warminster there were two rooms full of patient paper files that had been placed in their following the closure of a previous base in March 2015. These had not been catalogued or put in the rooms in an ordered way during the move and staff had no way of identifying or finding any file if they wanted to check historical information on a patient. Staff told us they were supposed to go to the trusts central storage but they

- were not accepted and were left there. The band seven team leader had requested that the issue was put on the risk register but they did not have access to it to confirm if the risk had been escalated to the trust.
- All of the community teams held either daily or regular meetings each week, some of which we attended, where the team discussed patients' care and the support they required. Staff were aware of the needs of patients and were putting plans in place to address these needs.
 - Patients receiving a service across all teams told us that the team approach was a recovery model. In North Somerset, for example patients had access to the Trusts' recovery education college. Patients told us they were offered information on different mental health issues, education on the principles of recovery and ways to enable recovery. Many of the workshops and courses were co-facilitated by people with lived experience.

Best practice in treatment and care

- The trust audited against the National Institute for Health and Care Excellence to monitor compliance, for example with treatment for schizophrenia, depression and prescribing medication.
- There was a range of psychological interventions available across all of the community teams. For example we saw that psychological interventions were available in the STEPPS (systems training for emotional predictability and problem solving) approach which was available in a group programme to assist patients using services in their recovery. A range of cognitive behaviour therapy, mentalisation based therapy, dialectical behaviour therapy, schema focused therapy, family interventions, art therapy and other supportive psychotherapy and social skills training was available, provided by the staff in the teams or by the psychology staff working alongside.
- Staff and patients who used services told us about the care pathway available for patients who had a diagnosis of personality disorder. In South Gloucester patients told us they used a peer support group, facilitated by a staff member trained in trauma to assist them to plan for managing crisis situations, the group was accessed on a self-referral basis. Patients were offered a variety of therapies both individually and on a group basis which actively included their involvement. For example we spoke to patients who had participated in groups to

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help with mood stabilisation, others who had joined groups to learn about recovery principles, crisis planning, health and wellbeing and to help build self-esteem and confidence.

- In North Somerset a pilot study and initiative using the, 'structured clinical management model' to work with people with a diagnosis of personality disorder had been developed. The post holder worked between primary care and secondary care. Over 30 patients were actively receiving treatment and therapy as part of this programme. Additionally in this team patients, their friends and carers were offered personality disorder awareness and education training sessions. This initiative culminated in the team being interviewed by a local radio station, thereby increasing awareness about mental health issues within the local community.
- Staff were available in all teams to ensure patients were supported to remain in employment. For example, staff told us about the, 'work matters' clinics in the South Gloucester teams which supported people with job retention, facilitated meetings with employers and their occupational health staff. These staff also provided mental health awareness training to employers and maintained contact with people to ensure they remained well and were able to cope well in their return to work plan.
- The community teams had achieved a 12% success rate in patients finding employment, compared to the National average of 6.7%.
- In the Bristol teams peer support workers were employed to offer people support and interventions by staff who had lived experience of receiving mental health services.
- Staff told us about the strong links they had with a charity called, 'developing health and independence' which supported patients to access a range of housing options, employment, voluntary work, training and education.
- A variety of other supports, provided by organisations other than the Trust were available to patients. For example, the 'men in sheds' initiative which brought together older men to meet and undertake woodworking projects either individual or shared.
- The recovery team at Swindon received national recognition for the clozapine clinic at the National schizophrenia conference for 'new routes to better care'. The clinic was locally centred on a doctor's surgery and was run by a psychiatric nurse.
- A locality wide initiative to reduce the length of hospital inpatient stays for patients with borderline personality disorder. The Swindon recovery team had been part of this care pathway work, in supporting people at home in collaboration with social care staff, psychology and in patient services.
- In Wiltshire, the care home liaison service provided support and developed care plans in collaboration with partnership agencies and care homes to keep people in their own home and in the community setting for longer and to reduce the need for admission.
- Staff told us, across all teams that general practitioners carry out physical health checks for people, where the person had agreed to, on being taken on by the community teams. Care plans were not always available for those patients with an identified risk associated with their physical health. Not all community teams offered physical health checks for the patients using services and two teams had no available clinic. The Trust had acknowledged that improvements were required in improving physical healthcare to reduce premature mortality in people with severe mental ill health. However, in the North Somerset team in Weston Super Mare a dedicated support worker post had been identified to provide an overview of physical health care, to ensure patients received the appropriate input they required and to develop a physical health clinic on site. We found consistently good physical health care checks with examples of physical health care monitoring in the Swindon and North East Wiltshire teams. This was also evident in the care plans. The Swindon team was working closely with primary care to ensure people were engaged in both mental health and physical health services. In addition in Swindon there had been a drive to improve physical health care checks for patients on longer term medication.
- Sports pound vouchers for discounted gym and leisure centre facilities were available to encourage and assist people to access mainstream physical health facilities.

