

# Avon and Wiltshire Mental Health Partnership NHS Trust

## Quality Report

Avon and Wiltshire Mental Health Partnership NHS  
Trust  
Head Office, Jenner House  
Langley Park  
Chippenham  
Wiltshire  
SN15 1GG  
Tel: 01249 468000  
Website: [www.awp.nhs.uk](http://www.awp.nhs.uk)

Date of inspection visit: 26-30 June 2017  
Date of publication: 03/10/2017

Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Fountain Way (Ashdown Ward)	RVN9A
	Fountain Way (Beechlydene)	RVN9A
	Green Lane Hospital	RVN6A
	Callington Road, Bristol (Elizabeth Casson)	RVN4A
	Callington Road, Bristol (Hazel Ward)	RVN4A
	Callington Road (Silverbirch Ward)	RVN4A
	Callington Road (Lime Ward)	RVN4A
	Callington Road (Larch Ward)	RVN4A
	Sandalwood Court (Applewood Ward)	RVN8A
	Longfox Unit (Juniper Ward)	RVN4B
	Hillview Lodge (Sycamore Ward)	RVN2A
	Southmead AWP (Oakwood Ward)	RVN3N

# Summary of findings

<b>Children and Adolescents Mental Health Services Inpatient</b>	Riverside	RVN3Q
<b>Children and Adolescents Mental Health Services Community</b>	Trust Headquarters (South Bristol)	RVN1H
	Trust Headquarters (Central Bristol)	RVN1H
	Trust Headquarters (South Gloucestershire)	RVN1H
	Trust Headquarters (Central Outreach and Assessment Team (COAT))	RVN1H
<b>Long stay/rehabilitation mental health wards for working age adults</b>	Whittucks Road	RVN5J
	Windswept	RVN8D
<b>Crisis and health based places of safety</b>	Trust Headquarters (Bristol Central and East Crisis Team)	RVN1H
	Trust Headquarters (Bristol South Crisis Team)	RVN1H
	Trust Headquarters (Bristol Access and Triage Team)	RVN1H
	Blackberry Hill Hospital (South Gloucestershire Intensive Support Team)	RVN3Q
	Sandalwood Court (Swindon Intensive Service)	RVN3Q
	Fountain Way (Wiltshire Intensive South Team)	RVN9A
	Green Lane Hospital (Wiltshire Intensive North Team)	RVN6A
<b>Wards for older people with mental health problems</b>	Callington Road Hospital, Bristol	RVN4A
	Fountain Way, Salisbury	RVN9A
	Longfox Unit, Weston-super-Mare	RVN4B
	St Martin's Hospital, Bath	RVN2B
	Victoria Centre, Swindon	RVNCE

# Summary of findings

**Wards for people with learning disabilities or autism**

Green Lane Hospital (The Daisy)

RVN6A

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

# Summary of findings

## Ratings

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

### Overall rating for services at this Provider

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



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

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

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

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

# Summary of findings

## Contents

### Summary of this inspection

	Page
Overall summary	6
The five questions we ask about the services and what we found	8
Our inspection team	16
Why we carried out this inspection	16
How we carried out this inspection	18
Information about the provider	18
What people who use the provider's services say	19
Good practice	19
Areas for improvement	19

---

### Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards	23
Findings by main service	24
Action we have told the provider to take	35

---

# Summary of findings

## Overall summary

Following the inspection in June 2017, we have not changed the overall rating for the trust from **requires improvement** because:

- During the comprehensive inspection of the trust in 2016 we told the trust it must make improvements in a number of areas. The two main areas of concern were the health based places of safety which we rated as inadequate, and wards for older people which was rated as requires improvement. Whilst we found on this inspection improvements had been made across all the areas we inspected, not all of the planned improvements had been made.
- In May 2016 at the previous inspection we rated six out of 10 core services as requires improvement. At this inspection the number requiring improvement is now seven out of 13 core services.
- Within the wards for older people core service, ward 4 at St Martins hospital in Bath still had dormitory style shared accommodation. The trust was continuing to work with commissioners to try and address the issues. However, this will require significant capital investment. Aspen ward at Callington Road hospital, had blind spots and there were no convex mirrors in place, which meant that staff could not fully observe patients. Laurel ward, at the same site, had been closed suddenly by the trust two weeks prior to this inspection and was the subject of an ongoing safeguarding inquiry by Bristol City council.
- Within acute wards and psychiatric intensive care units, we found that the work to minimise ligature risks was ongoing. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Although progressing, works to address all ligature risks across the service remained outstanding. Arrangements for the safe administration of rapid tranquilisation had improved, and work to address the privacy and dignity issues around the use of seclusion was ongoing. However, access to seclusion from Silverbirch ward at Callington Road hospital remained a concern. Although the trust was holding a consultation about the future use and provision of its seclusion arrangements, during the inspection. Alarm systems on Beechylidene and Ashdown unit were inadequate. The checking of medical equipment and emergency drugs was not always being done in line with organisational policy.
- In the Devizes health based place of safety, staff had not identified some potential ligature points as part of the risk assessment, and there was a lack of clear plans in place to mitigate the risks. There were significant problems accessing beds for people requiring admission to hospital. We saw examples of patients waiting 32 to 50 hours after being assessed in the place of safety before admission to hospital. This also put pressure on the crisis teams who had to deal with patients requiring a high level of care in the community.
- From 1 April 2016 the trust had taken on responsibility for children and adolescents mental health services (CAMHS) in the wider Bristol area. This included community teams and an inpatient unit (the Riverside unit). This service had lost its service managers during the transfer and many management tasks now fell to senior clinicians. In addition, there were shortfalls in staffing in young peoples' community mental health team, which had led to increased waiting times. Staff morale was variable in the service and the lack of a consistent contract with NHS England was having a negative impact. We found the current level of risk on the Riverside unit to be manageable, given the current level of challenges staff face with the children currently admitted to the ward.

