Avon and Wiltshire Mental Health Partnership NHS Trust

Inspection report

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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Good**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

We carried out this unannounced comprehensive inspection of the specialist community mental health services for children and young people, and the wards for older people with mental health problems provided by this trust as part of our continual checks on the safety and quality of healthcare services. We also inspected the well-led key question for the trust overall.

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

Avon and Wiltshire Mental Health Partnership NHS Trust serves four clinical commissioning groups and six local authorities, NHS England also commission specialist services. The trust employs over 4000 substantive staff. It operates from over 90 sites including eight main inpatient sites and services are delivered by 150 teams across a geographical region of 2,200 miles, for a population of approximately 1.8 million people. The trust has a total of 21 locations registered with CQC.

The trust sits within two Integrated Care Systems (ICS). These are:

- Bristol, South Gloucestershire and North Somerset (BNSSG)
- Bath and North-East Somerset, Swindon and Wiltshire (BSW).

At our last inspection we rated the trust overall as requires improvement. Overall, we rated safe, responsive and well led as ‘requires improvement’, and effective and caring as 'good'.

Services Inspected

Our findings

The specialist community mental health services for children and young people provided by Avon and Wiltshire Partnership NHS Trust in Bristol, North Somerset and South Gloucestershire are part of the community children's health partnership (CCHP), which includes all community-based children's healthcare services across the area. CCHP is made up of Sirona Care and Health, University Hospital Bristol NHS Foundation Trust, Barnardo's, Off the Record and Avon and Wiltshire Partnership NHS Trust.

We previously inspected this service in 2020, when it was rated as good overall and in all key questions. In 2020 the service incorporated North Somerset child and adolescent mental health services (CAMHS) from another provider. CAMHS are provided by locality teams across Bristol, North Somerset and South Gloucestershire. Referrals for Bristol and South Gloucestershire came through the Community Children's Health Partnership (CCHP), which serves as a single point of access to the CAMHS service. North Somerset referrals come direct to the CAMHS team. The locality teams are based in Kingswood (South Gloucestershire), Barton Hill Settlement (east and central Bristol), Brentry (north Bristol), Osprey Court, Knowle (south Bristol), Weston-Super-Mare and Clevedon (North Somerset). These teams deliver tier three (assessment and consultation services delivered by multidisciplinary CAMHS teams) and tier two (early intervention) services.

A warning notice (which requires the provider to take immediate action to make improvements) was served on the North Somerset service under the previous provider in 2019 due to concerns about staffing and waiting lists. We also found concerns around high caseloads, issues with care plans, incident recording, staff supervision and a lack of robust governance. The current inspection is the first time the North Somerset services have been inspected since Avon and Wiltshire Mental Health Partnership NHS Trust took responsibility for the services.

Avon and Wiltshire Mental Health Partnership NHS trust provide eight wards for older people with mental health problems across five sites; Aspen ward at Callington Road hospital, Cove and Dune wards at Long Fox Unit, Amblescroft North and South wards at Fountain Way hospital, Liddington and Hodson wards at Victoria Centre, and ward 4 at St Martin's hospital.

All wards except Amblescroft South and Cove ward look after patients with functional or organic illnesses. In response to the ongoing coronavirus pandemic, Amblescroft North and Cove wards admitted patients with mixed illnesses and have been identified as admissions wards. During this time patients are encouraged to isolate and complete regular testing before transferring to an assessment and treatment ward, following a negative coronavirus test.

During this inspection we visited all five sites and seven wards; Amblescroft South and North, Aspen ward, Cove and Dune wards, ward 4 (St Martins Hospital) and Hodson ward. During our visit to Aspen ward we only looked at the ward environment and did not review care records, or interview staff. Dune ward was closed in December 2020 due to concerns regarding the quality of care and staffing of the ward. The ward reopened in February 2021 following implementation of a quality improvement plan.

The service was last inspected in October 2017 and was rated requires improvement for the safe domain, and good overall. Following that inspection, we told the trust it must make improvements to:

- ensure clear risk management and staff must ensure they clearly document and review risk management. Staff must ensure they transfer patients' risks clearly to care plans.
- ensure blind spots on Aspen ward including the garden are observed safely and mitigated.
- ensure they prioritise removal of dormitory accommodation on ward 4 in order to ensure optimum safety of patients particularly at increased risk times such as at night.

Our findings

During this inspection we found that, although the trust had taken some action in response to these requirement notices, they had not all been fully met. Ward 4 continued to consist of dormitory accommodation.

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?

We inspected the wards for older people with mental health problems because we had a number of concerns about this service. We had not inspected this core service since 2017. The service was previously rated as good overall, with a rating of requires improvement in safe, and good in effective, caring, responsive and well led.

We did not inspect acute wards for adults of working age and psychiatric intensive care units (PICUs) and the child and adolescent mental health ward because the services had not had time to make the improvements necessary to meet legal requirements as set out in the action plan the trust sent us after the last inspection. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

Our rating of services stayed the same. We rated them as requires improvement because:

Overall, we rated safe, caring, responsive and well led as 'requires improvement', and effective as 'good'.

We rated both of the core services inspected as requires improvement.

In rating the trust, we took into account the current ratings of the ten core services not inspected this time.

The rating for the trust overall remains requires improvement.

With overall ratings of requires improvement for the key questions, are services safe and responsive and good for the key questions, are services effective, caring and well-led

We rated it as requires improvement overall because:

Since the last inspection, the trust had revised the governance structure and trust leadership demonstrated a high level of awareness of the priorities and challenges facing the trust. However, despite action plans being in place to address these, actions had not and did not always happen at pace. It must be recognised though that the trust leadership had responded quickly in taking action to keep staff and patients safe during the COVID-19 pandemic.

During the inspection we heard that there had been variability in the visibility, openness and transparency of senior and services leaders during the pandemic. This had impacted on the experience of staff in some areas where visibility, openness and transparency was seen to be poor. We heard about a disconnect in some areas between front line staff, service managers and executives.

Our findings

Most staff we spoke with during the core service inspections told us that team or ward managers and matrons were visible and supportive. However, staff did not always feel that senior leaders outside of the locality were approachable or had a good understanding of the services and staff experiences. Staff did not always feel able to raise concerns without fear of retribution.

The trust strategy was not supported by a long-term financial plan and indications were that this was some way off in the context of significant changes to the national financial architecture. The trust were unable to credibly evidence that the trust strategy was affordable or financially sustainable.

The trust did not have a clear, strategic, structured and systematic approach to engaging people who use services, those close to them and their representatives despite some examples of positive engagement.

Not all staff we spoke with, as part of the core services inspection, felt involved in developing the trust strategy and did not understand how this might impact on them or what might be required of them. Some staff felt the strategy was something that had been “done to” them, rather than with them.

The trust had not responded to all previous inspection findings where we had told the trust improvements must be made. The trust had not made the required improvements identified to ensure the dormitory accommodation on ward 4 had been changed to single room accommodation (although the ward moved to an alternative location the month after the inspection).The trust did not have a well-developed estates strategy, despite estates being identified as a key issue. However, the trust was recruiting a director of estates to join the executive team. The trust acknowledged that the issues with the trust estates had not been resolved, despite being a high priority.

Environmental risk management plans to reduce or mitigate identified risks, including known ligature points on the older adults wards had not been fully implemented. Staff did not consider environmental risks when developing risk management plans for patients. Clinical premises where patients were seen in the North Somerset and North Bristol specialist community mental health services for children and young people service were not all safe and clean. The North Somerset team did not have environmental risk assessments in place.

Staff did not complete and regularly update risk assessments in the North Somerset specialist community mental health services for children and young people service. The team did not have enough staff. The number of patients on the caseload of the team, and individual members of staff, was too high to enable staff to give each patient the time they needed. Staff did not always assess and treat young people promptly. The service did not meet target times and an increase in complex referrals meant that staff were finding it difficult to cope with the demand. The trust were aware of this and had action plans in place to address the concerns.

On ward 4 (St Martins Hospital) it was not always clear whether staff had considered the least restrictive interventions when managing patient risk, such as self neglect. The staff team on ward 4 were unclear on the key principles of the Mental Capacity Act. Staff on this ward were unable to describe the principles of the Mental Capacity Act and did not always consider capacity on a time and decision specific basis.

Staff on the older adults wards did not always treat patients with respect and dignity when entering their rooms or interacting with them during an activity.

Our findings

Our findings from the safe, and effective key questions on the older adults wards highlighted concerns with the governance processes at team level and the management of performance and risk. Ward managers' understanding and implementation of governance processes differed across the wards and ward managers did not monitor performance and quality consistently.

However:

Since our last inspection a number of new appointments had been made to the board; both non-executives and non executives and a number of new appointments were planned. The trust were in the process of recruiting a full time dedicated deputy chief executive, a director of transformation and a director of estates to join the executive team. The changes were being made to ensure a more diverse board with a wider range of skills and experience and the proposed new appointments would increase the executive team capability and capacity meaning that the board could provide high quality, effective leadership. All board members demonstrated dedication and commitment to improving the care delivered to patients. The chair provided clear leadership and the non executives provided appropriate input and challenge to the various sub-committees that they chaired or had input to and challenged executive members appropriately at board meetings.

Board members demonstrated a real understanding of the issues that faced the trust and were clear that the trust faced many challenges including a difficult financial position, challenges with the estate, a low bed base per population and a number of infrastructure and system issues. They were all clear that where investment was needed to improve the quality of services, this was supported.

The governance framework was now aligned with the Care Quality Commission domains of safe, effective, caring, responsive and well led. There were clear lines of accountability and governance arrangements in place to provide ward to board assurance. The five domain subgroups fed into the executive team and clinical directors. Executive leads took a lead on the domains, within the new structure designed to strengthen reporting arrangements and provide assurance to the trust board.

There were a range of mechanisms in place for identifying, recording and managing risks, issues and mitigating actions. Individual services maintained their risk registers which were submitted to the trust's electronic risk management system. All staff had access to the risk register and were able to escalate concerns when required. Staff concerns matched those on the risk register. The trust had introduced an early warning dashboard as part of their improvement work on one of the older adults wards. This enabled them to identify areas of concern using a series of data measures.

An external review into physical healthcare commissioned by the trust earlier this year and recently completed identified a number of areas for concern and made recommendations for improvement. This was on the trust risk register, an action plan in place, and the trust was drafting an updated strategy to address these issues.

There was a focus on aligning the strategy with both local and national priorities. The trust were engaged with the wider health economy and system locally. The trust was working with other providers in the strategic development of mental health services within the Integrated Care System (ICS). The trust board regularly discussed this, and acknowledged the challenges associated with working with two different Integrated Care Systems.

The trust had a clear set of visions and values which staff understood. Staff we spoke with during the core service inspections felt increasingly supported, valued and respected. We saw significant improvements in the culture, although there was still work to be done. Staff demonstrated a passion for delivering high quality patient care and put patients at the centre, despite morale being low amongst some staff groups.

Our findings

Leadership of medicines optimisation within the trust had improved. Recruitment of deputy chief pharmacists had allowed the chief pharmacist to work more strategically. Chief Pharmacist was accountable to the Medical Director and medicines optimisation issues remained visible to the trust board. Governance processes meant there was oversight of risks, performance and processes. However, the risk around medicines safety remained whilst the medicines safety officer role was vacant.

The trust Infection, Prevention and Control (IPC) lead was given a nursing award for their work within the trust. The Daisy Unit (inpatient ward) received a highly commended in the category of Learning Disability Initiative of the Year at the Health Service Journal Patient Safety Awards, in recognition of the work carried out to reduce restrictive practices on the unit. The trust was also a finalist in the category of Patient Safety Collaborative Mental Health Initiative of the Year for its work to reduce restrictive practice on Bradley Brook, a medium secure ward at Fromeside.

The specialist community teams for children and young people, where staff understood the principles underpinning capacity, Gillick competence and consent as they apply to children and young people and managed and recorded decisions relating to these well.

Within the specialist community services for children and young people, we saw staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

How we carried out the inspection

We used CQC's interim methodology for monitoring services during the COVID-19 pandemic including on site and remote interviews by phone or online.

Before the inspection visit, we reviewed information that we held about the services and asked a number of other organisations for information.

During the specialist community mental health services for children and young people inspection, the inspection team:

- visited the South Gloucestershire, Bristol North and North Somerset specialist community mental health services for children and young people and looked at the quality of the environment
- ran four focus groups with 35 staff members including, team leaders, child and adolescent mental health safeguarding lead, nurses, primary mental health specialists, administrative staff, clinical psychologists, a doctor, psychotherapists, family therapist and consultant psychiatrists
- spoke with a further seven staff which included three nurse leads, an administrator and three managers
- conducted a review of three clinic rooms
- spoke to nine parents/carers and five young people
- reviewed 22 care records.
- reviewed three supervision records, three team meeting minutes and two appraisals.

During the wards for older people with mental health problems inspection, the inspection team:

Our findings

- visited seven wards across all five sites, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with seven patients who were using the service
- spoke with ten carers of patients who were using the service
- spoke with the managers or acting managers for each of the wards
- interviewed 34 staff including, consultant psychiatrists, nurses, healthcare assistants, psychologists, occupational therapists, activity coordinators, physiotherapists, and speech and language therapists
- reviewed 38 care records for patients on six of the seven wards visited
- reviewed 58 patient medication charts
- attended three ward activities including handover meetings, and patient activity groups, and completed a short observational framework for inspection (SOFI2) tool
- carried out a specific check of medication management and clinic rooms on all the wards.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

Children and young people said staff treated them well and behaved kindly.