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- Occupational therapists were using evidence based assessment tools and outcome measures.
- All patients using community services were assessed using the Health of the Nation Outcome Scales. These covered twelve health and social domains and enabled clinicians to build up a picture over time of their patients' responses to interventions.
- A range of clinical audits were carried out by the teams, for example against set standards to improve the quality of care provided, by The Commissioning for Quality and Innovation (CQUINs) payments framework. For example, auditing that patients have a crisis and contingency care plan, auditing to ensure a clear care pathway and access to services for those patients with a personality disorder and auditing to ensure availability of psychological therapies. In addition audits we looked at covered reviews of the quality and timeliness of GP letters, a review of appointment waiting times and regular reviews of root cause analysis reports, following serious incidents.
- Evidence based therapeutic groups were delivered in a lot of the teams, for example in Sarum there was a group for patients with bipolar run by two nurses and a psychiatrist. That team also provided a 'coping with difficult emotions group for patients with personality disorders that was run by a psychologist and occupational therapist.
- Staff told us that they had received specifically tailored training to be able to deliver skilled care to patients. For example, senior practitioners in the South Gloucester teams were trained in the Thorn initiative and had a dedicated day to provide patients with cognitive behaviour therapy, supervised by the complex psychological therapy team. In Bristol, we observed a nurse using motivational interviewing techniques as they gave affirming positive reinforcement to a patient who was in relapse. The patient responded well to this approach, recognising the small achievements and working with the nurse to build on those towards recovery.

Skilled staff to deliver care

- In December 2015 when we issued a Section 29a warning notice, of the Health and Social Care Act 2008, we had concerns across the three Bristol teams that there was evidence of the lack of safe staffing in regards to skill mix and competence of staff. During this inspection visit we found improvements had been made.
- All 11 teams had a range of fully integrated professions, including doctors, nurses, recovery navigators (in Bristol only), support workers, social workers, occupational therapists and psychologists. Teams also had access to a separate team of psychologists and occupational therapists which could be accessed on a referral basis, called the 'complex psychological team'. Teams had access to a pharmacist on a once a week basis only.
- Additional funding had been secured from local commissioners for child and adolescent transition workers. In addition, in North Somerset, for example, a practitioner specialising in perinatal mental health provided support to parents with mental health needs which included facilitating a drop in support group for parents and their children.
- All teams had undergone a, 'skills mapping' exercise to ensure there were specifically trained staff to undertake leadership and training roles in a variety of areas which included, dual diagnosis, non-medical prescribing, British Sign Language and a range of therapy based interventions. For example in Wiltshire the early intervention in psychosis team had staff trained in cognitive behaviour in psychosis. Further staff were doing the accredited training in this as recommended by the NICE guidance.
- Substantive and temporary staff received an appropriate induction prior to starting work in the community teams. Newly qualified nurses were offered an extended period of preceptorship (This is a structured period of transition for newly registered nurses when they start their first job). We looked at the Bristol teams' induction booklet and found it detailed and comprehensive. We spoke to staff about their induction programmes and the feedback was overwhelmingly positive.
- We reviewed training records which showed that 82% of staff had completed their mandatory training. Staff we spoke with commented on how well supported they were with learning and development needs and professional development.

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- Where temporary staff were used they received a good induction to the service. Checks were made to ensure that temporary staff received the required training prior to starting work in the community teams.
- Over 95% of staff had received regular one to one supervision and an annual appraisal. Staff told us about one example in the North Somerset team where the consultant psychiatrist held regular supervision slots for staff to book into each week, called the , 'golden hour'. In South Bristol a supervision template was used which covered either caseload management supervision or management supervision. The template included a check box which checked on the welfare of the staff member, looked at mandatory and other role specific training required, looked at key performance indicators using the caseload waiting tool and an audit of five of the staff member's care records.
- Clinical lead managers said they monitored staff performance regularly and at the time of our inspection were managing a small number of cases where performance was being monitored for improvement.