However:

- The majority of the issues we previously identified with the environment at the places of safety had been addressed. There had been a reduction in the number of people exceeding the maximum 72 hours in the place of safety. This had occurred on two occasions in the previous year. This was in comparison to eight occasions in the year before our last inspection. The trust had introduced systems to alert managers to delays in the place of safety. There regularly remained significant delays in assessments commencing at the places of safety.

# Summary of findings

- At the time of this inspection, the trust was going through a significant period of change. The trust had a relatively new senior leadership team, with a range of appointments made over the last 12 months. This included a new chair, medical director, finance director, operations director and two non-executive directors. A new appointment to the director of human resources role was due to commence in post shortly after the inspection. The trust chair was implementing a considerable change programme. This included a new focus on the governance and reporting arrangements for the board, in order to improve its overall effectiveness. The trust was implementing a new divisional structure aligned to the two Sustainability and Transformation Plan footprints which maintained oversight of the six locality and three specialist delivery units. The Trust has embarked

on a significant cost improvement programme which had been caused by an overspend the previous year. The details of this cost reduction plan were still to be agreed by the trust board and commissioners; however the scale of the savings over the next 12 months will have a significant impact on the future operating model of the trust.

- In May 2016, the trust did not ensure staff adhered to Mental Health Act (MHA) legislation and the standards described in the MHA code of practice. When we visited in June 2017, we found managers had made improvements, so staff worked appropriately within the legislation.

The full report of the inspection carried out in May 2016 can be found here <http://www.cqc.org.uk/provider/RVN>

# Summary of findings

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

We always ask the following five questions of the services.

### Are services safe?

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

- Previously we told the trust it must take action to identify and mitigate ligature risks on all acute wards for adults of working age. When we visited in June 2017, we found the trust had made progress with this work but there were still further actions required to complete and not all risks had been identified.
- Personal alarm systems were not adequate on Ashdown and Beechlydene unit. Staff were supplementing the system by investing in personal attack devices.
- Arrangements for the secluding of patients on Silverbirch ward remained a concern, with patients still being secluded off the ward onto Lime unit or the female PICU.
- The rehabilitation ward at Whittucks Road still did not meet the Department of health Guidelines on same sex accommodation. Patients still had to enter into or pass through the opposite sex ward in order to access facilities such as the bath and the lift.
- Not all staff who worked with patients who were prescribed antipsychotic medication were familiar with the term neuroleptic malignant syndrome. Neuroleptic malignant syndrome is a potentially life-threatening reaction to antipsychotic drugs. This followed a recent death due to this condition. Most staff were unable to discuss the symptoms to look for or the actions needed to ensure a patient's health and safety.
- Although the trust was making efforts to address staffing issues across the service, some wards had many band 5 vacancies. For example, Juniper unit had no substantive band 5 staff on duty on the day of our visit.
- One of the older adult wards, Ward 4 in Bath, had dormitory style shared accommodation that increased risks particularly during the night. Aspen had blind spots that staff had not clearly mitigated and had no convex mirrors in place to aid this.
- Community-based mental health services for adults of working age had not addressed all medicines management issues.
- We did not find crisis plans on many of the crisis teams' case records. There was a lack of monitoring of the medicines held

**Requires improvement**





# Summary of findings

or prescribing in the North Wiltshire intensive team. In Salisbury we saw that potential safeguarding issues weren't always explored by staff. There were limited opportunities for staff in the Wiltshire crisis teams to learn from incidents, as this was not always shared by managers.

- There were significant problems accessing beds for people requiring admission to hospital. We saw examples of patients waiting 32 to 50 hours after being assessed in all the place of safety suites before admission to hospital.
- Personal alarm systems were not adequate at the Salisbury place of safety. Staff told us that this made them feel unsafe.
- Young person's community mental health teams did not have the right numbers of staff or skill mix to safely meet all the requirements of the children and young people using the services and there were staffing issues at each of the teams we visited. These included issues with recruitment and retention of staff to fill vacancies caused by increased numbers of staff leavers over the last 12 months. Efforts were being made by the trust and the local teams to recruit replacement and additional staff, but a significant number of vacancies had not yet been filled.
- A sizeable number of staff across the young person's community mental health teams were not up to date with their mandatory training. This training included areas of learning essential for safe practice such as safeguarding children, basic life support, and medicines management
- Information supplied by the trust indicated that just under a third of staff across the specialist community mental health services for children and young people teams did not have an up-to-date disclosure and barring check.
- At Riverside young people's inpatient unit there were multiple ligature points throughout the ward. There was no plan to address and remove all the ligature risks and the mitigation plan in place was not being followed by staff in all instances. The extra care bedroom, with multiple ligature risks, was left open all day when it should have been locked to ensure the young people did not use it unsupervised.