In all the specialist community mental health services for children and young people teams we saw examples of positive feedback from young people who had received a service. Feedback from the participation groups was overall positive but two young people said they had to wait for a long time to get a service.

Carers we spoke with told us staff listened to them.

Carers and families from the wards for older people with mental health problems told us that they felt involved and informed by staff. Carers and families had been given opportunities to join care meetings virtually or in person and received regular updates from staff. Carers told us that staff were considerate of their specific needs during discharge planning and when organising family visits.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with nine legal requirements. This action related to two services.

Specialist community mental health services for children and young people

Our findings

The trust must ensure that risk assessments are updated when young people's risk changes. (Regulation 12) (2)(a)

The trust must ensure that waiting lists for young people and staff caseloads are monitored and reduced. (Regulation 12)

The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced people to meet the care and treatment needs of the young people. (Regulation 18 (1))

The trust must ensure that premises are safe, clean, well equipped, well furnished, well maintained and fit for purpose. (Regulation 15(1)(a))

Wards for older people with mental health problems

The trust must ensure actions are identified and implemented to mitigate environmental risks on all wards, including ligature and blindspot risks. (Regulations 12(2)(a);12(2)(b);12(2)(d))

The trust must ensure that patient risk management plans are individualised, consider environmental risks, and updated following identification of new or changing risks. (Regulations 12(2)(b))

The trust must ensure that ward 4 staff develop individualised care plans to manage risk of self neglect and evidence consideration of least restrictive options. Use of restraint during personal care must be proportionate and necessary to manage the risks to the patient. (Regulations 13(4)(b))

The trust must ensure that all staff treat patients with dignity and respect, when interacting with them and entering their personal areas, such as bedrooms. (Regulations 10(1))

Action the trust SHOULD take to improve:

Specialist community mental health services for children and young people

The trust should ensure that all young people receive a copy of an up-to-date care plan and crisis plan.

The trust should ensure that that all young people assessed as low risk receive a timely service and oversight of young people waiting for a service is reviewed in North Somerset.

The trust should ensure that staff report incidents of verbal violence on the incident reporting system to ensure the trust has clear oversight.

Wards for older people with mental health problems

Ward staff should ensure that clinic equipment on Amblescroft South ward is cleaned, maintained and calibrated in line with trust policy.

The trust should ensure that there is enough consultant cover to ensure patients on Amblescroft North and South wards can always be seen by a consultant as needed.

Our findings

Ward staff should ensure that action is taken and documented in response to clinic room and medicines fridge temperatures being out of range.

The trust should ensure that all wards have adequate and suitable rooms to enable de-escalation of distressed patients outside of their bedroom.

Prescribing staff should ensure as required medication is prescribed in line with the trust policy, and different routes of administration are written separately.

Ward staff on Amblescroft North and South should ensure that physical health care plans for diabetes are comprehensive, up to date and implemented.

The trust should ensure all wards are using outcome measures and ratings scales consistently across the service.

The trust should ensure that staff on ward 4 have an understanding of the Mental Capacity Act and can apply this at an appropriate level for their role.

The trust should ensure that ward managers are aware of up to date clinical governance systems and processes and utilise these consistently across the service.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

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

Leadership

The trust board and senior leadership team had the appropriate range of skills, knowledge and experience to perform their roles. The trust board consisted of the chair and vice chair, chief executive, seven non-executive directors (NEDs) and five executive directors. The trust were in the process of recruiting a full time dedicated deputy chief executive, a director of transformation and a director of estates to join the executive team. The non-executive directors had the appropriate range of skills, knowledge and a wide range of NHS, corporate and service user experience.

The board had clear areas of responsibility and accountability. Board members including non-executive directors chaired specific committees or were leads on specific areas of work. The NEDs sat on each other's committees. Emerging themes could be identified and discussed in each of the committees in the regular meetings that took place between the NEDs and executive team.

Our findings

The trust board and senior leadership team displayed integrity in carrying out their roles. The trust executives and non-executive directors were professional and demonstrated a high level of commitment to ensuring people who used services and their families received the best care and treatment possible. Board members challenged each other professionally and openly. We observed this when we attended the board meeting prior to the inspection. We also noted good challenge at committees sitting below board level.

Fit and Proper Person checks were in place. The trust had an appropriate process for carrying out their duties in respect of the Fit and Proper Person Regulation. Files were compliant and there was an annual check and update process in place.

The trust leadership team had a comprehensive knowledge of current priorities and challenges, and actions were identified to address them. The trust board demonstrated awareness of the priorities and challenges facing the trust and how these were being addressed. Action plans were in place to address these, but actions didn't always happen as quickly as board members would have liked. However, the trust leadership had demonstrated an ability to adapt at a fast-changing pace during the COVID-19 pandemic. The trust quickly established a Clinical Leadership Oversight Group (CLOG), that met daily to review and authorise any clinical operational, policy, practice or procedural changes required.

There was a programme of board visits to services. All executives and non executive directors were linked to locality areas which they would visit. While this had paused during the pandemic, virtual visits had still taken place, and plans were in place to restart the visits shortly.

Most staff we spoke with during the core service inspections told us that team or ward managers and matrons were visible and supportive. However, staff did not always feel that senior leaders outside of the locality were approachable or had a good understanding of the services and staff experiences. Some staff also felt that senior leaders had not been visible, open or transparent during the Covid 19 pandemic which impacted on their experience of being at work.

The trust reviewed leadership capacity and capability on an ongoing basis. Leadership development opportunities were available, including opportunities for staff below team manager level. As part of their management development plan, the trust established a leadership forum, providing the cohort with leadership skills development. The trust also commissioned an independent healthcare consultant facilitated leadership programme to support leaders to achieve their potential through coaching and personal development programmes.

Succession planning was in place throughout the trust. The trust management development plan was a key part of this succession planning. Work took place within teams to identify the higher performing staff with ability and potential to progress within the organisation. This fed into succession planning for key roles within the trust as leaders were supported to plot staff performance against leadership models.

The recent recruitment to senior pharmacy roles helped the chief pharmacist to work in a leadership role, rather than operationally.

Vision and strategy

The trust had a clear vision and set of values with quality and sustainability as priorities.

The trust vision was to "improve the lives of people [we] serve". The mission statement was to provide "..high quality, compassionate care to people living with mental ill health, autism and learning disabilities as the provider of choice for our patients, carers, staff and partners".

Our findings

The trust had a set of values underpinning its work. These were:

- Passion (doing the best, all of the time)
- Respect (listening, understanding and valuing what you tell us)
- Integrity (being open, honest, straightforward and reliable)
- Diversity (relating to everyone as an individual)
- Excellence (striving to provide the highest quality support). …..

The trust's strategic aims were to provide "outstanding care" with "outstanding people" providing "sustainable services" "delivered in partnership".

The trust was drafting an updated strategy for meeting the physical healthcare needs of patients. An external review of physical healthcare commissioned by the trust had highlighted a number of areas for concern and recommendations for improvement in meeting physical health care needs. Physical health was included on the trust risk register, and highlighted as a priority focus for 2021/22. Following a full physical health review that took place in June 2021, the trust established a position statement and action plans to improve the provision of physical healthcare within the trust.

The trust had a five year strategy in place (from 2017-2022) to support with developing good quality, sustainable care. The three key priorities within this strategy related to supporting service users, engaging staff and being sustainable.

The trust's current priorities were all underpinned by the strategy, which set out the ambition to provide high quality services accommodating local and national drivers for improvement and collaboration. The priorities for 2021/22 are developing clinical pathways, delivering packages of care and discharge packages based on evidence based interventions, physical healthcare, sustain regulatory compliance and implement electronic prescribing (ePMA).

Leaders we spoke with were well cited on the ambitions of the strategy and were committed to refocusing and aligning this to both local and national priorities. Leaders felt they were in a solid place to take the strategy to the next level, with a clear focus on developing clinical structures and moving towards a more sustainable future.

The trust did not have an established infection prevention and control (IPC) strategy, but had developed a workplan and an IPC specific board assurance framework as a result of the work during the pandemic.

The trust strategy was not supported by a long-term financial plan and indications were that this was some way off in the context of significant changes to the national financial architecture. The trust were unable to credibly evidence that the trust strategy was affordable or financially sustainable.

The trust did not have a six facet survey or site master plan or a developed estates strategy, despite having identified estates as a key issue. Risks in the estate were identified through service issues. Having identified this as an issue the trust was in the process of recruiting a director of estates to join the executive team.

The pharmacy department had a three-year medicines optimisation objective plan. However, progress towards these objectives and service development had been delayed. This was in part due to pharmacy staff retention and difficulty in recruiting to specialist mental health roles although recent recruitment was going some way to addressing this.

Our findings

Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services. Staff working groups and workshops took place alongside trustwide briefings, staff surveys and meetings. However, not all staff we spoke with as part of the core services inspection felt involved in the strategy and how this impacted on them, and felt that things were being done to them, rather than with them.

Staff knew and understood the trust's vision, values and strategy and how achievement of these applied to the work of their team. The trust embedded its vision, values and strategy in corporate information received by staff. The trust's vision and values were generally well understood by staff and displayed throughout the trust and on the trust's website, emails and intranet pages. Values were largely embedded in the core services we inspected and staff understood how they related to their area of work.

The trust aligned its strategy to local plans in the wider health and social care economy. This included active involvement in sustainability and transformation plans. The leadership team regularly monitored and reviewed progress on delivering the strategy and local plans.

The trust were proactively working with other providers to facilitate the strategic development of mental health services within the Integrated Care Systems (ICS) both locally and nationally. The trust was actively involved across a wide range of workstreams and in ensuring that mental health services achieved a parity of esteem and equity in resources. The trust board regularly discussed joint working with the ICS, and acknowledged the challenges of working across two separate systems.

Culture

Staff increasingly felt respected, supported and valued, but there was further work to be done.

The most recent NHS staff survey (2020) had a response rate of 45% within the trust. This was slightly below the average response rate of 52% for other organisations, and had decreased since the previous year. The trust scored comparatively with other similar providers in 34 questions in the survey, scoring significantly better than the average in two questions and significantly worse in 42 questions.

The trust identified key areas to continue to work on following the 2020 survey. These included improving communication between managers and staff, line managers giving feedback on work, reducing bullying and harassment from service users and the public, and improving the rate of response in the next survey.

One of the key areas of improvement identified was the trust taking positive action on health and wellbeing. The trust had put a number of measures in place to address this. These measures (including all staff being given an additional day off as a thank you for their work) saw an 8% improvement in this measure within the survey.

In the early stages of the pandemic, the chief executive started regular staff briefings, which were well received from staff. There were plans for these briefings to continue.

Board members acknowledged that, while the trust felt like a more positive place to work, there was still a lot of work to be done. We heard about a variation across the regions in terms of the visibility and apparent transparency of leadership, and a disconnect between front line staff, middle managers and executives. This impacted on the experience of staff working within these areas.

Our findings

The trust's strategy, vision and values underpinned a culture which was patient centred. A clear person centred approach was evident throughout the well led inspection.

Staff felt increasingly positive and proud about working for the trust and their team. The staff survey identified that 58% of staff (7% increase on the previous year) would recommend the trust as a place to work. Staff demonstrated a passion for delivering high quality patient care and put patients at the centre of everything they did. However, morale among some staff groups was low. While staff increasingly reported feeling valued, this was not the case in all areas. Some staff had less positive experiences working for the trust in terms of their working arrangements, access to flexible working, and the environments they worked in.

Pharmacy staff felt that issues raised in the staff survey had been acknowledged and a proactive effort was in place to understand staff concerns. This was helped by recent recruitment of senior pharmacy leaders to support the chief pharmacist.

The trust recognised staff success by staff awards and through feedback. The trust held an annual staff awards event to recognise and acknowledge achievements. This was held virtually for the first time during the pandemic, enabling a greater attendance. Staff received praise and compliment feedback from patients and carers at team business meetings.

The trust worked appropriately with trade unions. The trust recently supported the creation of a full time chair role for the Joint Union Council to enhance employee relations and engagement. The full time representative met bi-monthly with executives, as well as attending meetings relating to the caring domain, workforce development and leadership forum. We heard how things are slowly improving, the trust is being challenged and is becoming more inclusive.

Managers addressed poor staff performance where needed. The trust had policies and procedures in place for managing staff capability and performance concerns. The trust had developed a disciplinary decision tree and had recently employed independent investigators for disciplinary proceedings, although had not involved staff side representatives in interviewing or training for these posts.

The trust had appointed a Freedom To Speak Up Guardian and provided them with resources and support to help staff to raise concerns. Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian.

The trust appointed its first full time dedicated Freedom to Speak Up Guardian (FTSUG) in June 2020. The role was promoted to staff through induction, an internal advertising campaign, a dedicated intranet page, and the recruitment of over 50 freedom to speak up champions. The FTSUG attended locality meetings, wards and community teams, and quality and standards meetings, focusing on areas with known hotpots. The FTSUG reported to the director of nursing, provided a six weekly report to the safe committee, and a six monthly board report.

The FTSUG received 90 concerns from July 2020 until Dec 2020 (following their appointment full time to the role), in comparison to 21 cases in the same period the previous year. Bullying and harassment were the main category of concerns raised, followed by staff relationships.

The trust did not have a FTSU strategy in place. A strategy was being drafted during early 2021, but was put on hold awaiting the launch of a national strategy from the National Guardian's Office, which the trust will adhere to.

Our findings

The handling of concerns raised by staff met with best practice. The Freedom to Speak Up Guardian, staff side representatives and the Guardian for Safe Working Hours worked closely with the Director of Human Resources to ensure concerns were handled appropriately.

Staff did not always feel able to raise concerns without fear of retribution. However, this was an improving picture, and something the trust continued to work on.