Multi-disciplinary and inter-agency team work

- We observed 15 multi-disciplinary meetings which, with one exception in North Bristol, were all well planned and organised. We saw the use of lap tops and electronic interactive boards to enable access directly into the care records. We saw that all new referrals and assessments were discussed as well as those patients admitted into or discharged from hospital. Each person receiving care was discussed and staff discussed their caseloads and the complexities of patients' needs. Patients with increasing risks were discussed at all meetings. All staff worked well together and respected one another's contributions.
- Within each locality and on a weekly basis managers and senior practitioners met from all the available community and inpatient services to discuss care pathways, individual patients (where appropriate) and issues concerning access, risk, move through services and discharge. The teams involved included, primary care liaison and triage, crisis, early intervention, older peoples and inpatient services.
- We observed appropriate sharing of information to ensure continuity and safety of care across teams including involvement of external agencies, for example

the local authority and the care quality commission. The Trust widely advertised information explaining why information about patients using services was collected and the ways in which it may be used, for example in the teaching and training of healthcare professionals.

- We saw many examples of strong working relationships and excellent communication with, for example primary care and social services. In North Somerset, Weston Super Mare, for example, we saw that regular and effective meetings took place with North Somerset council, chaired by the assistant director of social services. The meeting took account of issues such as the effectiveness of joint working arrangements, safeguarding, the Mental Health Act, key performance indicators and appropriate care planning for patients. In Bristol, we saw a nurse showing a good knowledge of local services and third sector agencies as she enabled a patient to choose which would offer the best support for their needs. In Sarum we observed a nurse visiting a patient in supported living. There was a clear positive relationship between the nurse and staff in the supported living environment that was focussed on the patient's needs.
- Each team allocated duty staff to work each day on a rota basis. This role was primarily to add additional support for care co-ordinators, triage phone calls, carry out urgent assessments and enable patients to be treated in a timely manner.
- In Wiltshire the trust was working in a partnership project with a local third sector provider and the local authority to run an individual placement and support employment service from April 2015. The service aimed to help those with mental health problems access employment. In two months the service had 102 referrals with 69 open cases with 22 patients being helped to find employment. Clinicians worked closely with this service to help patients achieve positive outcomes.

Adherence to the MHA and the MHA Code of Practice

- 84% of staff had received training in the Mental Health Act.
- We reviewed a sample of care records specifically in relation to the Mental Health Act. We reviewed all of these records, including those for patients receiving

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services who were subject to community treatment orders. The documentation was found to be in order and up to date. Staff we spoke with providing care and treatment to these patients subject to a community treatment order were aware of the conditions stipulated within the order. They were also aware of the statutory requirements of the Mental Health Act.

- All of the teams had approved mental health professionals either integrated within the teams or accessible to the teams. The duty staff member co-ordinated and arranged any Mental Health Act assessments required. Staff said there were no specific delays in carrying out the assessments but that there were sometimes delays in accessing a local bed should admission to hospital be required.
- Staff told us that they did not receive much notice for the writing of tribunal reports from the central Mental Health Act office. For example one member of staff was given 1.5 days to prepare a report with no consideration for their workload or booked appointments. Several staff said the timescales meant that they had to work evenings to complete them as they could not cancel their planned appointments. Concern was expressed that this affected the quality of the tribunal reports and they felt uncomfortable producing reports that was not

the best they could do for the patient. Staff found the wording of the requests with the timescales intimidating. The emails informing them they had to complete a report cut and pasted the wording from the statutory documentation. This stated that "failure to comply with this legal deadline will result in you being issued with directions from the first-tier tribunal service". Some staff described this as a bullying approach coupled with the unrealistic timescales.