However:

- In May 2016, we found that the use of rapid tranquilisation (RT), including the monitoring of patient physical health after administration did not follow National Institute of Health and

# Summary of findings

Care Excellence (NICE) guidelines or trust policy. When we visited in June 2017, we found that the trust had revised its RT policy and we saw evidence of staff monitoring and recording patient physical health after administration.

- In May 2016, the seclusion rooms on Elizabeth Casson, Hazel, Lime and Oakwood did not have access to toilet facilities to maintain the dignity of patients in seclusion. When we visited in June 2017, we found that Oakwood ward had a new toilet facility in its seclusion room. A recent seclusion review had identified the need for updating these facilities.
- Staff received feedback following incidents and staff we spoke with told us they received debriefs and support following serious incidents.
- Statutory and mandatory training levels across the service were good.

## Are services effective?

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

- During our May 2016 inspection we had rated the health based places of safety as inadequate and wards for older people as requires improvement. These core services had now changed to requires improvement and good respectively. However, we rated both the Daisy unit and the community CAMHS services as requires improvement for this key question.
- Staff on wards for older people were not completing health of the nation outcome scales (HoNoS) for over 65's (older adults) to measure treatment outcomes. When we visited in June 2017, we saw some improvement in this although it was not consistent across all wards.
- On the Daisy unit (wards for people with a learning disability) Staff had not provided care plans to residents and they were not in an accessible format. There were no outcome measures used and there was no occupational therapist at the service and activities lacked a therapeutic focus.
- There was limited access to Section 12 Doctors (a Psychiatrist who acts as a second opinion in the application of the MHA) which was causing delays to Mental Health Act assessments, in order to work within the trust's Section 136 joint protocols and the Mental Health Act Code of Practice.
- In young people's community mental health services we found some variance in the quality, completeness and in how up-to-

## Requires improvement



# Summary of findings

date care records were across the different teams. Care records were not sufficiently holistic or recovery focused. They contained limited evidence of specific outcomes, treatment goals or patients' strengths.

- In young people's community mental health services there were issues related to the storage and accessing of care records, which were kept on different systems and in different formats. The challenges of negotiating multiple IT systems and changes to care records, and the time these consumed, were key concerns raised by staff at each of the teams visited.
- Not all staff within the child and adolescent community services had received regular supervision, attended regular team meetings and received an appraisal in the past year.
- At Riverside young person's inpatient unit there was confusion about the use of the extra care unit and whether young people in this area were secluded.

However:

- Within wards for older people the service had addressed the issues that had caused us to rate effective as requires improvement in the May 2016 inspection. During the May 2016 inspection, we said the trust should ensure that staff involve patients in their care plans. When we visited in June 2017, we saw some improved documentation around involvement in care planning. There was now psychologist cover for Hodson and Liddington wards in Swindon.
- In the Daisy unit, the physical health lead completed hospital passports, which were kept in the residents' records. They identified a resident's likes and dislikes including how they preferred to communicate. The passports also had relevant details on physical health histories and strategies to support resident's behaviours. These were ready in case any resident required admission to an acute hospital. All residents had a health action plan in place, that identified physical health needs and treatment plans to meet them.

## Are services caring?

We rated caring as good because:

- In May 2016 we rated all the core services as good and this remained so on this inspection.

**Good**



# Summary of findings

- We observed the staff in all of the teams to be caring, compassionate and kind. People we spoke to were positive about the care and support they received. Staff demonstrated that they knew the needs of their people on their caseload, and discussions in handovers were patient focussed and respectful.
- Staff generally demonstrated a high level of knowledge about the needs of their individual patients. We saw evidence in care plans that staff engaged with patients to establish their likes and dislikes to help plan the care they provided.
- We found evidence to show across all services that patients had been included in the planning of their own treatment and care.
- Where necessary and with patients consent, families and carers had been included in patients care and treatment plans.

However:

- Young people within the Riverside inpatient unit gave mixed feedback about their involvement in their care plans. Two young people we spoke with explained that care plans were written for them. Another said they weren't asked for any contribution to the plan and felt that it was unlikely to change even if they disagreed with the plan. All young people said they had not seen a copy of their plan

## Are services responsive to people's needs?

We rated responsive as good because:

- The service had addressed the issues in older adult inpatient wards which had caused us to rate responsive as requires improvement in the May 2016 inspection. In May 2016, the majority of wards nursing patients with dementia were not considered dementia friendly. When we visited in June 2017, we saw significant improvements with further plans for positive changes to the environment.
- The Daisy was built to promote residents independence whilst supporting their needs. Each resident had their own pod which was a self-contained flat with their own front door.
- The majority of patients (55%) waited 12-24 hours before being assessed in the health based places of safety. This was similar to the levels at our inspection in 2016. Some staff told us that people could become increasingly frustrated and agitated the longer they waited.
- The trust monitored inpatient capacity locally and through the corporate risk register. It identified that patients may not receive the most appropriate care and treatment if the trust did

Good



# Summary of findings

not manage inpatient capacity. This could lead to further pressure on existing resources and a requirement to use out of area beds for adult, PICU and older adults, creating significant cost pressures on the trust. Actions were in place to mitigate this risk, such as bed management meetings, a 'bed management escalation protocol' and bed availability information on the trust intranet for prompt access. The trust had made block purchases of beds from the private sector to alleviate some of the bed pressures.