The trust applied Duty of Candour appropriately but not always in a timely way. Duty of Candour was being applied across the trust and guidance was in place. The trust had identified five aspects to the process (verbal apology and offer to discuss with family, a record of the discussion in patient notes, formal summary letter and written apology, involving the patient/ family in the investigation and sharing the findings). Having tracked all five stages, they were able to identify that these were not always met in a timely way. Board papers showed that trust targets had only been met in 70% of cases in February 2021. This had improved to 80% in June 2021. The learning from experience group had identified timescales and capacity as the main themes impacting on compliance. The trust was arranging additional training to support clinical teams.

The trust took appropriate learning and took action as a result of concerns raised. We saw examples of responses to complaints that demonstrated action taken and learning. The trust had also demonstrated learning from concerns raised into services, applied to improvement projects including the Daisy Unit and Dune Ward. However, it was not evident that this learning was being applied across the trust.

Staff had the opportunity to discuss their learning and career development needs at appraisal. This included agency and locum staff and volunteers. Most staff we spoke with as part of the core services inspection experienced an emphasis on training and personal development opportunities.

Staff had access to support for their own physical and emotional health needs through occupational health. A range of support was available to staff and was described as clear and really accessible. Trust wide briefing calls and regular bulletins meant staff felt informed during lockdown periods when they were working remotely.

Sickness and absence figures were not outliers. Overall staff sickness absence in the financial year 2020/21 was 4.5%,a reduction from the 2019/20 figure of 4.9%.

The trustwide vacancy rate was 16%. Staff turnover rates for 2020/21 were 13%, a reduction from 17% in 2019/20. The trust had undertaken significant recruitment activity in the 12 months before the inspection. The trust had continued to develop strategic workforce plans as part of business planning and was prioritising recruitment.

Staff attendance at statutory and mandatory training at 91% (above the trust target), although some directorates had not met the target.

All staff had the opportunity to discuss their learning and career development needs at an annual appraisal. The trust appraisal rate had improved to 86%. The target was previously 95%, but this had been amended to 90% to offer a more realistic rate, in alignment with the turnover rate.

As of 2020/21 performance the trust target for supervision was 85%. The compliance rate was 77%. Supervision had been identified as a key area of focus and plans were in place to improve compliance. It was expected that these rates would improve in line with a reduction in operational disruption as a result of the pandemic. During the core service inspections staff we spoke with told us they had regular supervision.

Our findings

Pharmacy staff had regular 1:1s, clinical and management supervision. Daily huddles allowed local issues to be discussed.

Staff networks were in place promoting the diversity of staff. The equality framework was developed within the last 18 months, based on staff feedback following focus groups. As part of the trust's work around equality, diversity and inclusion there were a number of established staff networks, including those for race, disability, gender and LGBTQ+. These networks focused on the promotion of diversity in the workplace. They were used as a safe space for peer engagement and support as well as a forum for providing feedback to the trust senior leadership on areas and opportunities for improvement.

The Equality, Diversity and Inclusion (EDI) group reported to the caring domain group, who fed back to the board. The group met monthly and was tasked with tackling EDI issues identified across the trust and driving positive change. Issues were identified through the annual NHS Staff Survey, Workforce Disability Equality Standards (WDES), Workforce Race Equality Standard (WRES), gender pay gap reports and feedback provided from each of the trust's 13 peer support networks. The board chair was the sponsor for equality, diversity and inclusion.

The trust produced an annual Equality, Diversity and Inclusion (EDI) annual report in 2020 and had an EDI strategy in place for 2020-2024. This formed part of the wider workforce strategy. A board seminar was delivered in May 2021 with a focus on integrating EDI into strategic decision making.

Workforce Race Equality Standard (WRES).

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. To comply with the WRES, trusts have to show progress against nine measures of race equality in the workforce.

The percentage of black and minority ethnic (BAME) representation amongst staff increased slightly from 11.9% in 2020 to 12.1% in 2021. In comparison to the overall BAME working age population of 8.6% in the trust area of coverage, the trust had a better representation. There were more BAME staff in non clinical roles than in the previous reporting year. Overall there had been a decrease in BAME staff in lower pay bandings, and increases in middle and higher pay bandings. There were more BAME staff in clinical roles than in the previous reporting year. Overall, there was an increase of BAME staff in lower clinical pay bandings, and decrease in middle and higher pay bandings. The higher up the bandings, the greater percentage differential between white and BAME staff in both clinical and non clinical roles.

Following analysis of the WRES data, the trust identified a number of actions. These included addressing the disproportionate impact of disciplinary processes on BAME staff, to establish and launch a trustwide BAME staff network, audit the application of the Bullying and Harassment Policy and reporting of discrimination through trust processes and review approaches for recruitment of staff with protected characteristics.

Workforce Disability Equality Standard (WDES)

The trust had measured itself against the WDES standards. The WDES is a set of standards that aims to improve the experiences of disabled staff in the NHS. From April 2019, all NHS trusts had to measure themselves against ten data standards.

Our findings

The trust had published its WDES data report. This showed that 5.9% of trust staff had a declared disability (a reduction from 7.3% in the previous year). 49% of disabled staff believed that the trust provides equal opportunities for career progression (as opposed to 50% in the previous year). 78% of disabled staff said that their employer has made adequate adjustment(s) to enable them to carry out their work (a reduction of 1% from the previous year).

Staff with a disability were 6% more likely to experience bullying, harassment and abuse from service users and members of the public than non-disabled staff, 9% more likely to experience harassment, bullying or abuse from managers and 8% more likely from colleagues. The trust highlighted the importance of promoting the Prevention of Bullying and Harassment Policy and Freedom to Speak Up as channels for reporting abuse in response to these concerns.

Governance

Financial Governance

The trust has a clear vision and mission; however, the trust strategy is out of date and a number of key enabling strategies were not evident (Estates and Digital). The trust long-term financial plan is understood by the trust but has not been captured in an up-to-date financial strategy. The developing long-term financial plan varies significantly from the Financial Recovery Plan of 2019, and the underlying financial position of the trust has deteriorated. As such, it is not currently possible to conclude that the trust strategy is financially sustainable.

The trust's productivity and efficiency plans are developing but remain high-level and are not supported by robust plans to deliver or detailed and evidenced indicators of delivery.

The trust demonstrates a clear commitment to high quality care. The trust's reporting is transparent and effective and presents a clear picture of the current position of the trust. Reporting and management of infrastructure risks is less well developed and thus the quality of the trust infrastructure and the associated risks are less transparent.

The trust's systems of accountability are developing. Although responsibilities are clear, the development of clear actions that are specific, measurable, actionable and time constrained are less well developed and the trust recognises the need for improvement in this area.

The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. Leaders regularly reviewed these structures.

The trust brought in an external consultant as a quality advisor to the board to review their governance structure having identified issues around structure, use of information, and locality and divisional ownership. As a result of this review, the governance framework was reframed around the Care Quality Commission domains of safe, effective, caring, responsive and well led.

The five domain subgroups fed into the executive team and clinical directors. Executive leads took a lead on the domains, within the new structure designed to strengthen reporting arrangements and provide assurance to the trust board. Quarterly progress reports on the effectiveness of these changes were considered at committee level, providing a detailed overview of the embeddedness of the structures, and giving a clear steer on the next steps required for the trust improvement journey.

Our findings

The board was supported by six sub-committees (Nomination and Remuneration, Audit and Risk, Charitable Funds, Finance and Planning, Quality and Standards, Delivery and Mental Health Act Legislation). There were three operational divisions in the trust (West, East and the Specialised, Secure & CAMHS division). Each division was managed by a clinical director and an associate director of operations. Each locality or specialised service had an operational manager and a clinical lead.

Papers for board meetings and other committees were of a reasonable standard and contained appropriate information. The trust board met at least ten times per year. The papers for the board had a clear agenda with some standing items. Papers that fed into the board were detailed and to a high standard. They demonstrated discussion at committees was robust and escalated when appropriate. The board discussed board assurance, quality, safety, workforce delivery, strategy and transformation, finance and commissioning. There was an appropriate level of challenge and healthy discussion during the board meeting.

Non-executive and executive directors were clear and well cited about their areas of responsibility. They chaired board sub-committees and had executive leads with defined areas of responsibility. They worked to ensure there was an appropriate level of communication between the sub-committees and the trust board. There were clear lines of accountability and governance arrangements in place to provide assurance from service level to board level.

Appropriate governance arrangements were in place in relation to Mental Health Act administration and compliance. The Mental Health Act legislation committee had only been in place for approximately six months. Before this was in place, there was a Mental Health Act working group which used to report to the Quality and Standards committee. The additional committee was established to allow increased focus on the Mental Health Act.

The governance framework addressed the need to meet people's physical health care needs. The medical director had overarching responsibility for physical health care.

A clear framework set out the structure of ward/service team, division and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to take action as needed. Each ward and team manager had access to a range of information containing essential performance information for their team. This helped inform the management of their service.

The trust had established medicines governance groups. These groups provided reports to the Medicines Optimisation Group (MOG) which reported key issues to the trust effective sub-group. MOG was responsible for ensuring the safe, effective, efficient and cost-effective use of medicines within the trust and was attended by localities and specialities to ensure appropriate clinical representation. Medical and nursing representation on medicines governance groups was improving, having been difficult during the pandemic period, where they struggled to be quorate.

Complaints and compliments.

The complaints team received 246 complaints in 2020/21, a reduction from 277 complaints in the previous year. During 2020/21 95% of complaints were acknowledged within three days. Trust compliance with the internal target of complaint response timescales was consistently over 80%. The trust had set up action plans to address the three most frequent complaints issues.

The trust had received 723 compliments in 2020/21. Local teams received compliments via phone calls, letters and postcards.

Our findings

Management of risk, issues and performance

The trust had been unable to achieve financial targets in recent years.

There was evidence that the finance function of the trust was considered integral and strategy decisions were multi-disciplinary. There was evidence the trust understood the risks and current challenges to its financial position and was taking a proactive approach and actions to mitigate and address them. The board meeting we attended and review of recent board meeting minutes identified that finances were discussed regularly.

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. The governance team regularly reviewed the systems. Risks were identified, assessed and managed at all levels of the organisation. The risk management process in place set out the key responsibilities and accountabilities to ensure that risk was identified, evaluated and controlled. Risks were escalated as necessary.

The board assurance framework (BAF) highlighted the need to embed learning from incidents to improve clinical care. Our review of a range of incidents, mortality reviews and safeguarding reports identified a number of recurrent themes around recording and risk assessments, suggesting that, while lessons were learnt and improvements made, these improvements were at times localised, and not shared out amongst the wider organisation.

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance. Risk management group meetings were scheduled to provide a rolling programme of risk management review, as well as reviewing the risk register in the audit and risk committee.

Leaders were generally satisfied that clinical and internal audits were sufficient to provide assurance. Teams acted on results where needed. The trust internal auditors confirmed that the trust had an effective framework for risk management, governance and internal control. Work had identified further enhancements to the framework of risk management, governance and internal control to ensure that it remained adequate and effective. The trust audit committee monitored and provided assurances to the board. Not all board members felt that significant risks were fully visible to the committee and board, although this was an improving picture.

Staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed. Services maintained their own risk register which was submitted to the trust's electronic risk management system. Staff had access to the risk register and were able to effectively escalate concerns as needed.

Staff concerns matched those on the risk register. Risk registers reflected the risks staff in local teams identified during their team meetings.

Robust arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. Recorded risks were aligned with what staff said were on their 'worry list'. The corporate risk register and board assurance framework (BAF) aligned and confirmed the BAF reflected the trust's most significant and strategic risks. Risks were aligned with strategic priorities.

Our findings

The BAF was used to provide assurance to the board that there was a system of internal control in place to manage key risks. The BAF was comprehensive, with clear governance arrangements around it. It was reviewed at board meetings, discussed in sub-board committees and updated following board seminars. Each risk within the BAF was allocated to a board sub-committee which regularly reviewed those risks. The allocated lead executive was responsible for oversight of the risk.

Board members spoke about finance, learning from incidents and workforce as key risks, in addition to bed capacity (resulting in out of area placements). The highest scoring risk on the board assurance framework related to learning from incidents and embedding improvements. It was acknowledged that the wide geographical spread and number of teams within the trust increased that challenge.

Responsibility for medicines safety and incident investigation was picked up by the chief and deputy chief pharmacists. Not having a dedicated person to fill this role was on the trust risk register as a risk to patient safety.

The trust board had sight of the most significant risks and mitigating actions were clear. The trust risk management group met on a monthly basis to review all risks. Subject matter experts were invited to participate in the group and support with recommendations for actions to be taken. The group fed back to the board.

There were plans in place for emergencies and other unexpected or expected events. For example, adverse weather, a flu outbreak or a disruption to business continuity. The trust completed an annual emergency preparedness, resilience and response (EPPR) annual report, including an EPPR strategy and risk register. The trust was 98% compliant with the EPPR standards assurance, an increase from 85% in the previous year. The trust had demonstrated their ability to respond to emergencies and unexpected events during the pandemic.

Where cost improvements were taking place there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability. Board members were confident that decisions made within the trust were done so with a clear focus on patient safety and quality. They expressed confidence in the chief executive and director of finance to ensure that finances were not prioritised over quality and safety.

Board members acknowledged that the trust was in a difficult position financially, alongside a number of system issues in terms of the infrastructure, challenges with the estates, and a low bed base. However, they expressed confidence that these issues were well understood within the trust, and that where investment was needed to improve the quality of services, this was supported.