Good practice in applying the MCA

- Staff were familiar with obtaining a person's consent although they commented that patients using community services had a high degree of autonomy to determine many aspects of their daily lives, including contributing to their risk assessments and care plans.
- Staff were able to explain the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions, in accordance with the Mental Capacity Act. Patients had access to independent mental capacity advocates if required.
- 75% of staff were up to date with refresher training in the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- In all the community teams we observed the staff to be kind, caring and compassionate. This was demonstrated by all the staff we shadowed.
- When we spoke with patients receiving support they were without exception very positive about the support, therapy and treatment they had been receiving. All 56 patients we spoke with and 12 carers reported that they were treated with respect and found staff to be supportive and helpful. The majority of patients and their carers commended individual staff highly and gave examples of how they had been cared for and assisted towards their recovery. Patients commented specifically about how thoughtful and recovery focussed staff were in their work and had them, the 'client' at the forefront of their thinking.
- Staff demonstrated a good knowledge and understanding of patients using the services. In the home visits we attended, it was clear that staff had a good understanding of patients' needs. Staff communicated with patients in calm and professional manner using an empathetic approach at all times.
- Patients' confidentiality was maintained by all the community teams. When we accompanied staff on home visits the staff members asked if the person was content for a CQC team member to be present prior to the visit. All staff spoken with were aware of the need to ensure a person's confidential information was kept securely. Staff access to electronic case notes was protected. Information was publicised for patients to read how the Trust handled personal information held and also about information sharing. We saw in the care records we looked at that patients had signed their consent to sharing information.

The involvement of people in the care they receive

- During our visits in the community we saw that carers were invited to attend discussions with their relatives. The meetings provided an opportunity for the carer to be involved with any potential changes to care planned. All carers we spoke with had been offered the opportunity of a carer's assessment.

- Not all patients who used services told us they had received a copy of their care plan although the vast majority said they had been involved in developing their care plan.
- We discussed recovery goals which had been set and the involvement that patients had in their care planning. We heard that they had a good deal of involvement, for example one person told us they were asked on each visit whether their needs had changed and whether they were happy with the recovery goals set and treatment options offered and accepted.
- We attended 15 care review meetings and saw that these involved the person receiving care. Records showed that patients had received at least a six monthly review of their care under the care programme approach protocols.
- The Trust had developed and publicised a family, friends and carers' charter which was co-produced by the Trust staff and a representative group of carers. The charter set out a list of commitments the Trust undertook to work effectively alongside carers and families and to work together and recognise a carer's unique experience, value to people and the importance of their involvement. We saw that the community teams made good use of supports available for carers such as the Bristol and Gloucester Carers' support centre which offered a variety of training, involvement and support. Each locality had regular mental health carers' support groups which offered an opportunity for carers to get together, receive and exchange information, find out about services and influence service development and changes.
- Across all community teams patients who used services, their relatives and carers were encouraged to complete the, 'friends and family test' to give feedback to the Trust about their services. Feedback could be given via a smart phone, a telephone call, an email, online survey or via a letter with a pre-paid envelope provided. We looked at the results of these surveys over the last six months and found overwhelmingly positive comments made, for example in February 2016, 89% of respondent's feedback was positive.
- Suggestion and comment boxes seeking feedback were available in all community bases.

Are services caring?

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- Involvement co-ordinators were working across all teams in each of the six localities. Each locality had developed a leaflet explaining how patients could become involved in shaping services and what support and training they could expect to receive. Opportunities included, recruiting new staff, taking part in interviews, taking part in consultations and discussion groups, advising on premises, staff training and induction, chairing and participating in groups and meetings, reviewing services and providing feedback and reviewing and designing quality measures for the Trust. The leaflets had all been co-produced with patients who used community services. For example, in Bath the coordinator had worked with service users on a comprehensive “My wellbeing toolkit” for patients to use, as well as working with other third sector providers to create the “Hope guide” which was an information guide on groups and activities for people with mental health or substance misuse needs. The trust funded the printing of this guide and clinicians and patients found it useful for accessing support, however continued funding for this was not certain.
- The trust ran a confidentiality conference in Bath and North East Somerset with workshops facilitated by a triad of a patient, clinician and carer. The conference worked with third sector providers and helped all parties to think about what each other wanted to share and know. It was described as a positive learning experience for all. Recommendations from this were being rolled out to the teams.
- Peer support workers were in paid posts across the community teams and we were told their roles were being reviewed by the Trust, with the involvement co-ordinators. ‘Service user champions’ were being recruited into paid positions to assist the service user involvement agenda.
- Regular service user forums were held across each locality, which met monthly and discussed a range of topics including premises, service developments and treatment options, for example.
- Patients using community services were trained to and encouraged to participate with staff recruitment processes.