However:

- Dune ward was still awaiting improvements in the environment. The flooring was inappropriate, as it was multi-tonal and shiny potentially increasing visual perception problems and confusion in this client group. Ward clocks were too high for patients to see clearly.
- In young people's community mental health services due to a number of forces, including staff vacancies and increased acuity of referrals which required more time and input, there were waiting lists at each of the four locality teams. Of greatest concern was the waiting list at Bristol South. This team had previously not had any waiting list and over the past 18 months the waiting list had grown to the largest list of the four localities.

## Are services well-led?

Good



We rated well-led as **Good** because:

- In May 2016 we rated well led as requires improvement. This was due to finding the trust did not have effective governance arrangements in place to enable it to assess, monitor and improve the quality of services (including the quality of the experience of service users in receiving those services). We were not assured that governance arrangements and board oversight were robust enough to identify, address and learn from key risks in a timely manner.
- On this inspection we found some improvement to its risk processes had been made since our last inspection, as there was now a corporate, trust wide risk register and board assurance framework.
- The Board were clear about the breadth and depth of the challenges, both internal and external the trust faces. In particular dealing with the complexities of the scale and variety of issues across six clinical commissioning groups and two sustainability transformation plans.

# Summary of findings

- The trust just had just completed an external financial review, in collaboration with NHS Improvement (NHSI). This was as a result of ongoing support from NHSI following assessment by them into the third segment of support. This review highlighted key areas for consideration in addressing the financial recovery. The trust had identified a 20 million pound overspend accrued over the last two years. The scale of the financial improvement plan would have a potentially significant impact on the way the trust operates in the future.
- Board members we interviewed stated consistently that the quality of debate and discussion at board meetings and its committees had improved considerably. There is an ongoing programme of board development, one aspect of which has focussed on the relationships between the executives and /non-executives.
- The trust had a relatively new senior leadership team, with a range of appointments made over the last 12 months. This included a new chair, medical director, finance director, operations director and a couple of non-executive directors. A new appointment to the director of human resources role was due to commence in post shortly after the inspection. This would mean the trust had a full complement of board members to lead it over the next 12 months.
- Senior managers we spoke with felt that the new chair had started to set a new culture for the trust board. They also felt the chief executive was open and approachable. She had generated a weekly update for all staff in which she invited comments and where feedback was acted on. There was also more visibility of executives visiting services and taking on a link role with each of the localities.

However:

- Although the trust has adopted a quality improvement plan (QIP) as a key tool and resource to drive improvement after our last inspection, there was no clear statement about what it was intended to achieve or how it was supposed to be used.
- The young people's community mental health services had undergone a lot of changes in the previous year and was still very much in a state of flux. Staff were still not entirely clear who they worked for, and which organisation was ultimately responsible for overseeing and delivering the service.
- There was considerable variation in performance and quality between the community mental health teams for children and

# Summary of findings

young people. This demonstrated that the governance of this core service was not yet sufficiently robust or effective. Also some of the staff in this core service had low morale , thought that the transfer had been poorly managed, and did not really understand who was who in the new structure.

- At Riverside young person's inpatient unit there was not an effective governance system in place to ensure the environment was safe for young people. The staff team were inconsistent in ligature management, the application of the locked door policy and repair of the perimeter fence. The ward could not offer treatment to young people who were acutely unwell or high risk who would be typically treated in a general child and adolescent inpatient ward due to the risk of the current limitations of the building. The young people currently in the service were not at the acuity the service was commissioned for. There was no clear plan in place to address this.

# Summary of findings

## Our inspection team

Our inspection team was led by:

**Team Leader:** Karen Bennett-Wilson, Head of Inspection, Care Quality Commission

The team included:

- CQC inspection managers
- Inspectors
- An assistant inspector
- Inspection planners.
- A Pharmacist specialist
- Mental Health Act reviewers
- A variety of specialist advisors including approved mental health practitioners, mental health nurses and governance specialists.

## Why we carried out this inspection

We undertook this announced and focussed inspection to find out whether Avon and Wiltshire Mental Health Partnership NHS Trust had made improvements since our last comprehensive inspection of the trust in May 2016. At that inspection we rated the trust as **requires improvement** overall.