There was an acknowledgement that the issues with the trust estates had not been resolved, despite being aware of risks and priorities in relation to estates and this being considered a high priority. While work was ongoing to address estates, issues raised in previous inspection reports had not all been addressed. The core service inspection confirmed that patients on ward 4 (St Martins Hospital) were still in dormitory accommodation, although the ward did move to an alternative site shortly after the inspection.

Information management

Our findings

The board received holistic information on service quality and sustainability. The board and senior staff expressed confidence in the quality of the data. Board members were confident in the core data provided and that metrics were in place to underpin each of the domains, although acknowledged that some key performance indicators were incomplete. There was less confidence in the delivery of outcomes related to the data. Board members challenged the data provided and were assured that this was followed up.

The trust was aware of its performance through the use of key performance indicators (KPIs) and other metrics. This data fed into a board assurance framework. The trust routinely published key metrics (such as safer staffing details) on their website. Key performance indicators were routinely monitored, with routine reporting in place to enable the trust to quickly identify services that are potentially at risk or under stress. Discrepancies within the metrics helped to highlight any of these potential issues. The trust held performance meetings with the Clinical Commissioning Groups.

Following a quality improvement project within one of the older adults wards, an early warning dashboard was put in place to support the identification and increase the visibility of concerns through close monitoring of workforce, incidents and metrics. The early warning dashboard was updated daily, and all data reviewed by a monitoring group on a weekly basis. The system has in built alerts place to highlight specific concerns. If specific concerns are raised, an email is sent to senior staff and executives to notify them. The dashboard had proven useful in picking up issues within the primary care liaison service in terms of access to the service.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. **Information was in an accessible format, timely, accurate and identified areas for improvement.** Much of the information produced (such as board reports and reports to commissioners) was of a historical nature. The trust had access to operational management tools that provided team leaders with daily refreshed data related to their team, such as waiting list and time management data, as well as inputting of data (such as risk assessments). There were a small number of reports that were refreshed in real time, including live data in relation to bed management reports. Team managers had access to the early warning dashboard data to highlight any issues within their teams.

Systems were in place to collect data from wards/service teams and this was not over burdensome for front line staff. We heard that data systems were not always efficient, and information was sometimes difficult to locate or drill down to access details. Some improvements had been made to the system, including provision of a physical health dashboard and the early warning dashboard.

Implementation of electronic prescribing and recording of medicines administration was a top priority within the trust. The chief pharmacist was working across the two integrated care systems to develop system wide medicines information.

IT systems and telephones did not always work well, potentially impacting on the quality of care. Difficulties with IT meant that wards or teams were sometimes unable to scan requests to pharmacy. This led to delays in providing medicines to patients and pressure on pharmacy staff, which could increase the risk of error. This was included on the trust risk register and mitigated by development of templates that could be used during downtime.

The trust had invested in a range of mobile equipment for staff including implementing a new telephone system based around increased remote working during the pandemic.

Our findings

Staff had access to the IT equipment and systems needed to do their work. The trust had rolled out the issue of laptops for staff during the pandemic to enable more staff to work remotely. In addition, they had implemented the use of Attend Anywhere (a remote appointment system to enable patients to continue to attend appointments during the pandemic).

Leaders submitted notifications to external bodies as required.

The trust had completed the Information Governance Toolkit assessment. An independent team had audited it and the trust took action where needed.

Information governance systems were in place including confidentiality of patient records.

The trust had guidance and processes in place to support information management. There were clear governance arrangements for information management and confidentiality.

The trust's existing digital strategy expired during the pandemic. A decision was made at committee level to delay the updating of the strategy in line with the trust and clinical strategy, which was still in development. Pending the updated strategy development, the trust produced a digital principles document that is being applied to current digital projects.

The trust learned from data security breaches. The Data Security and Protection Toolkit (DSP) is the new set of NHS standards for information governance and cyber security. It draws together the legal requirements, central guidance set out by NHS policy and best practice, presenting them in a single standards process to improve the handling and protection of IT systems and information held by NHS providers. The trust was on track to achieve compliance with the current standards and no significant issues had been identified. In 2020/21 there were 420 information governance incidents reported, of those three met the criteria to be reported to the Information Commissioner's Office, but with no further actions identified in addition to action already taken by the trust.

Engagement

The trust did not appear to have a clear strategic, structured and systematic approach to engaging people who use services, those close to them and their representatives. There were some examples of positive engagement. Each public board meeting included a patient story. The trust had appointed patients and carers to be part of the Experts by Experience programme, and had also appointed a number of people to be part of the Strategic Experts by Experience Group (SEG) meetings, reporting directly to the director of nursing and quality. The Strategic Experts by Experience group had opportunities to speak with executives to discuss organisational plans and coproduction. Senior managers invited the group to their meetings, as well as their involvement in transformation work, ligature reduction and risk assessment training. However, there were only a limited number of people within the group, and not all managers were as sighted on their potential involvement, so this was not a consistent approach, and only a small number of groups had the involvement of the strategic experts by experience.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used. Staff had access to weekly online briefings that had started during the pandemic and were continuing, as well as ongoing information on the internet for staff, patients and carers.

Patients, carers and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The trust acknowledged that there was still work to do to ensure patient and carer

voices were heard. The trust's response rate for the Friends and Family test for feedback had remained low since restarting in December 2020. In December 2019 there was around a 13% response rate and this decreased since then to a 2.9% response rate. The trust have worked on improving the responses, including different methods of data collection, such as text messaging.

The trust participated in the Annual Community Mental Health Survey commissioned by the Care Quality Commission. The survey was undertaken between February and June 2020, with a response rate of 29%. The trust were in the top 20% for three questions. The survey identified areas for improvement, in particular there was a reduction in the number of people who responded to say that they were given enough time to discuss their needs and treatment and that other areas of the patient's life were taken into account alongside their care needs. The trust were in the lowest 20% for five out of 37 questions.

The trust sought to actively engage with people and staff in a range of equality groups. They had recently appointed a dedicated member of staff two days per week to support staff from a black and minority ethnic (BAME) background.

The trust did not appear to have a structured and systematic approach to staff engagement. Staff did not always feel involved in decision making about changes to the trust services. We heard that executives generally worked well in terms of staff engagement. However, there were some issues in terms of some senior managers who were less engaged with staff and staff representatives. Some staff felt that things were done to them, rather than with them. Staff on some of the wards during the core service inspections did not feel listened to or involved in the development of the future vision and strategy for their wards.

Patients, staff and carers were able to meet with members of the trust's leadership team to give feedback. We heard examples of patients and carers giving feedback to board meetings, formal engagement meetings with staff side representatives, and feedback gathered from staff during consultation processes and fed back to senior leaders.

Division leaders/middle managers, on behalf of front line staff, engaged with external stakeholders such as commissioners and Healthwatch. However, the trust acknowledged that the pandemic had reduced the number of formal engagement events with stakeholders from those of previous years.

The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans. The trust was pro-actively engaged with the wider health economy and system locally. Senior leaders acknowledged the challenge of working across two Integrated Care Systems (ICS), and the commitment required and challenges brought by this. The trust played an active role in the system, and senior leaders had key roles within the systems, including leading the implementation of the community health framework.

Learning, continuous improvement and innovation

The trust had a planned approach to take part in national audits and accreditation schemes and shared learning. During 2020/21, the trust participated in all four National Clinical Audits covering relevant services provided by the trust. During this period they participated in the National Audit of Inpatient Falls, National Audit of Psychosis, Prescribing Valproate and Use of Clozapine, with improvement actions identified to be taken as a result of these audits.

Our findings

NHS trusts can take part in accreditation schemes that recognise services' compliance with best practice standards. Accreditation usually lasts for a fixed time, after which the service must be reviewed. The Psychiatric Intensive Care Units (PICU) in Hazel and Elizabeth Casson House units had been awarded the Accreditation for Inpatient Mental Health Services (AIMS) from the Royal College of Psychiatrists.

The trust was actively participating in clinical research studies. In the financial year 2020/21 the trust recruited 2,053 service user, carer and staff participants into National Institute for Health Research (NIHR) research. This was across 42 studies (37 NIHR adopted studies and five student and non-NIHR research studies).

There were organisational systems to support improvement and innovation work. The trust started the Clinical Leadership Oversight Group (CLOG) which supported the rapid Quality Improvement process during the pandemic. The majority of the Quality Improvement team were redeployed during 2020/21 to support the management of the pandemic which understandably impacted on Quality Improvement work within the trust.

Staff had training in improvement methodologies and used standard tools and methods. The trust encouraged service development and innovation at both team and service level, and recently appointed an interim director of transformation. Due to the redeployment of a number of the quality improvement team during the pandemic, a number of the projects were paused. In March 2021, the trust established an internal dedicated QI tools page. These tools were developed as a training and guidance resource for staff to support them to use formal evidence based methodology in improvement activities.

Effective systems were in place to identify and learn from unanticipated deaths. Suspected suicide in the community was the most commonly reported serious untoward incident in the trust. The trust had a Suicide Prevention Strategy. Learning recommendations from serious untoward incident investigations had a specific, measurable, achievable, relevant, timely (SMART) action plan developed. The trust used an incident reporting database (Ulysses) to establish a greater level of understanding through data and linked this directly to reports related to the incident. This enabled the trust to identify a number of themes in relation to vulnerabilities, to be reflected in a Quality Improvement Plan. The trust additionally created a new quality governance structure including the Learning and Improvement Panel to support learning from serious incidents. Action plans were reviewed for completion and evidence of improvement was examined to ensure learning from experience is evidenced.

Staff had time and support to consider opportunities for improvements and innovation and this led to changes. The trustwide drive to increase the numbers of non-medical prescribers had allowed recruitment of two pharmacist prescribers. However, existing staff described how it was difficult to get approval to train to be an independent prescriber before having a confirmed prescribing job role.

External organisations had recognised the trust's improvement work. Individual staff and teams received awards for improvements made and shared learning. The trust Infection, Prevention and Control (IPC) lead nurse was given a nursing award for their work within the trust. The Daisy Unit (inpatient ward) received a highly commended in the category of Learning Disability Initiative of the Year at the Health Service Journal Patient Safety Awards, in recognition of the work carried out to reduce restrictive practices on the unit. The trust was also a finalist in the category of Patient Safety Collaborative Mental Health Initiative of the Year for its work to reduce restrictive practice on Bradley Brook, a medium secure ward at Fromeside. However, the trust had not as yet been able to demonstrate the application of this learning across the trust.

Our findings

Staff used data to drive improvement. The trust had introduced an early warning dashboard as part of their improvement work on one of the older adults wards. This enabled them to identify areas of concern using a series of data measures.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Nov 2021	Good →← Nov 2021	Good →← Nov 2021	Requires Improvement →← Nov 2021	Good ↑ Nov 2021	Requires Improvement →← Nov 2021

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Mental health	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
Overall trust	Requires Improvement ➔➔ Nov 2021	Good ➔➔ Nov 2021	Good ➔➔ Nov 2021	Requires Improvement ➔➔ Nov 2021	Good ↑ Nov 2021	Requires Improvement ➔➔ Nov 2021

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community-based mental health services of adults of working age	Requires improvement Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016
Mental health crisis services and health-based places of safety	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018
Community-based mental health services for older people	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement May 2020	Good May 2020	Good May 2020	Requires improvement May 2020	Good May 2020	Requires improvement May 2020
Wards for older people with mental health problems	Requires Improvement ↔ Nov 2021	Good ↔ Nov 2021	Requires Improvement ↓ Nov 2021	Good ↔ Nov 2021	Requires Improvement ↓ Nov 2021	Requires Improvement ↓ Nov 2021
Substance misuse services	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016	Outstanding Sep 2016	Good Sep 2016
Forensic inpatient or secure wards	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016
Long stay or rehabilitation mental health wards for working age adults	Requires improvement Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017
Community mental health services for people with a learning disability or autism	Requires improvement Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016
Child and adolescent mental health wards	Requires improvement Dec 2018	Requires improvement Dec 2018	Requires improvement Dec 2018	Requires improvement Dec 2018	Requires improvement Dec 2018	Requires improvement Dec 2018
Specialist community mental health services for children and young people	Requires Improvement ↓ Nov 2021	Good ↔ Nov 2021	Good ↔ Nov 2021	Requires Improvement ↓ Nov 2021	Good ↔ Nov 2021	Requires Improvement ↓ Nov 2021
Wards for people with a learning disability or autism	Good May 2020	Good May 2020	Good May 2020	Good May 2020	Good May 2020	Good May 2020
Overall	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement

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

Specialist community mental health services for children and young people

Requires Improvement

Is the service safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Safe and clean environments

Not all clinical premises where young people received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff did not complete and regularly update thorough risk assessments of all areas and remove or reduce any risks they identified. The range and availability of risk assessments was mixed across the three locations. For example, in South Gloucestershire they had a full, comprehensive range of risk assessments about the environment. These included ligature assessments, first-aid assessments, video screen assessments, slips trips and falls checklists, health and safety risk assessments, fire induction checklists and the fire compliance risk assessment.

In North Somerset there were no risk assessments in relation to the environment. The fire doors were wedged open. This was identified at inspection as a potential risk and was resolved immediately. The manager told us that the fire officer had agreed for the fire doors to be wedged open but there was no information to support this.

In North Somerset (COSHH) cleaning items were not locked away when in use and were left unattended. This was brought to the attention of senior staff and resolved during our visit. The Control of Substances Hazardous to Health (COSHH) Regulations 2002 is a law that requires employers to control substances that are hazardous to health. COSHH is a set of regulations put in place to protect workers from ill health when working with specific substances and materials.

In all locations the interview rooms had alarms and staff were available to respond quickly.