Are services responsive to people's needs?

Good 

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

Our findings

Access and discharge

- In December 2015 when we issued a Section 29a warning notice, of the Health and Social Care Act 2008, we had concerns across the three Bristol teams that care and treatment was not always provided in a timely way. During this inspection visit we found considerable improvements had been made.
- Referrals into the Trust came from a variety of sources which included; primary care doctors, social care, the non-statutory sector, accident and emergency departments, self-referrals, the police and the criminal justice system.
- Each locality provided a single point of access and assessment. In Bristol the access and triage service was responsible for performing a telephone triage to determine the urgency and prioritisation of the referral. In the other five localities the primary care liaison service carried out this function. These teams acted as a conduit to all services offered by the Trust, including the assessment and recovery teams and the community mental health teams. These services used an electronic 'mental health access trigger tool' for screening and categorising levels of risk and acuity for people referred as part of the initial triaging and allocation process.
- Trust targets for the assessment and recovery teams and community mental health teams were to provide over 95% of people with an assessment within four weeks of referral and to commence treatment within 18 weeks of referral. Urgent referrals would be either assessed by the crisis service or more quickly by the assessment and recovery teams.
- In January 2016 an extract taken from the Trust's IQ system showed that 88% of people received an assessment within a four week period following referral, falling short of the Trust target of 95%. The Bath and North East Somerset, North and central Bristol and the Swindon teams fell short of this target. In the same extract 95% of people who went on to receive treatment, commenced treatment in less than 18 weeks. There were however three teams which fell short on this target, Bath and North East Somerset, Central Bristol and North Somerset. During this inspection visit all teams were achieving the Trust set targets. This was as a result of the Trust increasing the staffing levels to improve the ability of the teams to assess people within the four week target period.
- Each team held a daily referrals meeting where all prospective patients were discussed based on the information received by their assessment service. This negated the requirement for any duplication of assessment. Urgent referrals would be prioritised and processed by the duty staff member, if required on a daily basis across all community teams. No teams had a waiting list. In Salisbury, four cases at the daily meeting were GP's contacting the service for advice on medication. A consultant psychiatrist attended the meeting who contacted the GP's to address their concerns.
- All teams now had an operational policy with standard operating procedures. Clear criteria were laid out about the scope of the service and acceptance criteria. Exclusion criteria were available and did not exclude people who needed treatment and would benefit from this.
- We saw several examples of the teams proactively engaging with people who were, at times reluctant to engage with staff. For example, in Bristol the 'assertive contact and engagement' service worked across primary care and the Trust's services to ensure harder to engage people were able to access services. This may involve accompanying patients to appointments, for example.
- Staff told us about the proactive approach they had towards engaging with patients who did not attend appointments. Efforts included making telephone calls and sending letters. More proactive attempts such as welfare home visits were made if the level of risk indicated this was required.
- We received no adverse comments from patients about the flexibility of appointment times or indeed about cancellation of appointments. We saw that patients were asked about appointments running on time in the family and friends test and that people responded positively to this question.
- In Wiltshire, community teams ran regular depot and Clozaril clinics. In the Melksham clinic, there were 85 patients whose only contact with the service was for

Are services responsive to people's needs?

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depot injections. Staff told us this was due to local GP's were reluctant to provide the depots and that there was some discussion with the CCG to address this. We observed two clinics which were well run, with good engagement of patients. Patients using these clinics were positive about the convenience of them and felt reassured that the mental health team checked on their well-being regularly this way.

The facilities promote recovery, comfort, dignity and confidentiality

- The facilities in the majority of community bases we visited promoted recovery, dignity and confidentiality. All areas that people had access to were clean, tidy and well maintained. Furniture was in good condition and most areas were decorated to a good standard. Reception areas were welcoming in the majority of sites and some teams had worked locally to improve the environment further. For example in Bath and North East Somerset, there was artwork from therapy groups throughout the site.
- However Brookland Hall was too small for the size of the team. This had been partially addressed since our last visit with new premises nearby to which some of the team had been moved as an interim measure until a permanent solution was agreed. We saw that there were active plans to address this. In the Greenways centre there were concerns about a lack of dedicated waiting area for patients and office space. A project group had been started to address this.
- The Trowbridge Civic Centre satellite site initially had challenges which were being addressed. Although the interview rooms were comfortable and appropriate, the waiting area was in the main reception where members of the public bought tickets for the theatre shows. There had been incidents and use of alternative side rooms for patients to wait were being negotiated. This could affect the privacy and dignity of patients having to wait in such a public area. The civic centre staff had not received training in how to support a patient who may be waiting in the area, but would call up to the AWP office. The office was intended in the change program to be a drop in location with no permanent staff, however due to the need to have support for staff with appointments the team had to ensure that there was someone always available to respond to reception or to an incident in the meeting rooms.