At the inspection in May 2016 we served the trust with a warning notice under Section 29A of the Health and Social Care Act 2008 which required it to make the following improvements to its mental health crisis services and health-based places of safety:

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

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

In addition, we told the trust it must take the following actions to improve:

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

- The provider must ensure that rapid tranquilisation practices are in line with National Institute for Health and Care Excellence and Department of Health guidelines and local policy.
- The provider must ensure that all ligature risks are identified through audits and continue with their ligature reduction programme.
- The provider must ensure that Silver Birch provides adequate resources and facilities for the management of patients requiring de-escalation and seclusion.
- The provider must ensure that they review the seclusion facilities on Elizabeth Casson, Oakwood, Lime and Hazel unit and patients have access to toileting facilities whilst secluded.

### **Wards for older people with mental health problems**



# Summary of findings

- The trust must ensure it takes all actions required to protect patients from the risk of ligatures in a timely fashion.
- The trust must ensure that appropriate and effective alarm systems are in place for the use of patients and staff in all wards.
- The trust must ensure that ward environments are dementia friendly and fit for the purpose of managing patients with these conditions.
- The trust must ensure changes to ward environments to protect patients' dignity and privacy.
- The trust must ensure that all staff members complete the physical emergency response training or practical patient handling training. Managers must receive training in root cause analysis to ensure that they can complete their role effectively when investigating incidents.
- The trust must ensure that there is psychologist cover for Hodson and Liddington Wards in Swindon.
- The trust must ensure that staff follow risk assessment and care plans completed to ensure both their own staff and patient's safety.
- The trust must identify a safe and dignified method of transferring patients in need of seclusion between wards.
- The trust must ensure that staff adhere to Mental Health Act legislation and standards described in the Mental Health Act (MHA) 1983 code of practice.

## **Community mental health services for people with learning disabilities or autism**

- The provider must ensure that the intensive support team has an effective procedure in place to ensure staff have amalgamated all risk information available prior to visiting people.

## **Community-based mental health services for adults of working age**

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

These actions related to the following regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

Regulation 10 Dignity and respect

Regulation 12 Safe care and treatment

Regulation 13 Safeguarding patients from abuse and improper treatment

Regulation 15 Safety and suitability of premises.

Regulation 17 Good governance

Regulation 18 Staffing

We used the findings of previous inspections plus ongoing monitoring information to decide which services to inspect at this inspection (June 2017). Prior to this inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the trust. These included clinical commissioning groups, NHS Improvement, NHS England and Healthwatch.

At this inspection we inspected the following core services:-

- Crisis teams and health based places of safety.
- Acute wards for adults of working age and psychiatric intensive care units.
- Wards for older people with mental health problems.
- Long stay/rehabilitation mental health wards for working age adults.

We also inspected the following three core services which were newly acquired by the trust on the 1 April 2016, using the standard key lines of inquiry: -

- Wards for people with learning disabilities or autism.
- Specialist community mental health services for children and young people
- Child and adolescent mental health wards.

We did not inspect community mental health services for people with learning disabilities or autism or community-based mental health services for adults of working age, as the trust had indicated these outstanding actions had not yet been addressed. Therefore, the ratings for these services remain as per the previous inspection.

During the comprehensive inspection in May 2016 we rated forensic inpatient/secure ward, community based services for older people and substance misuse services a 'good'.

# Summary of findings

Since that inspection we have had no further information that would lead us to believe that this has changed so did not inspect the services. Therefore, the ratings for these services remain the same.

At the comprehensive inspection in May 2016 we also inspected specialist inpatient service, for example, eating disorder and perinatal services but did not rate these. We did not inspect these service on this inspection.

## How we carried out this inspection

To get to the heart of people who use services' experience of care, we ask the following five questions of every service inspected and of the provider:

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

Before visiting, we reviewed a range of information we hold about Avon and Wiltshire Mental Health Partnership NHS Trust and asked other organisations to share what they knew. We carried out an announced visit on the 26 and 30 June 2016.

During the inspection we visited 24 wards, four health based places of safety, six crisis service intensive teams, one crisis triage team and spoke with:

- 100 patients
- 24 carers
- members of the executive team and trust board, including the chief executive, chair, service and ward managers and acting managers and a selection of senior managers including modern matrons
- 130 other staff, including registered nurses, health care support workers, doctors, psychologists, psychiatrists, occupational therapists and practitioners

- spoke with three police representatives with mental health lead responsibilities for Avon and Somerset and Wiltshire police forces

In addition, we:

- attended and observed seven meetings including handovers, multidisciplinary meetings and patient and staff check-in meetings
- held focus groups and drop-in sessions for staff and patients
- reviewed 133 patient records
- reviewed 70 prescription charts
- carried out a specific check of the medication management on the wards
- looked at a range of policies, procedures and other documents relating to the running of the services
- received 26 comments from patients, relatives and staff collected from comment cards placed in comment boxes at various trust sites.

The team would like to thank all those who met and spoke with inspectors during the inspection and were open and balanced in their experiences of the quality of care and treatment at Avon and Wiltshire Mental Health Partnership NHS Trust.

## Information about the provider

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 was formed in April 1999 following a review of mental health services in the Avon Health Authority area

carried out by the Sainsbury Centre for Mental Health. The formation of the trust brought together mental health services in Bath and North East Somerset, Bristol, North Somerset, South Gloucestershire, Swindon and Wiltshire into one organisation. The trust also provides specialist services for a wider catchment extending throughout the south west.