All clinic rooms had the necessary equipment for young people to have physical examinations. Apart from the eating disorder pathway, young people had only their height and weight monitored.

Not all areas were clean, well maintained, well-furnished and fit for purpose. Staff did not make sure cleaning records were up-to-date and the premises were clean. In North Somerset and North Bristol there were no cleaning schedules or records to provide reassurance the areas were being cleaned thoroughly. The art therapy room at North Somerset was dirty with dust gathering along surfaces and the skirting boards.

Staff did not always follow infection control guidelines apart from those in relation to handwashing. Staff did not make sure equipment was well maintained, clean and in working order. In North Bristol and North Somerset, there were no cleaning rotas for toys. Staff said they shared the cleaning of the toys, but there wasn't a specific team taking responsibility for the management of infection prevention and control. In North Somerset equipment in the art room was dirty.

Safe staffing

Specialist community mental health services for children and young people

The service did not have enough staff, who knew the young people and received basic training to keep them safe from avoidable harm in one of the teams. The number of young people on the caseload of the teams, and of individual members of staff, was too high to prevent staff from giving each young people the time they needed.

In the North Bristol and South Gloucestershire teams they had enough nursing and support staff to keep young people safe. There were few vacancies and they had sufficient staff to support comprehensive care and treatment for young people. For example, in the North team they had 92% staff with just two vacancies which were recruited to and were starting shortly.

However, in the North Somerset team there was a very different picture. Vacancy rates were high. There were eight vacancies which included a family therapist, a psychologist, a senior nurse, a senior psychologist and band seven nurse. The service had full complement of three band four workers.

The trust knew about the high numbers of vacancies and were working hard all to fill these posts. They had an active recruitment programme and offered a variety of incentives to encourage applicants.

The caseloads in North Somerset were also high. For example, staff in the learning disability team held caseloads in the region of 50% higher than their colleagues in Bristol. They had caseloads of around 33 which was between 10 and 20% higher than colleagues in other teams in the service. The manager said they knew these were high, but they were actively trying to reduce them by signposting and the implementation of the new strategy. They had achieved a reduction of around 10% since 2020.

Across the teams staff spoke more about the number of contacts with young people than caseloads. There was an expected target of holding 14 one hourly sessions a week with young people.

In South Gloucestershire the caseloads for non-medical prescribers for example was lower at between 15 and 20 young people. However, staff told us the complexity of the young people and the numbers of meetings and liaison with other agencies had increased.

Since the end of August 2020 there had been a 50% increase in caseload for staff in the eating disorders team in South Gloucestershire. This was mirrored in Bristol and North Somerset teams.

The service had low rates of bank, agency nurses and agency nursing assistants in the North Bristol and South Gloucestershire teams. But in North Somerset 65% of the staff team were agency staff.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had low staff turnover rates in the North Bristol and South Gloucestershire teams. Across the teams the average staff turnover was between five and 17.2% in the period from March 2020 to March 2021. In the North Somerset team staff turnover was high at around 53%. The manager said that staff turnover was in part due to career progression. But staff had also left because of the services new shift towards a non-specialist generic model of working.

Managers supported staff who needed time off for ill health.

Sickness levels were low in all locations. On average they were between 2% and 4% across the service although it fluctuated from month to month.

Specialist community mental health services for children and young people

Managers used a recognised tool to calculate safe staffing levels. In the North Bristol and South Gloucestershire teams the number and grade of staff matched the trust staffing plan. However, in North Somerset the current number of vacancies meant that the location did not have the number of staff in line with the establishment level set by the trust.

Medical staff

The service had enough medical staff in the North Bristol and South Gloucestershire teams. In North Somerset they had a locum psychiatrist and were in the process of recruiting additional psychologists.

Managers could use locums when they needed additional support or to cover staff sickness or absence.

In all locations managers made sure all locum staff had a full induction and understood the service.

In all locations staff and young people could get support from a psychiatrist quickly when they needed to.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. Staff members across the teams were up to date with the trust target of 90% compliance.

The mandatory training programme was comprehensive and met the needs of young people and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. In all locations managers were able to access information about staff training on their electronic recording systems.

Assessing and managing risk to young people and staff

Staff did not assess and manage risks to young people and themselves. They generally responded promptly to sudden deterioration in young people's health. When necessary, staff working in the mental health crisis teams mostly worked with young people and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Assessment of young people's risk

In both the North Bristol and South Gloucestershire teams staff completed risk assessments for each young person on admission using a recognised tool, and reviewed this regularly, including after any incident.

In North Somerset staff members did not assess and manage risk to young people. In four of the 10 files we reviewed risk assessments were not fully complete. For example, one young person had a risk assessment on file which was not theirs and belonged to an entirely different young person. In another file in the risk assessment the gender of the young person changed with no explanation. In two other files the assessed risk did not correspond to the risk identified in the narrative recorded by the clinician.

Specialist community mental health services for children and young people

Staff in South Gloucestershire and the North Bristol team could recognise when to develop and use crisis plans and advance decisions according to young people's needs. Crisis plans were available, where appropriate, in all young people's files across the North Bristol and South Gloucestershire teams that we reviewed. However, in two of the ten files seen in North Somerset a crisis plan to protect a young person assessed as potentially being at risk was not in place in a young person's file.

Management of young people's risk

Staff members in North Somerset had not responded to changing risks. In one file the young person had involvement from other agencies including the police. Their risk rating remained low and had not been updated to reflect the increased risk. In another file the young person's risk assessment had been reviewed but had not been updated to include increased risk of self-harm, despite involvement from other agencies including the police and social services.

Staff members in the other teams responded quickly to deterioration in young people's health for all groups of young people apart from those assessed as low risk.

Staff did not continually monitor young people on waiting lists for changes in their level of risk and responded when risk increased. The monitoring of risk was mixed across the teams. In South Gloucestershire teams recognised that they were not contacting young people routinely to ensure the risk had not increased, but there were systems like supervision in place to address this. In North Bristol young people assessed as low risk were not routinely monitored or offered a service. The staff team was aware there was no system in place to monitor the low risk young people and had put this on the agenda for the next staff away day.

In North Somerset there was very little monitoring of young people assessed as low risk. There were approximately 400 young people awaiting assessment whose risk was waiting to be assessed by the staff team. Although there was a new system starting two weeks after the inspection to address this.

Staff followed clear personal safety protocols, including for lone working.

Safeguarding

Staff understood how to protect young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role. Senior staff confirmed they had made several child sexual exploitation referrals which were becoming prominent within the locations especially in North Somerset and North Bristol.

Staff received child sexual exploitation training as part of their on-line safeguarding training.

Staff kept up to date with their safeguarding training. All community teams met or exceeded the trust targets in relation to safeguarding training.

Staff could give clear examples of how to protect young people from harassment and discrimination, including those with protected characteristics under the Equality Act.

Specialist community mental health services for children and young people

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Managers took part in serious case reviews and made changes based on the outcomes. Recent examples included changes in the way the service communicated with young people.

Staff access to essential information

Staff working for the child and adolescent community mental health teams kept detailed records of young peoples' care and treatment. Records were mostly clear, up-to-date and easily available to all staff providing care.

Young people's notes were comprehensive, and all staff could access them easily in the North Bristol and South Gloucestershire teams. Staff members in North Somerset working in the building had trouble in accessing files on the day of inspection due to the Wi-Fi not working. Staff members working at home said that access was easier but working in the office was often problematic.

When young people were transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on young people's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. None of the locations stored medicines. Responsibility for the young person in relation to administering and prescribing lay predominantly with young person's GP.

Staff reviewed young peoples' medicines regularly and provided specific advice to young people and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check young people had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so young people received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each young people's medication on their physical health according to NICE guidance.

Specialist community mental health services for children and young people

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed young people's safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave young people honest information and suitable support.

Staff mostly knew what incidents to report and how to report them. Staff members in all community teams visited knew what incidents they should report but were under reporting. On average, staff reported two incidents a month. Staff recognised they did not report the increasing number of incidents of verbal violence as incidents, so the trust did not have clear oversight of this.

Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave young people and families a full explanation if and when things went wrong.

Managers in all the community teams ensured staff were debriefed after any serious incident.

Managers investigated incidents thoroughly. Young people and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to young people's care. There was evidence that changes had been made as a result of feedback. For example, following the death of a young person after discharge from the service there was learning about better communication with young people prior to discharge. Managers now reviewed cases to ensure the voice of the child was heard at their initial assessment, ongoing and at discharge.

Is the service effective?

Good 

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

Assessment of needs and planning of care

Staff assessed the mental health needs of all young people. They worked with young people and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

Specialist community mental health services for children and young people

Staff completed a mental health assessment of each young person. We reviewed nine records and found care plans in all but two of the records. However, we found that while these two records did not include a care plan, they had a clear and concise safety plan and food management plan. The records identified goal-based outcomes which they had created with the young person and their families or carers. Goals and plans to achieve these were personalised and recovery oriented.

In North Somerset four of the five young people's files had a care plan. In South Gloucestershire four of the care files seen had a care plan but one plan was kept on the team's shared drive system and was not easily accessible to all staff.

Staff made sure that young people had a full physical health assessment and knew about any physical health problems. As previously stated, in the community teams the young person's GP retained responsibility for the young person's physical health.

Staff regularly reviewed and updated care plans when young peoples' needs changed.

Care plans were personalised, holistic and recovery orientated.

Best practice in treatment and care

Staff provided a range of treatment and care for young people based on national guidance and best practice. They ensured that young people had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the young people in the service.

Staff delivered care in line with best practice and national guidance from relevant bodies such as the National Institute for Health and Care Excellence. Staff provided a range of therapies and care that were suitable for the young people. These were recommended by, and delivered in line with NICE. These included risk management, psychological therapies, psychotherapy and family therapies. Staff could explain how they used the NICE guidance on eye movement desensitising and reprocessing (EMDR). EMDR is best known for treating post-traumatic stress disorder (PTSD) and it can also help with a range of mental health conditions in people of all ages.

The intensive behaviour support team provided treatment in line with NICE guidance NG11: Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges.

The service had professional leads for each professional staff group and for specific treatment pathways. Staff had a range of relevant skills including EMDR, cognitive behaviour therapy, art therapy and play therapy.

Staff made sure young people had support for their physical health needs, either from their GP or community services.

Staff supported young people to live healthier lives by supporting them to take part in programmes or giving advice.

Staff used recognised rating scales to assess and record the severity of young people's conditions and care and treatment outcomes. They used routine outcome measures such as the revised child anxiety and depression scale and the strengths and difficulties questionnaire. In the learning disability service they used the Sheffield questionnaire which looked at outcomes for children.

Specialist community mental health services for children and young people

Staff used technology to support young people. For example, during the lockdown staff members had creatively used technology to support young people who could not physically meet them.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. For example, in the North Bristol team there were case notes audits, audits of young people offered virtual follow-up following admission to hospital in the assertive outreach team, and audits about access to the service.

Managers used results from audits to make improvements. For example, they introduced a new crisis line for young people following findings from audits about young people's access to the service.

Skilled staff to deliver care

Some of the community child and adolescent mental health teams had access to the full range of specialists required to meet the needs of young people under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service did not consistently have access to a full range of specialists to meet the needs of the young people. For example, in the North Bristol and South Gloucestershire teams, they had a full range of specialists including consultant psychiatrists, family therapists, social workers, psychotherapists and primary infant mental health nurses. But the North Somerset service did not have access to a full range of specialists to meet the needs of the young people. This meant young people waited for specialist treatments.

The South Gloucestershire and the North Bristol team managers ensured staff had the right skills, qualifications and experience to meet the needs of the young people in their care, including bank and agency staff.

Managers in all teams gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. Across all the teams the appraisal rates were high and either met or exceeded the trust targets.

Managers supported permanent medical and non-medical staff to develop through yearly, constructive appraisals of their work and through regular, constructive clinical supervision of their work.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. In all the community teams there were regular team meetings which were minuted so staff members not able to attend on the day had access to the information.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role.

Managers recognised poor performance, could identify the reasons and dealt with these. In the teams visited there were no current performance issues. In North Somerset staff members provided us with information about an investigation into staff performance that had been resolved.

Multi-disciplinary and interagency team work

Specialist community mental health services for children and young people

Staff from different disciplines worked together as a team to benefit young people. They had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss young people and improve their care. Staff in all community teams held weekly regular multidisciplinary meetings to discuss young people and improve their care. Teams also held monthly business meetings for all staff.

Staff made sure they shared clear information about young people and any changes in their care, including during transfer of care.

Staff had effective working relationships with other teams in the organisation.

All teams demonstrated close and effective working relationships with teams within the organisation to ensure young people received a consistent and comprehensive package of care and treatment.

Staff had effective working relationships with external teams and organisations.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Young people had easy access to information about independent mental health advocacy.

Staff explained to each young people their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the young people's notes each time.

For young people subject to a Community Treatment Order, staff completed all statutory records correctly.

Care plans clearly identified young people subject to the Mental Health Act and identified the Section 117 aftercare services they needed.

Specialist community mental health services for children and young people

Staff informed us that young people under the Mental Health Act were assessed by the Approved Mental Health Professional (AMHP) who input the information onto a separate electronic system. There was no link within the records seen directing staff to this recording system which meant that staff may not have the most up to date or relevant information to provide support and advice.

Staff completed regular audits to make sure they applied the Mental Health Act correctly.

Good practice in applying the Mental Capacity Act

Staff supported young people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16. Staff assessed and recorded consent and capacity or competence clearly for young people who might have impaired mental capacity or competence.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access.

Staff knew where to get accurate advice on Mental Capacity Act.