- Patients using services had access to a wide and relevant range of information which included information on; employment support services, support following a bereavement, alcohol and drugs advisory service, support for people suffering from domestic abuse, signs and support if elder abuse was suspected, support for people with anxiety and depression and the care programme approach explained. There was access to leaflets in different languages if needed. Interpreting services and advocacy services were available if required and contact numbers were advertised.

Meeting the needs of all people who use the service

- A wide selection of literature was available in all reception areas or bases of the community teams, which included: how to raise a concern or complaint, access to advocacy services, mental health diagnosis defined, treatment options available, medication explained, advise about drugs and alcohol, support following rape and sexual abuse, access to self-help groups and voluntary sector mental health support organisations such as the Samaritans and MIND.
- Disability access was available in all of the team bases.
- Good signage, including pictures, symbols and hearing loops were apparent in all bases for those people who may have difficulty communicating. In Bath and North East Somerset, which has a large deaf population, there were clinicians trained in British Sign Language.
- People's diverse needs such as ethnicity and religion were recorded in their care records.
- There was good access to interpreters across all teams.
- Staff showed a good understanding of their local populations cultural needs and the impact on mental health. This was especially evident in Central Bristol with an in-depth understanding of the needs of a large Somali population. For example how to address the issues of interpreters with different local dialects and the impact of "khat" use – a substance that can induce psychosis but is culturally important to that population.

Listening to and learning from concerns and complaints

- In the preceding 12 months the Trust received 286 complaints and 102 of these were about the community

Are services responsive to people's needs?

Good 

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

teams. 21 of these were upheld and a further 46 partially upheld. Community services received 402 compliments over the last year, out of a trust total of 947 compliments.

- Information about how to complain was on display in reception areas of all of the community sites and on the Trust's website. Reception areas also had information available about the patient advice and liaison service which supported patients in raising concerns. Patients using the community services were given information about how to make a complaint as part of their introductory information leaflets.
- Staff were able to describe the complaints process and how they would process any complaints. Staff knew how to respond to anyone wishing to complain and the team managers demonstrated how both positive and negative feedback was used to improve the quality of services provided. For example, where patients had complained they had not been involved in their care planning, this was introduced into the staff supervision template to ensure that this was checked to have happened.
- All of the patients using community services we spoke with told us they were confident to raise any concerns or complaints and that they thought they would be listened to and their complaints taken seriously. Many patients said they would feel extremely confident to ring the team manager if they had any concerns at all.
- We looked at some of the complaints received and the related correspondence. We found complaints were taken seriously and responded to promptly in adherence to the Trust's complaints policy and associated procedures. All complainants received an individual response to their complaint as well as contact details of other bodies they could approach if they were unhappy about the outcome.
- We saw through staff team meeting minutes that complaints were discussed and actions were taken to ensure any lessons highlighted were learnt. We saw discussions took place in one team meeting to agree to provide patients with a quiet waiting area following a complaint received about the facilities provided.
- Patients using community services were given the opportunity to participate in an annual satisfaction survey in addition to feeding back their experiences at care review and planning meetings. The survey of patients who used community mental health services in 2015 found that the community services were not rated in any section of the survey as one of the worst performing Trusts, however they were rated in four areas as one of the best performing Trusts. The areas where the community teams scored well were in patients having a regular meeting with staff to discuss care, receiving help in finding work, receiving information on medicines and on being given sufficient information on therapy and treatment options and in deciding which to pursue.

Are services well-led?