The trust serves six clinical commissioning groups and six local authorities, NHS England also commissions specialist

# Summary of findings

services. It has an annual income of £196 million and employs 3,500 substantive staff. It operates from over 90 sites including eight main inpatient sites and services are delivered by 150 teams. It has a total of 16 locations registered with CQC.

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

We spoke with 100 patients and their carers. Patients told us that staff were kind and helpful in all the services we looked at. Patients told us that they felt involved in their care.

## Good practice

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

- We saw a good example of where staff demonstrated using least restrictive principles on Lime ward. An incident had occurred where one patient had caused damage to property on the ward and was behaving aggressively towards staff. There were clear decision-making processes documented as to why staff would not use seclusion. They considered this in the context of the patient's mental health needs. Staff managed the situation without injury to either patient or staff.

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

- The south Gloucestershire team had employed a peer support worker in research to trial the open dialogue model of care. This model involves a consistent family/social network approach to care, in which the primary treatment is carried out through meetings involving the patient together with his or her family members and extended social network. This member of staff also undertook friends and family questionnaires with discharged patients in order to encourage more detailed and meaningful feedback. The south

Gloucestershire team had enabled many of its team members to train as open dialogue practitioners to undertake interventions with service users and families.

- In Wiltshire, there were regular inter-agency planning meetings attended by the police, ambulance services, emergency departments, community teams, local authority and the crisis teams. The crisis team had championed these meetings. They discussed high-risk individuals that had multiple contacts with services. The meetings produced comprehensive shared care plans across all the services and worked well in reducing the risk for those patients.

### **Wards for people with learning disabilities or autism**

- The trust had designed the service at the Daisy Unit to be able to provide bespoke care for the residents. This covered the model of treatment, the package of care offered and how the residents chose to furnish and decorate their living environment. The staff strived to ensure that being in hospital did not prevent the residents from living an independent life, free from unnecessary restrictions.

## Areas for improvement

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

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

- The trust must ensure that it continues to deliver its ligature improvement plan in a timely manner.

# Summary of findings

- The trust must ensure that staff complete all monitoring of medical emergency equipment, including emergency medication, in line with trust policy.
- The trust must ensure staff complete patient observations in line with trust policy.
- The trust must ensure that where there are issues with personal alarm systems these are addressed quickly and replaced if necessary, to ensure optimum safety of patients, staff and visitors.
- The trust must ensure that it revisits the seclusion arrangements for Silverbirch and provides facilities that are safe, accessible and meet the privacy and dignity needs of patients.
- The trust must ensure that it revisits the learning and embeds the actions across the service from the serious incident on Lime ward and the death of a patient due to neuroleptic malignant syndrome (NMS). Most staff we spoke with were not aware of or were unable to recognise symptoms relating to NMS.

## **Children and Adolescents Mental Health wards**

- The trust must ensure that prompt action is taken to remove and/or mitigate the risk posed by potential ligature points.
- The trust must ensure that risk assessment are completed in relation to the locked external doors.
- The trust must ensure that the fences are made secure.

## **Specialist community mental health services for children and young people**

- The provider must ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are employed in each team in order to meet the needs of the people using the service at all times.
- The provider must ensure shortfalls in mandatory staff training are addressed as soon as is possible.
- The provider must ensure that all staff have a valid and up-to-date criminal background check in place.

## **Long stay/rehabilitation mental health wards for working age adults**

- The trust must ensure the accommodation at Whittucks Road meets the requirements of the Department of Health guidance on same sex accommodation so that patients do not have to pass through opposite sex areas to reach facilities, such as the lift or the bath.

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

- The provider must ensure that where there are issues with personal alarm systems these are addressed quickly and replaced if necessary, to ensure optimum safety of patients, staff and visitors.
- The provider must ensure that all staff in clinical roles complete training in the Mental Capacity Act that enables them to have a good understanding relevant to their role, and that appropriate assessments are done and recorded.
- The provider must demonstrate that action is being taken to ensure that limitations on access to Section 12 doctors are not responsible for delays to Mental Health act assessments in order to work within the trust's Section 136 joint protocols and the Mental Health Act Code of Practice.
- The provider must ensure that there are clear procedures and joint working arrangements in place with local authorities, to ensure assessments take place in a timely manner in the each place of safety and reduce the level of transfers between places of safety.

## **Wards for older people with mental health problems**

- The trust must ensure clear risk management plans and that staff clearly document and review risk management plans. It must ensure patients risks are clear on care plans.
- The trust must ensure blind spots on Aspen ward including the garden are observed safely and mitigated.
- The trust must ensure they prioritise plans to provide alternative accommodation to dormitories on ward 4 in order to ensure optimum safety of patients particularly at increased risk times such as at night.

# Summary of findings

## **Action the provider SHOULD take to improve Acute wards for adults of working age and psychiatric intensive care units**

- The trust should ensure that it continues to monitor that when staff administer rapid tranquilisation best practice guidance is followed at all times, regardless of route.
- The trust should ensure that it has oversight of all ligature assessments that are undertaken and that the service continues to complete its annual ligature assessments and update accordingly and on an ongoing basis. They should complete all identified actions including environmental changes to reduce the level of risk to patients.
- The trust should ensure that it progresses the suggestions and actions related to seclusion arrangements that will address the privacy and dignity issues previously raised by us in May 2016.
- The trust should continue with their recruitment campaign, targeting areas within the service with the most vacancies and highest need.