Staff gave young people all possible support to make specific decisions for themselves before deciding a young people did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time young people needed to make an important decision.

When staff assessed young people as not having capacity to make a specific decision, they made decisions in the best interest of young people and considered the young people's wishes, feelings, culture and history.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary. Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Staff understood how to support children under 16 wishing to make their own decisions and applied the Gillick competency principles when necessary. In the South Gloucestershire team, the consultants had designed a bespoke training package to ensure staff were trained in Gillick competency principles.

Staff knew how to apply the Mental Capacity Act to young people aged 16 and 17 and where to get information and support on this.

Staff spoken with understood how to support children under 16 wishing to make their own decisions and applied the Gillick competency principles when necessary. However, none of the records seen identified recorded conversations with the young person to ensure they were able to make their own decisions and understood the implications of those decisions.

Specialist community mental health services for children and young people

Is the service caring?

Good 

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated young people with compassion and kindness. They understood the individual needs of young people and supported young people to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for young people.

Staff gave young people help, emotional support and advice when they needed it. We spoke with five young people across three locations who were receiving the service, and all said they were given emotional support when requested. Young people were particularly positive about their experiences with the eating disorders team.

Staff supported young people to understand and manage their own care treatment or condition.

Staff directed young people to other services and supported them to access those services if they needed help. For example, young people were signposted towards specialist counselling services and bereavement services.

Young people said staff treated them well and behaved kindly.

In all the locations we saw examples of positive feedback from young people who had received a service. Feedback from the participation groups was overall positive but two young people said they had to wait for a long time to get a service.

Staff understood and respected the individual needs of each young person.

Staff members in all locations said that they were confident they could raise concerns about any disrespectful, discriminatory or abusive behaviour or attitudes towards young people.

Staff followed policy to keep young people's information confidential. Staff members ensured they carried confidential information in locked bags. They had recently updated their systems about how they sent information to young people.

Involvement in care

Staff involved young people in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that young people had easy access to independent advocates. Staff informed and involved families and carers appropriately.

Involvement of young people

Specialist community mental health services for children and young people

Staff mostly involved young people and gave them access to their care plans. In the North Bristol and South Gloucestershire teams young people had access to their care plans. We found all records reviewed at South Gloucestershire identified that the young people, carer or relative had received a copy of their care plan. However, six of the ten files reviewed at North Somerset, had no evidence of care plans being shared or received by young people, families or carers.

Staff made sure young people understood their care and treatment and found ways to communicate with young people who had communication difficulties. For example, in the learning disability service young people routinely received information in an easy read format.

Staff involved young people in decisions about the service, when appropriate. For example, in the learning disability service young people were actively involved in the recruitment process. They were allocated a pre-set part of the interview and could assess applicants via an easy read scoring system.

Young people could give feedback on the service and their treatment and staff supported them to do this. Young people in North Somerset did not have the same access to giving feedback as young people in the rest of the service. Young people in the North Bristol team and the South Gloucestershire team worked closely with Barnardo's to develop the website for the service. They were currently putting together an entirely new website. Young people gave feedback on how the website was presented and its accessibility. In North Somerset the team had started to develop ideas for feedback. In the North Bristol team young people had asked for feedback boxes to be in all the treatment and interview rooms and this was implemented quickly by the staff team.

Staff made sure young people could access advocacy services. In all locations young people were given leaflets about advocacy services and accessed advocacy support.

Involvement of families and carers

Staff supported, informed and involved families or carers. They were encouraged to be involved in the service in the South Gloucestershire and North Bristol teams. In the North Somerset team, they were in the process of developing groups for parents to work alongside them in the care and treatment of young people.

Staff helped families to give feedback on the service by providing them the information to do so. Carers spoken with told us staff listened to them.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Requires Improvement 

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

Access and discharge

Specialist community mental health services for children and young people

The mental health crisis service was available 24-hours a day and was easy to access – including through a dedicated crisis telephone line. Staff did not always assess and treat young people promptly. Staff followed up young people who missed appointments.

The service had clear criteria to describe which young people they would offer services to and offered young people a place on waiting lists. For example, in North Bristol the manager for the learning disability team said that the criteria they used was moderate to severe learning disability and they kept tightly to this criteria.

Children and young people whose needs could not be met by the service were referred and signposted to the most appropriate service to support their individual needs.

The commissioners set target times but the service did not always meet the target times from referral to assessment and assessment to treatment. All three locations visited said there was an increase in referrals that was putting a strain on its ability to meet the trust target of 18 weeks for referral to treatment. Staff in North Somerset told us that their workload had increased and often saw young people that were increasingly more complex and unwell in their presentation. Staff felt that it was difficult to cope with the demand.

The service had a system to manage, triage/screen referrals through to assessment and treatment. All referrals were triaged using a red, amber, green (RAG) rating system and all urgent cases were reviewed on the day of receipt. Staff said they struggled to keep up with referrals. Not all staff understood how they managed team-held waiting lists.

In North Somerset the team worked independently of the other CAMHS teams. Young people there were triaged by the small assessment team of one band seven and one band six staff members. The two staff members also held a small caseload of around 40 young people. The team was shortly (in two weeks) transitioning into another triage and assessment system whereby decisions would be made by a larger more multidisciplinary team.

All locations had waiting lists for assessment. These were in the region of 490 for North Somerset, 70 for North Bristol and 110 for South Gloucestershire. Senior staff at North Somerset said they had a recovery plan and the aim was to assess all patients referred to them up to December 2020 by October 2021. They were currently reviewing all patients referred to them in September 2020 which meant there was up to a 10 months wait. Staff at South Gloucestershire said they were currently around six months behind in patients being assessed.

In North Somerset they had introduced a new process to reduce waiting lists called the rapid assessment for parents (RAP) group. This was an educational programme for parents to understand and manage their child or young adult's difficulties with a view of avoiding admission into the service. This was offered to all families. Figures seen showed 60% had completed the RAP intervention programme. Staff said they would try and engage with people who found it difficult or were reluctant to take up the offer of RAP. Staff said that in some cases an intervention assessment and individual decision process would be implemented to manage the patient's needs.

Figures seen showed that North Somerset team and the North Bristol team were not meeting the trust target times of seeing patients from referral to assessment and assessment to treatment. For example, in North Somerset there were 258 patients waiting over 18 weeks for their referral with an average wait of 147 days (21 weeks).

In North Bristol the average wait was 22 weeks and did not meet the trust standard 18 weeks. The trust was aware of this. The service was on the trust risk register and a service improvement plan was in place to address the issues.

Specialist community mental health services for children and young people

Urgent referrals were seen quickly in line with the trust policy. They had no waiting list for young people assessed as being red with immediate allocation. Non urgent young people who were assessed as low risk were a low priority and were not seen as promptly.

The intensive outreach team had skilled staff available to assess young people seven days a week. The team now managed an open all hours crisis line. It was a new service that started in March 2020 in response to staff and young people's feedback about access to the service. Staff spoke very positively about the impact it had on their work experience and young people's access to the service.

The team tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. The team tried to contact people who did not attend appointments and offer support. The numbers of young people who did not attend appointments had increased during the lockdown. Staff were investigating the use of texts to remind young people about an appointment time.

Young people had some flexibility and choice in the appointment times available. Staff said they had adapted how they consulted with young people. Staff had been flexible due to the COVID-19 pandemic and had introduced virtual voice conferencing meetings. Feedback from young people said they would prefer to use the "WhatsApp" call system and staff said they had adapted this method to ensure the voice of the young person was being heard.

Staff worked hard to avoid cancelling appointments and when they had to they gave young people clear explanations and offered new appointments as soon as possible. Staff contacted people who did not attend appointments and offered support. The current "did not attend" (DNA) rate averaged 4%. However, at North Somerset this had increased to 8.5%. Senior staff said this was partially due to inappropriate recording. For example, staff reported a missed call as a DNA even though they had made contact after a second phone call.

Appointments ran on time and staff informed young people when they did not.

The systems across the teams to help them monitor waiting lists / support young people were varied across the locations visited. Staff said that all patients risked as green were provided with a letter and a telephone contact number should their child or young person's condition deteriorate. There was no clear consistent process to ensure those patients assessed as "green" were appropriately monitored and supported across the teams.

For example, in the North Bristol team there were in the region of 25 young people who were rated as low risk green and had very little engagement from staff members. The oldest low risk young person who had not been allocated for treatment was dated January 2021. Staff confirmed they did not always provide adequate monitoring for changes to risk for those patients assessed as green. Therefore, it was unclear how they would respond promptly to sudden deterioration in a patient's health.

Staff supported young people when they were referred, transferred between services, or needed physical health care.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms did not support young peoples' treatment, privacy and dignity.

Specialist community mental health services for children and young people

The services in North Somerset and South Gloucestershire did not have had a full range of rooms and equipment to support treatment and care. In South Gloucestershire the staff members had limited space. This had been alleviated by the introduction of staff working at home. The manager said there was also a satellite service in Patchway, Bristol which staff and young people could use. In North Somerset there was a limited amount of room for staff. The only space big enough in the building where staff worked was the staff room which was used by other people in the organisation.

Interview rooms in the service had sound proofing to protect privacy and confidentiality,

Young peoples' engagement with the wider community

Staff supported young people with activities outside the service, such as work, education and family relationships.

Staff made sure young people had access to opportunities for education and work and supported young people.

Staff helped young people to stay in contact with families and carers.

Staff encouraged young people to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all young people – including those with a protected characteristic. Staff helped young people with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The North Bristol and South Gloucestershire offices were wheelchair accessible. In the North Bristol office, there was a lift so young people could if required access the first floor. The offices had adapted toilets and washing facilities.

Staff made sure young people could access information on treatment, local service, their rights and how to complain. In South Gloucestershire there was a wide range of information for young people in the waiting rooms. In North Bristol they had closed their waiting rooms due to the pandemic, but leaflets were available on request. In North Somerset there was a small waiting room with limited availability of leaflets due to the concerns about the risk of cross contamination during the pandemic.

The service provided information in a variety of accessible formats so the young people could understand more easily.

The service had information leaflets available in languages spoken by the young people and local community.

Managers made sure staff and young people could access interpreters or signers when needed.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Specialist community mental health services for children and young people

Young people, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in areas accessed by young people.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. The number of complaints was low across all teams with an average of five per year. In North Somerset there were slightly more with nine complaints. Two were partially upheld and none had been referred to the Ombudsman. In North Bristol there had been two formal complaints since April 2021 and four in the last year. One complaint was not upheld, and the others were partly upheld. One complaint had gone to the Ombudsman, but it had not been upheld. The themes across the locations included clinical decisions, access to the eating disorder service, waiting times and communication.

Staff protected young people who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and young people received feedback from managers after the investigation into their complaint. All complaints were investigated by the managers and complainants received a letter detailing the outcome of the complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. All teams could describe learning as a result of complaints from young people. For example, in North Bristol recent learning included developing communication between staff members and young people. They were in the process of developing information about the role of the care coordinator to ensure that young people were clear in their expectations about the service.

The service used compliments to learn, celebrate success and improve the quality of care. The learning disability team had a large book of compliments from young people, their carers and families. Success stories were discussed at team meetings and staff members received recognition from the trust.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for young people and staff.

Staff in all teams spoke very positively about their team leaders and managers and reported feeling valued, respected and supported.

Vision and strategy

Specialist community mental health services for children and young people

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

The service had a vision for what it wanted to achieve. Staff knew and understood the trust's vision and values and how they were applied in the work of their team.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff morale was good and staff felt supported with the challenges of managing large waiting lists and caseloads.

At a South Gloucestershire team away day, they created a "tree of life" which outlined the services core values and gave staff the opportunity to provide feedback. Staff reported that this had developed their wellbeing and had been beneficial.

The trust had prioritised staff well-being throughout the challenges of the pandemic. Staff felt recognised and valued. Staff were given badges which said they were proud to be a staff member in the trust. In South Gloucestershire staff were given a few hours every week to develop their own well-being. Staff went on walks, yoga classes or some staff took the opportunity to catch up on pieces of work. Throughout discussions with over 50 staff across three locations the overwhelming feeling was resilience and pride in the work they had done in overcoming the challenges raised by the pandemic.

There was an emphasis on development and staff were encouraged to engage in training and personal development opportunities.

Staff confirmed they received praise and compliment feedback from young people, family and carers at each team business meeting.

Staff could be nominated by their colleagues for an Avon and Wiltshire Partnership Trust "Proud Certificate." We saw these on display at North Somerset.

All staff knew how to access the whistle blowing policy.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level. Performance and risk were mostly managed well.

The trust had an open culture to incident reporting, this had not encouraged staff to report incidents. Feedback from staff said they would prefer to deal with the incident instead of reporting.

Specialist community mental health services for children and young people

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Overall the teams had access to the information they needed to provide safe and effective care and were able to identify shortfalls.

The management of risk in the North Bristol and South Gloucestershire teams was managed well except for young people rated as being low risk.

The management of risk in the North Somerset team was currently not being managed well but there was a clear recovery plan in place. The trust was aware of the challenges they faced in relation to staff vacancies, staff retention, high caseloads and waiting times. The trust had only recently taken over the North Somerset teams and had started the implementation of the new strategy. The model of working was designed to address the management of risk shortfalls, but it was in the early days of development.

Information management

Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Managers worked closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) to ensure that there was an integrated local system that met the needs of children and young people living in the area. There were local protocols for joint working between agencies involved in the care of children and young people.

The trust worked closely with the clinical commissioning groups and NHS England. They had over £1 million to further develop the service and address the shortfalls they had identified. For example, they were investing money in the development of the eating disorder service to meet the growing number of referrals during the pandemic and following the reduction in the restrictions.