Good 

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

- The Trust's vision was to provide the highest quality mental healthcare to support recovery and hope. The Trust's values were those of passion, respect, integrity, diversity and excellence (PRIDE) and many staff were familiar with these, however in most teams staff commented they had a stronger link with their locality than the overarching Trust.
- We saw that each locality had developed a different model to deliver services. This meant it was difficult for managers to compare their performance with that of other teams and this potentially provided a further disincentive for improvement. Staff said this made it difficult to compare their services. We recognised however that this was the intended model of commissioners in each locality. We also saw that the Trust had developed an overarching performance reporting system which enabled teams to compare an agreed set of performance indicators with one another.
- Most staff knew who the senior managers and executive directors were. All staff said they could raise issues with their manager if required and action would be taken. Staff on a number of sites commented about the lack of visibility of very senior managers in the organisation.

Good governance

- In December 2015 when we issued a Section 29a warning notice, of the Health and Social Care Act 2008, we had concerns across the three Bristol teams that there was a lack of governance systems in place to manage the quality and effectiveness of the service. During this inspection visit we found considerable improvements had been made.
- Managers and the Trust had instigated several systems which meant that managers were now aware of how effectively their teams were performing. Where performance was below the standard expected, managers were alerted in a timely way so that they could plan and take action to correct any poor performance.
- The managed learning environment was the electronic training record system used effectively by managers across all teams for ensuring that staff received

mandatory training. A monthly report was produced which was reviewed at governance meetings and team meetings. Staff had access to this system to monitor their own compliance with mandatory training. 82% of staff in the community teams had received and were up to date with mandatory training.

- The IQ system was the electronic system used by managers to monitor whether staff had received supervision and a yearly appraisal. Clinical and managerial supervision was taking place. Over 95% of staff had received regular one to one supervision and an annual appraisal. This system also monitored absence reporting for each team.
- There were strong governance systems to enable managers and teams to gauge their performance and a number of electronic systems were used regularly by staff. The caseload management tool monitored care records. Alerts were available to notify staff and their managers about whether risk assessments had been completed and reviewed, care programme approach and non-care programme approach reviews held, care plans present and reviewed at least yearly, crisis and contingency plans present and reviewed at least yearly. All staff received an audit of five care records during each supervision slot they attended. All of this information was available to senior staff in the Trust and published in a dash board format, monthly.
- We looked at the community teams' performance management framework and saw that data was collected regularly. The Trust key performance indicators included; waiting times from referral to assessment and from assessment to treatment starting, patients receiving a yearly review under the care programme approach, risk and crisis plans in place for everyone, care plans shared with the person using services and patients being asked if they had a carer.
- The assurance overview dashboards summarised and circulated monthly were discussed in team meetings as well as the locality quality forums, held monthly. In addition, every week an 'assurance call' was made by each team through to their triumvirate directors to ensure all key performance indicators were being met and to escalate any concerns and develop an action plan to address those concerns.

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- The team managers, senior practitioners and locality service managers were visible within the service during the day-to-day provision of care and treatment, they were accessible to staff and they were proactive in providing support.
- Teams could raise items for the risk register when necessary and we saw that they had done this. For example concerns had been raised by staff about the inability to recruit sufficient recovery navigators in Bristol and staff at both Brookland Hall and the staff from the Greenway centre had raised issues about the unsuitability of the premises.