## **Children and Adolescents Mental Health wards**

- The trust should ensure all staff; young people and visitors are made aware that there is a two minute wait before the locked fire doors open if there is a fire. They should ensure the fire officer regularly reviews the two minute delay on fire doors to ensure they are safe.
- The trust should ensure there are clear lines of sight on the ward and night time checks are carried out uniformly by staff to ensure the safety of the young people.
- The trust should ensure all staff are clear about the use of the extra care area to ensure that young people are not being placed in seclusion.
- The trust should ensure that there is a fully stocked grab bag (a bag with emergency medication that could be accessed quickly if there was an emergency) available.
- The trust should ensure all young people are involved in their care planning.

- The trust should review their referrals into the ward to ensure they did not prioritise young people from Bristol, South Gloucestershire and North Somerset. This would ensure all young people in the south west region had equal access to care and treatment.
- The trust should ensure all care plans reflect the young person's views.
- The trust should ensure that there are sufficient activities for the young people at the weekend.
- The trust should ensure that there is a social worker on the team.
- The trust should ensure that the clinics room is well maintained.
- The trust should ensure that MCA audits take place.

## **Specialist community mental health services for children and young people**

- The provider should take steps to ensure consistency of quality of care records, that all care plans are holistic and sufficiently recovery focused, and that they contain clear evidence of how staff respond to patients' physical health care needs. There should be clear evidence to demonstrate patients have been involved in their own care.
- The provider should take steps to reduce the waiting lists across the service.
- The provider should ensure all staff receive appropriate information about the future shape of the service and clarification about which organisation is ultimately responsible for its delivery.
- The provider should support the individual teams to embed the necessary governance and support systems to enable the service to be as effective and efficient as possible within resource and financial constraints.
- The provider should be mindful of low morale of some of the service's staff, and ensure steps are taken to ensure all staff feel a part of the provider organisation's vision and are able to share in its values.

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

# Summary of findings

- Should ensure that privacy and dignity is not compromised at Mason unit seclusion suite via the external window.
- Should ensure that damp is addressed in the ward kitchen in Devizes place of safety.
- Should ensure that staff effectively monitor fridge temperatures, emergency medical and fire equipment at Devizes place of safety.
- The trust should ensure care plans in all intensive/ crisis teams are holistic.
- The trust should ensure that all crisis teams have a good understanding of identifying safeguarding issues.
- The trust should ensure that risk is always discussed at intensive/ crisis team handover meetings and that good practice for handovers is shared.
- The trust should ensure all teams take a proactive approach to assessing, monitoring or care planning for general physical health of patients on their caseloads.
- The trust should ensure that all protocols that cover the places of safety contain guidance on prescribing and administering medication before a Mental Health Act assessment
- The trust should ensure crisis teams pro-actively follow up patients that can't be contacted.
- The trust should ensure that compliments and complaints are discussed and reflected on in all crisis team meetings.
- The trust should ensure that they monitor response times to callers to the crisis teams out of hours.
- The trust should ensure that learning from incidents is shared in all crisis teams

## **Long stay/rehabilitation mental health wards for working age adults**

- The trust should carry out plans to return the responsibility for emergency out of hours calls back to the intensive support service in September 2017.
- The trust should ensure that viewing panels are installed in patients' bedroom doors, so patients are not disturbed more than necessary during general observations.

## **Wards for older people with mental health problems**

- The trust should ensure they continue attempts to recruit staff to fill the registered nursing shortfalls and occupational therapy and psychology staff to support patients to carry out activities.
- The trust should ensure care plans are relevant, person centred and individualised, avoiding use of generalisation.
- The trust should ensure managers who have not yet received root cause analysis training do so.
- The trust should ensure all staff complete mandatory training in order to achieve trust targets.
- The trust should ensure consistency in the use of HoNOS 65+ (older adults) to effectively measure treatment outcomes.
- The trust should ensure the timely completion of the work to make environments dementia friendly.
- The trust should review the bedroom window coverings in order for patients to not have such restricted view to the outside areas.

# Avon and Wiltshire Mental Health Partnership NHS Trust

## Detailed findings

### Mental Capacity Act and Deprivation of Liberty Safeguards

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

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

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



# Are services safe?

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

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

## Summary of findings

At our last inspection in May 2016 we rated safe as requires improvement and this has not changed.