In North Somerset they were on the verge of implementing the new strategy. This would develop the assessment team into working within a more multidisciplinary team approach and move the whole team from a specialist way of working to a more generic model. The trust had worked hard to meet the needs of the young people during the pandemic however this was still in the developmental stage in North Somerset.

In North Bristol they worked very closely with other local healthcare services and organisations.

Specialist community mental health services for children and young people

In South Gloucestershire the team had worked closely with the local authority to fund additional posts to help identify unmet needs. These included a full-time primary mental health specialist in the local hospital education site, one for the locality social care team and another who was the lead for changes in school policy and culture with a focus on risk of exclusion and children who are struggling to attend school. The manager said there was an ambition to create additional posts across the whole of the service in South Gloucestershire to meet the needs of young people who were hard to reach living in complex family situations.

Learning, continuous improvement and innovation

The trust had an innovative autism intensive service. This was the only service of its kind in the south-west. Its aim was to reduce hospital admission and community placement breakdowns for young people with autism.

Wards for older people with mental health problems

Requires Improvement ↓

Is the service safe?

Requires Improvement →←

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

Safe and clean care environments

The wards had environmental risks, including ligature points and blind spots, and most staff were unaware of the actions to mitigate the identified risks. Ward 4 (St Martins Hospital) was not fit for purpose, although a new purpose-built ward had been identified, which staff and patients moved to following the inspection.

Safety of the ward layout

Although staff completed environmental risk assessments, not all ward staff were aware of the actions to mitigate the identified risks. The trust had removed and replaced some ligature risks appropriately. However, ligature anchor points remained within communal and bedroom areas on all wards. Some staff told us that the remaining environmental risks were mitigated through observations and individual risk assessments. However, we found that staff did not consider environmental risk within individual risk management plans.

Amblescroft North and South wards staff showed us bedrooms with reduced ligature risks for use of patients presenting with higher risks. However, only some ligature anchor points had been removed or changed to anti-ligature fittings. Ward managers were unaware of any plans to remove or replace the remaining risks with anti-ligature fittings and devices.

Although some action had been taken by the trust to remove blind sports, there were blind spots on Aspen, Cove and Dune ward. Ward managers had not completed environmental risk assessments which included reference to these and actions to be taken to mitigate these risks. Although, the blindspots were in communal areas, there was not always staff observing these areas.

Ward 4 continued to have dormitory bedrooms. At our previous inspection of the service we told the trust they must prioritise removal of dormitory accommodation on ward 4 in order to ensure optimum safety of patients, particularly at increased risk times such as at night. A new location for the ward, which would enable single rooms, had been identified. The patients and staff moved to the new ward following the inspection in September 2021.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

All ward areas were clean, and well furnished. Housekeeping staff completed and audited cleaning schedules.

Ward 4 was not well maintained and there were broken fittings, including the lock to the staff room.

Wards for older people with mental health problems

The environment on Dune ward had recently been improved and national guidance consulted to make this more dementia friendly. This included the development of a sensory room and sensory table that staff and patients provided positive feedback on.

Staff followed infection control policy, including handwashing.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

On most of the wards staff checked, maintained, and cleaned equipment. However, on Amblescroft South ward we found that some equipment including a nebuliser, had not been calibrated since 2019 and remained in use. The equipment in Amblescroft South clinic did not have clean stickers or maintenance dates. We spoke with the ward manager and were advised that a new lead had recently been identified to review all equipment to ensure these were calibrated and routinely cleaned.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

While the wards had registered nurse vacancies, the records seen showed the service had enough nursing and support staff to keep patients safe by using bank or agency staff. Managers monitored their use of agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Dune ward had a ward manager vacancy which was currently being filled by the senior practitioner for the ward.

Cove ward had high turnover rates over the previous 12 months. Staff told us that a number of staff had left due to high patient turnover following the ward being allocated as an admissions ward in response to the coronavirus pandemic. There was a plan in place to improve recruitment on Dune and Cove ward, and bed numbers on Dune ward had been capped to ensure the ward was safely staffed.

Managers supported staff who needed time off for ill health.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift.

The ward manager could adjust staffing levels according to the needs of the patients. Ward managers increased staffing in response to increased acuity and need for enhanced observations.

Patients had regular one-to-one sessions with their named nurse.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

Wards for older people with mental health problems

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

Most wards had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. However, Amblescroft North and South shared consultant cover with community teams. Staff told us that this led to patients only meeting with their consultants once a week and a consultant was not available when required outside of the weekly ward review. The ward had access to junior doctors but nursing staff told us that there were occasions when consultant input would have been beneficial to aid clinical decisions.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Overall, the majority of staff had completed their mandatory training and had met the trusts target of 85%. Training compliance was lowest for Amblescroft South, for example; this was less than 75% for, understanding, preventing and managing aggression in later life services, moving and assisting, and the Mental Health Act.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Ward managers displayed mandatory training compliance and future training dates in staff areas and prompted staff to attend. Mandatory training was monitored as a key performance indicator and discussed with ward managers regularly.

Assessing and managing risk to patients and staff

Generally, staff managed risks to patients and themselves well. However, staff did not always consider environmental risks when assessing risk of self-harm or suicide. The ward staff participated in the providers restrictive interventions reduction programme. It was not always clear in the care records whether staff had considered or implemented less restrictive interventions when managing certain risks.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly. However, in three care records we saw that risk assessments had not been updated following a recent risk incident. Staff had documented new risks in patient progress notes.

Management of patient risk

Staff knew about risks to each patient and acted to prevent or reduce risks. However, on five wards, staff had not included reference to environmental risks, such as ligature points and blind spots when developing risk management plans for patients presenting with risk to self.

Wards for older people with mental health problems

Staff on wards for patients with organic mental health problems, told us that they did not admit patients with current risk of suicide or self-harm. However, we reviewed five care records on Amblescroft North, Amblescroft South, Cove, Dune, and Ward 4 for patients that had identified current risks of suicide or self-harm. Staff did not always complete risk management plans to manage these risks. We found that none of the individual risk management plans for these patients referred to the environmental risks on the ward or consideration for use of reduced ligature bedrooms.

We reviewed falls risk management plans across all wards we visited and found, overall, these risk management plans were personalised, and detailed. Staff on Cove, Hodson and ward 4 told us about falls risk management quality improvement projects which had led to a reduction in falls and more personalised, and proactive management plans.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were low.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. However, on ward 4 it was not clear in four of the care records whether staff had considered or implemented less restrictive interventions when managing some risks. Staff had documented in personal care management plans that 'safe holds' may be used in a patient's best interest to support with personal care. These management plans did not clearly describe the rationale for use of restraint during personal care, although staff told us this was to manage risks to prevent severe self-neglect. Staff had referred to best interest decisions within the management plans but there was no associated documentation for capacity assessments and best interests discussions within the care records. Staff used generic and impersonal wording regarding the use of restrictive interventions in all four self neglect management plans.

Staff followed the National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation.

On Amblescroft South, North, Cove and Dune wards, staff told us that if patients became distressed there wasn't a suitable room to enable de-escalation or use of safeholds. Staff told us that if it was necessary to use physical restraint or move patients away from the communal areas, this took place in their bedrooms. Staff received appropriate training in the use of de-escalation techniques and safeholds for older adults as part of the trusts mandatory training; understanding, preventing and managing aggression in later life services.

The wards did not have seclusion rooms. However, staff told us that where necessary, patients had previously been secluded in their bedrooms, although this was a rare occurrence. Staff followed the trust policy for seclusion.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff recognised and reported abuse as appropriate and knew where they could get advice if needed.

Staff kept up to date with their safeguarding training.

Wards for older people with mental health problems

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

Medical staff on ward 4, Cove and Dune wards did not always prescribe medication in line with the trust policy. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. On ward 4, Cove and Dune wards, medical staff did not adhere to the trust policy when prescribing "as required" medicines, including benzodiazepine medicines to treat for example; agitation and anxiety.

Medical staff did not prescribe intramuscular and oral doses separately. Doctors told us that this led to easier tracking of administration and doses over a 24-hour period. However, this was against trust policy which referred to the risk that maximum daily doses could be different for each route.

Staff reviewed patients' medicines regularly and provided specific medicinal advice to patients and carers. Pharmacists visited the wards and completed medicines audits and provided advice as needed.

The clinic room and clinic fridge temperatures, were regularly out of range on ward 4, Dune, Cove and Amblescroft South wards. Although staff documented this, it was not always clear what action they had taken to ensure medicines stored during this time remained safe and effective to use.

Staff followed current national practice to check patients had the correct medicines.

Medical staff reconciled patient medicines on admission and this was audited by visiting pharmacists.

Wards for older people with mental health problems

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff completed contemporaneous notes following administration of as required medication and following medication reviews.

Staff completed covert medicines documentation and care plans in line with trust policy. However, the covert medicine management plans referred the reader to the trust policy which was not easily accessible to agency or locum staff.

Staff reviewed the effects of each patient's medicine on their physical health according to NICE guidance.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff understood the duty of candour and gave patients and families a full explanation when things went wrong.

Managers investigated incidents, gave feedback to staff and shared feedback from incidents outside the service. Managers gave feedback through team meetings, emails and on staff display boards.

There was evidence that changes had been made as a result of feedback. On Hodson ward the speech and language therapist provided learning sessions for staff in response to an increase in incidents of patients aspirating fluids.

Staff met to discuss the feedback and look at improvements to patient care.

Managers debriefed and supported staff after any serious incident.

Is the service effective?

Good 

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

Assessment of needs and planning of care

Wards for older people with mental health problems

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. The quality and detail of care plans was varied but overall, these reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

On four of the six wards staff had developed staff had developed care plans with patients that reflected their assessed needs and were personalised and holistic. However, on two of the six wards staff did not always develop a comprehensive care plan for each patient that met their mental and physical health needs. On Amblescroft South and Amblescroft North wards we reviewed four care plans for patients with diabetes. These care plans did not include clear guidance and rationales for blood glucose level checks. We saw within physical observation records that blood glucose level monitoring was sporadic for these patients and it was not clear from the care plans, whether these were being completed as necessary.

On ward 4 the quality of care plans was varied. Most of these were individualised and reflected patients' assessed needs. However, patients did not have personalised and future-oriented care plans for their mental health recovery.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes but the level of completion of these differed across the service. Staff also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. This included interventions and therapies provided by occupational therapists, physiotherapists, and psychologists. All ward staff provided meaningful activities and supported patients to become more independent.

Staff delivered care in line with best practice and national guidance.

Staff made sure patients had access to physical health care, including specialists as required. However, staff told us that for patients on wards that were outside of their general practice area it was more difficult to access community nursing teams. Managers told us that the trust was working with the integrated care system to resolve this.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes, such as HONOS65+, and pain and agitation scales. However, HONOS65+ was not completed for all patients

and ward 4 staff told us they did not use this scale. We saw evidence of rating scales being used in care records, but it was not always clear when these should be completed and reviewed. Staff told us that during the pandemic the completion of assessment bundles, which included rating scales, was sporadic due to other priorities and a high workload impacting on their ability and time to complete these.

Staff took part in clinical audits, benchmarking and quality improvement initiatives.

Managers used results from audits to make improvements. Senior nurses and ward managers completed audits on care records, safer staffing, triangle of care and the environments. This had led to actions and improvements in the full completion of admission paperwork, personalisation of care plans on some wards, and the involvement of carers. However, ward managers were not aware of the concerns within care and risk management plans that we highlighted during the inspection.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills

The service had access to a full range of specialists to meet the needs of the patients on the ward. Ward staff included registered nurses, healthcare workers, medical staff, occupational therapists, psychologists, art therapist, music therapists, dietitian, speech and language therapists and physiotherapists.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. On Dune and Hodson wards managers supported senior staff and staff with specialist skills to provide ad hoc training sessions to other staff. There were staff identified as leads and champions for specific skills or areas on all wards.

Managers gave each new member of staff a full induction to the service before they started work. Staff told us the induction was thorough and staff worked as supernumerary for their initial shifts, until they were competent and confident.

Managers supported staff through regular, constructive appraisals of their work. However, some staff on Amblescroft South did not feel their appraisal was effective in supporting them to create a personal development plan.

Managers supported staff through regular, constructive clinical supervision of their work. The trust had recently updated the clinical and management supervision policy and not all managers were clear on the types of supervision available and their role in providing this. However, staff told us that their clinical and management supervision was effective and that they felt able to access support where necessary.

Psychologists on the wards provided regular group supervision and case formulation sessions for staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Most staff told us that they were supported to access specialist training and development opportunities. Dune ward team had allocated a section of the afternoon handover to receive bespoke training or reflection sessions. Hodson ward managers had organised additional training in subjects including alcoholism, wound dressings and patient safety.

The trust provided online dementia modules training and had supported all staff on Dune ward to complete this as part of a ward improvement project. However, staff on the wards for patients with organic illnesses were not always aware of this course and had not completed it. The trust planned to make this training mandatory for staff from older adult's wards.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff from all disciplines attended multidisciplinary meetings as necessary. However, ward 4 did not have full time occupational therapists' input and therefore there was not always an occupational therapist at these meetings

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Staff on Hodson ward were completing a quality improvement project to improve communication during handovers.

Ward teams had effective working relationships with other teams in the organisation.

Care coordinators were involved in all care programme approach and discharge planning meetings, and attended multidisciplinary meetings either in person or virtually as appropriate. Staff documented details of external teams and organisations involved in patients care. Staff used the red to green daily meetings to highlight actions for, and to ensure involvement of, external teams. (Red to green meetings enabled staff to monitor patient's progress towards discharge through identifying needs for, and barriers to, discharge).