Leadership, morale and staff engagement

- Sickness and absence rates were 4.5% in the community teams. This compared to a Trust wide figure of 4.5%.
- There was a non-executive director lead for bullying and harassment and staff we spoke to were aware of this. There was a confidential hotline for staff to call if they felt they were being bullied.
- Staff were aware of the whistleblowing process if they needed to use it. Some concerns had been raised about the changes across all of the locality community services. Staff told us that they knew how to whistle blow and felt able to do this. On the Trust intranet system 'our space' there was information available on how staff could whistle blow in confidence.
- We were assured that the local leadership within the service was aware of the issues and concerns that were raised by some staff in the majority of services. We saw a robust risk register and action plan had been developed prior to our visit which set out a credible plan to address those concerns.
- Most of the staff we spoke with were enthusiastic and engaged with developments within the service.
- Most staff described morale as very good with their team leaders being highly visible, approachable and supportive. Staff in two of the Bristol teams spoke of marked improvements within the services since the last CQC visit with managers who now listened.
- Staff across all services reported that the number of service redesigns in all teams over the past few years was high and that they were not always engaged in the process. They stated this caused uncertainty. Some staff felt that this was due to commissioners others felt that it was due to the Trust. Some managers recognised that management of change could be done better at times.
- There was strong competent leadership evident within nine of the 11 services we inspected. However, we were concerned by issues in the leadership of the North Bristol and WWYKD (West Wiltshire, Yatton, Keynell and Devizes) community mental health teams. There was evidence of poor morale in both teams.
- In North Bristol there was not a consistent approach from the local leadership team including the team leader, senior practitioner and consultant. This resulted in staff not always feeling fully supported and risks going unaddressed.
- Although staff in WWYKD felt supported by their team leader there was a disconnect between them and more senior management who were not consistent in their approach.
- Staff reported a lack of engagement by the Trust and managers with the teams in WWKYD. Staff did not feel that the Trust had considered them in the redesign. The main office base in Trowbridge was closed after services being present at that site for nearly 30 years. Staff told us that they were informed in January 2016 and moved out in March 2016. Staff morale was low as to how they felt they were treated with a long period of uncertainty. The office base in Trowbridge civic centre was not arranged at the time of the announcement of the March closure and was only agreed three weeks before the move. Staff moved some furniture and office equipment to the new sites in their own cars. There were practical implications to the change. Appointments could not be sent out to patients as there was no confirmed office base. There were not sufficient laptops or mobile phones for the workforce, despite the closure of the office base and an expectation for mobile working. As the office in the Trowbridge civic centre was intended as a drop in work base it did not have all the facilities needed to work including printers and no phone line which meant it was difficult for staff to complete work when based there. Printing required a 20 mile round trip to Warminster. Staff and the band seven team leader raised these issues repeatedly but with no access to the

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risk register were unsure whether the issues had been raised. When we raised the lack of IT to the Trust during our inspection the issue was resolved immediately with new phones and laptops being provided.

- Staff confirmed that they were supported to develop; staff were provided with leadership training. For example in the South Gloucester team the senior practitioner had participated in the Mary Seole leadership programme.
- Recovery support workers in Bristol who worked for third sector employers felt that they identified as being part of the Trust. They reported that managers in the Trust were supportive and visible and took responsibility for their caseload.
- The majority of medical staff felt more engaged with the Trust than they had been and were positive about the changes in senior leadership, especially the appointment of the new Chief Executive.
- We saw some excellent examples of team working and mutual support, across all of the teams, for example in the North East Wiltshire team a registered practitioner was supporting the non-registered recovery staff with group supervision which they were finding supportive and helpful. In the Swindon team there were examples of mutual support, staff members told us they were supportive towards each other. The North Somerset team had recently won the, 'Trust team of the month' and they told us how this was in recognition of their effective team working and mutual support. The South Bristol team had developed a workplace stress assessment questionnaire to check that staff felt adequately supported. The South Gloucester teams had successfully implemented a preceptorship programme for newly registered nurses.
- Staff told us they felt able to report incidents, raise concerns and make suggestions for improvements. They were confident they would be listened to by their line managers. Some staff gave us examples of when they

had spoken out with concerns about the care of patients and said this had been received positively as a constructive challenge to practice. All of the community teams had a regular team meeting.

- Staff did not always feel involved in the Trust changes, for example the psychology service in Wiltshire did not feel part of the service development to make all staff care co-ordinators.
- The model of service provision in Bristol had been in place for almost two years. Whilst acknowledging the sizable changes the model had brought about, most staff said that they felt increasingly settled and integrated and felt that the new arrangements were working better and particularly now that the skill mix review had agreed to increase the numbers of senior practitioners and specialist practitioners and recovery practitioners. All staff commented on their main objective which had been to cause as little disruption as possible for their patients using services.

Commitment to quality improvement and innovation

- All the localities had a quality director as part of their triumvirate who assisted the teams develop improvement methodologies. For example the development of the the assurance overview dashboards which were circulated monthly and discussed in team meetings as well as the locality quality forums, held monthly. In addition, every week an 'assurance call' was made by each team through to their triumvirate directors to ensure all key performance indicators were being met and to escalate any concerns and develop an action plan to address those concerns.
- The confidentiality conference in Bath and North East Somerset looked at information sharing from carer's perspectives as well as patients and staff. Third sector involvement in the conference showed a commitment to quality improvement from other areas.

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

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA 2008 (Regulated Activities)

Regulations 2010 Cleanliness and infection control

The Trust must have a system in place for monitoring uncollected medication from the community team bases.