Staff described effective interagency working for a patient who was provided daily physical care from staff at the local acute hospital to prevent a transfer between hospitals.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them. However, there was no process in place for ward staff to routinely audit compliance with the Mental Health Act.

Most staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Generally, compliance with the Mental Health Act training for the service was good. However, on Amblescroft South this was below the trust target of 85% at 69%.

Wards for older people with mental health problems

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy.

Staff made sure patients could take Section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Staff on all wards were not routinely completing Mental Health Act audits.

Good practice in applying the Mental Capacity Act

On five of the six wards, staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity. However, staff on ward 4 were unclear on the principles of the Mental Capacity Act and used the term 'best interests' within care plans without ensuring documentation of capacity assessments and best interests discussions.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which most staff could describe and knew how to access. However, staff on ward 4 were unable to describe the principles of the mental capacity act and did not always consider capacity on a decision specific basis.

Across the service, five of the eight wards were below the trust target of 85% for completion of Mental Capacity Act and Deprivation of Liberty Safeguards training level 1. Training compliance was below 75% on Cove, Aspen and Amblescroft North wards. However, staff we spoke with on these wards had a good understanding of at least the five principles of the Mental Capacity Act.

On ward 4 it was not clear whether staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff referred in care records to risk management decisions being made in patients' best interests, but it was not always evident that capacity assessments and best interest discussions had taken place.

On all other wards, when staff assessed patients as not having capacity, they made decisions in the best interests of patients and considered the patient's wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards authorisation only when necessary and monitored the progress of these applications.

Wards for older people with mental health problems

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Requires Improvement 

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Although patients and carers told us that staff treated them with kindness, we observed some staff behaving and interacting in ways that were not respectful of patients' privacy and dignity.

On four of the wards we visited, we observed staff entering patient bedrooms without knocking on their door, communicating with the patient or asking for consent or interacting when already in their room. On two wards staff did not ask for patients' consent for our team members to enter bedrooms without prompting from our team. Staff told us that some patients did not have the capacity to consent to us entering their bedrooms, but they did not initially attempt to communicate or discuss this with the patient. On most of the wards, we did also observe examples of staff providing care that was respectful, responsive and discreet.

On ward 4 we observed staff entering bedroom dormitories to access supply cupboards without interacting with the patients in their bedroom. We completed an observation of staff interactions on ward 4 and observed limited interaction with patients in communal areas as well as staff discussing other patients in front of patients. We joined an activity session and observed staff making inappropriate comments in front of patients and noted staff treating patients in a manner inappropriate for their age and experience.

The patients we spoke with told us that staff provided emotional support and advice when they needed it. Patients told us that staff were kind and cared about their wellbeing.

Staff attempted to support patients to understand and manage their own care and treatment.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff told us that they could discuss concerns with their manager or the trust's Speak Up Guardian.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Most of the wards had admission welcome packs for patients and staff talked through these with patients.

Wards for older people with mental health problems

Staff involved patients and gave them access to their care planning and risk assessments. Staff completed individualised documents with patients and carers that identified their personal interests and experiences and used these to support care planning.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties.

Staff were unable to provide examples of how they involved patients in decisions about the service. However, patients could give feedback on the service and their treatment and staff supported them to do this. Staff facilitated regular community meetings so that patients could give feedback. Staff encouraged patients to complete family and friends' tests.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Carers and families told us that they felt involved and informed by staff. Carers and families had been given opportunities to join care meetings virtually or in person and received regular updates from staff. Carers told us that staff were considerate of their specific needs during discharge planning and when organising family visits.

Ward staff provided family and carers with information packs about the wards. Most carers and families had received copies of their family members' care plans and had been involved in treatment decisions and planning. Families and carers had been given details about patient's medicines.

Carers and families were able to visit the wards and told us that staff were friendly and supportive to them and patients. During the pandemic staff had ensured carers and families could contact patients virtually and on the telephone. Amblescroft North and South wards had a visiting pod off the ward to make visits more accessible during the pandemic. Cove and Dune ward staff told us about extra steps they had taken to enable visiting including, using rooms that had been out of use for the family of a patient receiving end of life care, and supporting off ward visits.

Staff had recently completed triangle of care audits for all the wards and these evidenced good involvement and support for carers and families. However, three wards had identified that they did not always identify carers details in a timely way. All wards had developed action plans to meet unmet areas.

Staff on Hodson ward had collaborated with patients' relatives to create a mutual expectations board which referred to areas such as listening and respect.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Wards for older people with mental health problems

Access and discharge

Staff managed beds well. A bed was available when needed and patients were not moved between wards unless this was for their benefit. Managers monitored delayed transfers of care and took action to resolve delays.

Bed management

Managers monitored bed occupancy and during the previous 12 months only two wards (Hodson and Amblescroft South) had regularly been above 85%. Manager's attended daily bed management calls. Staff were involved in the assessment and acceptance of referrals.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

Staff used a red to green proforma to assess patients' progress towards discharge daily and identified actions to ensure progress towards discharge and recovery.

The service had low numbers of out-of-area placements.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interests of the patient. In response to the coronavirus pandemic patients were initially admitted to admission wards for 14 days. Following a negative coronavirus test, patients were moved to assessment and treatment wards.

Cove and Amblescroft North wards were reassigned as admission wards and therefore had high numbers of transfer for admission and discharge. Staff told us it was difficult to implement care and treatment plans and assess patients during their admission due to the high turnover of patients.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

The service had low numbers of patients who had delayed discharges in the past year. During the inspection, ward 4 had four patients whose discharge was delayed, and Dune ward had three. In all cases this was due to delays in identifying an appropriate accommodation.

Managers monitored the number of patients with delayed discharges. Managers attended weekly delayed transfer of care meetings and were able to discuss the actions taken to resolve this. Staff told us that the main reason for delayed discharge was due to unavailability of residential home beds, due to coronavirus outbreaks and control measures.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Care coordinators and families attended care planning review meetings and discharge planning meetings.

Facilities that promote comfort, dignity and privacy

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The design, layout and furnishing varied across the different wards and sites. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time. Dune ward had recently been re-decorated to ensure the environment was dementia friendly. Hodson and Amblescroft North wards had additional rooms for therapy to take place. Ward 4 did not have single use bedrooms or en-suites and the ward required some maintenance. However, the ward was due to move to a new purpose-built location in Bath. There were rooms on Amblescroft North and ward 4 that did not always ensure patients' privacy and dignity.

Although ward 4 was due to move to a new ward with single bedrooms and en-suites, at the time of the inspection shared dormitories were in use for two, three or four patients. One patient was being nursed in a lounge area, due to specific needs. We observed that the room did not have privacy film on the windows and had a public pathway outside the window. Staff told us that they could close the curtains to ensure privacy and ordered privacy film for the windows while we were on site. On Amblescroft North ward, privacy film had been placed on the windows to prevent the public seeing into patients' bedrooms. However, staff had raised a concern that during the night the film prevented patients from seeing out and the public could see in. Staff and patients closed curtains to maintain privacy as an alternative method to ensure privacy.

Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. Hodson ward had additional facilities and rooms, including a gym, art room and therapy room. Amblescroft South ward had a well-equipped patient kitchen for patients to access as part of their occupational therapy. Dune ward had a sensory room and sensory table and staff had added paintings, art and photos of their dogs to the walls to make the area more homely.

The service had quiet areas and a room where patients could meet with visitors in private on each ward. Patients could make phone calls in private.

All wards had an outside space that patients could access easily. Amblescroft South and North wards had been successful in securing funding from the trust to create therapeutic and relaxing garden areas and had worked with patients to develop the outside areas. Staff on Hodson ward had received an award from the trust for their garden painting.

Patients could make their own hot drinks and snacks and were not dependent on staff.

The service offered a variety of good quality food.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, and family relationships.

Staff helped patients to stay in contact with families and carers. Staff supported patients to spend time in the community and maintain regular visits. During the coronavirus pandemic staff supported patients to keep in touch with family and friends using telephones and virtual calls.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

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The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and adjust for disabled people and those with communication needs or other specific needs. Staff gave us examples of adjustments they had made to support patients that were sight or hearing impaired.

Managers on wards for patients with organic mental health illnesses had completed a recognised assessment tool to ensure the wards were dementia friendly.

Staff made sure patients could access information on treatment, local services, their rights and how to complain.

The service had access to information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. The service had received six formal complaints over the previous 12 months. Three of these complaints were regarding Dune ward safeguarding processes and communication. These complaints were received prior to the ward closing for quality improvements to be made. No further complaints had been received since the ward reopening. Staff told us that they recorded and responded to any complaints and aimed to resolve complaints and concerns informally where possible.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

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Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles and had a good understanding of the services they managed.

Most staff told us that ward managers and matrons were visible and supportive. However, staff did not always feel that senior leaders outside of the locality were approachable or had a good understanding of the services and staff experience.

Ward managers had the skills and knowledge to perform their roles and could access further training and development opportunities. Ward managers had recently engaged in compassionate leadership training and provided positive feedback on this. Dune ward did not have a ward manager but staff told us they felt supported by the advanced practitioner and matron. Recruitment for the role was ongoing.

Vision and strategy

Most staff knew and understood the provider's vision and values and how they were applied to the work of their team.

Staff on Cove and Amblescroft North wards did not feel involved in the development of the future vision and strategy for their wards. These wards had been allocated as admission wards during the pandemic and staff told us they felt uncertain and uninformed of proposed changes for the future of the wards. Staff did not feel listened to and involved in the design of these wards. Staff told us that they felt the workload created by high level of transfers to and from the ward was not sustainable long term. Therapists on these wards also told us that they experienced less satisfaction in their roles due to not seeing patients progress or recover before discharge.

Culture

Staff felt respected, supported and valued by their line managers. Most staff told us the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff told us they were supported and valued by ward managers and matrons. Staff told us that the trust response during the coronavirus outbreak was delayed and not all staff felt that senior management had taken steps to demonstrate their support for the team and understanding of their experience.

The trust had a Freedom to Speak Up Guardian and staff felt able to raise concerns with both managers and speak up champions.

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Ward teams spoke highly of each other and told us that the teams worked well to support each other when under pressure and to improve patient experiences.

Most staff told us they had opportunities for development and career progression and knew how to access funding and support to develop professionally. However, staff on Amblescroft South ward did not feel they were supported to create a development plan as part of their appraisal.

Governance

Our findings from the other key questions highlighted concerns with the governance processes at team level and the management of performance and risk.

The trust ensured that ligature risk assessments had taken place for all the wards. However, ward managers were unclear on the most up to date assessment available and the type of tool in use. Ward staff had not been involved in the completion of these and could not describe all the risks and mitigations to manage those risks identified on the assessments. Staff had not considered the environmental risks within individual risk management plans and were not always mitigating these risks.

Ward managers and senior nurses completed audits of care records. The trust had introduced care record audits on their online system and weekly quality walkabout audits. We found that some ward managers were using these effectively, but others were unsure on the processes for these or unaware of their existence.

Ward managers were unclear and inconsistent in their implementation of the most up to date processes to monitor and improve quality and performance.

Some ward managers provided separate clinical and management supervision in line with the new trust policy but others were unsure on the types of supervision and when this should be provided. The type and regularity of audits on each ward differed and not all ward managers were routinely completing these or responding to areas of concern. This included medicines and Mental Health Act audits. Ward managers did not complete a specific audit of implementation and adherence to the Mental Capacity Act.

Staff and ward managers were unclear on processes and tools that were used to monitor health outcomes and how this information was monitored and used by the trust. We observed differing and incomplete use of tools and measures across the wards.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care.

Ward managers and matrons were able to access and add to the relevant risk registers for their ward.

Managers had access to dashboards and key performance indicators through the trust electronic system. Key performance indicators included physical health care and discharge summaries. Ward managers accessed key performance indicator data and dashboards and were provided feedback on these from matrons. Ward managers provided narratives and implemented action plans in response to dashboard data as necessary. Ward managers and matrons could escalate issues and concerns to quality divisional and locality meetings.

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The trust had implemented an early warning signs dashboard and managers used this to identify risk areas and respond or resolve these as appropriate. Managers told us that this enabled them to monitor for patterns and there was a process to follow based on themes and the number of risk areas identified.

Information management

Staff engaged actively in local and national quality improvement activities.

Staff told us about several quality improvement projects, including, environment, incident reporting and falls management. Managers were able to discuss the recent quality improvement activities on each ward and how these had led to better outcomes for patients. On ward 4, staff had completed a review of falls and identified learning and actions to improve falls management. We saw that falls management plans within care records on this ward were more personalised and holistic leading to more proactive care.

Staff on Dune ward had implemented a quality improvement project around incident reporting. Staff used a new approach to structure their reports to ensure better identification of learning and actions to improve future outcomes and experiences for patients.

The ward manager on Amblescroft South ward had implemented an annual ward improvement week. During the week staff had identified a list of potential improvements and were tasked with choosing a specific item from the list and implementing an action plan to achieve the improvement.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Staff on ward 4 and Dune ward told us that they had the opportunity to feedback on services and input into the service development in relation to the reopening or Dune and relocation of ward 4. Staff from ward 4 had visited the new site and had input into environmental needs of the service and patients.

Learning, continuous improvement and innovation

There was an ongoing quality improvement project for Dune ward. The ward had closed in December 2020 following concerns about staffing numbers and safeguarding incidents. The trust had developed and implemented a comprehensive quality improvement action plan. Senior managers had completed quality assurance visits following the reopening of the ward and were developing the actions further to implement these as part of a service wide quality improvement project.