## Our findings

### Safe and clean environment

- Environments were clean and in reasonable condition across the various sites. However, there remained a number of places which required further work to bring up to a modern standard. Ward 4 at St Martins hospital in Bath was an old style dormitory ward for older adults, and the acute wards in Bath and Weston super Mare were in need of redecoration
- The trust's board assurance report identified a risk in relation to safe and clean environments. The trust identified that if they are unable to improve their estate to ensure it is fit for purpose then, they are in jeopardy of not providing safe and effective care.
- The trust had 20 mixed sex accommodation breaches in the last year (1 April 2016 to 31 March 2017), nine were in wards for older people, Aspen had four, Laurel and Liddington both had two each and Dune unit had one. Six of these incidents were due to the design of the physical environment on older adult wards. The trust were in negotiations with the respective commissioners to address these. There were ten incidents in acute/PICU wards - two in Beechlydene, six in Applewood and two in Imber ward.
- The rehabilitation ward at Whittucks Road continued to breach Regulation 10 (2)(a) which states that patients should have access to segregated bathroom and toilet facilities without passing through opposite sex areas to reach their own facilities. Although all bedrooms had en-suite facilities and staff followed a protocol for the

safe use of the female bathroom so male patients did not pass by female bedrooms; the only bath for both male and female patients was located in the female ward.

- There were many ligature points throughout Riverside CAMHS ward. These were in public areas, bedrooms and the extra care bedroom. There was no plan to remove or minimise the risks and the mitigation planning place was not being followed by staff in all instances.
- The trust was undertaking a consultation on the future provision of the health based places of safety in Wiltshire at the time of the inspections. There were four in use at the time; all needed various remedial works. The trust were planning to eventually use only one which was fit for purpose in Wiltshire.
- The 2016 PLACE score for cleanliness was 99.3% for Avon and Wiltshire Mental Health Partnership Trust. The trust scored higher than the England average for cleanliness for mental health and/or learning disabilities wards (97.8%) for eight sites, with one of those scoring 100%. The trust scored lower than the England average for Hillview (96.2%) and St Martins sites (93.7%).

### Safe staffing

- There were staffing pressures across the services, although the trust was well aware of these and taking actions to ensure patients were safe. Recruitment was described by senior staff as ongoing to fill vacancies, but they acknowledged more work was needed to retain staff. A new director of human resources was due to take up post after the inspection and would take the lead on recruitment and retention of staff.
- There were 3552 substantive staff in post as at March 2017, 568 leavers throughout the twelve months. This meant that the annual rate of staff turnover was 16%. As at February 2017 there was a 4.7% staff sickness rate. The trust target for sickness was 4.6%. This compares to the most recent NHS sickness rate information which shows an average 5.3% sickness as at January 2017 for



# Are services safe?

mental health / learning disability trusts. As at February 2017, both CAMHS and wards for people with learning disabilities and autism had the highest percentage of staff sickness with 12% each.

- Acute wards for adults of working age and psychiatric intensive care units had the highest number of shifts filled by bank staff to cover sickness, absence or vacancies with 15,508 shifts in 2016/17. In addition, they also used agency staff to fill 7,999 shifts for the same period. Wards for older people with mental health problems followed acute wards for the usage of bank and agency staff to fill shifts. The services used bank staff to fill 11,008 shifts and agency staff to fill 4,341 shifts.
- Staff at Whittucks Road were still covering the intensive support team (IST) phone calls at night. The trust had added an additional staff member to work 4pm-12 midnight to help with the busiest time. However, staff told us this had not addressed the issue of having to make a choice of whether to support patients on the ward or respond to the crisis. The ward manager had organised supervision from the IST team and we saw evidence that the IST team had delivered training to half of the staff team on the ward.
- The majority of staff were up-to-date with mandatory training within services. As of 31 March 2017, 85% of staff had completed mandatory training which was in line with the trust target of 85%.

## Track record on safety and reporting incidents and learning from when things go wrong

- Staff reported incidents via the trust electronic incident reporting system. These were collated into a monthly board performance report, but board members we spoke with felt this could have been better at looking at trends or themes.
- Commissioners we spoke with told us that there was still room for improvement in the timeliness of the investigation reports following serious incidents. Trust data showed variable reporting against the national serious incident reporting timelines of 60 days, since June 2016. However, commissioners did say that fewer reports were now being returned to them for major issues. Of those that were these were usually associated with the quality of the action plans, needing to reflect a more specific approach.

- The trust reported 118 serious incidents to STEIS between 1 April 2016 and 31 March 2017. The vast majority of serious incidents were 'apparent/actual/suspected self-inflicted harm meeting serious incident criteria' with 78 (65%) recorded.
- Overall, incident reporting at the trust was good; however, there were issues with the sharing of learning from incidents across the organisation. There were 50% of incident reports submitted more than 16 days after the incident occurred. The trust reported 8,303 incidents to the NRLS between 1 April 2016 and 31 March 2017. When benchmarked, the trust was in the upper middle 50% of reporters in the NRLS report covering 1 April 2016 to 31 September 2016. Of all the incidents reported to NRLS, 74% (6,165) resulted in no harm, 24% (2,028) of incidents were reported as resulting in low harm, 1% (58) in moderate harm, 1% (45) resulted in death and 0% (7) resulted in severe harm. The NRLS considers that trusts that report more incidents than average and have a higher proportion of reported incidents that are no or low harm have a maturing safety culture.
- There were two new staff recruited to the patient safety team just prior to the inspection, and their remit was to develop a better culture of reporting on incidents and to increase the associated learning across the trust.
- We found a positive incident reporting culture amongst staff, who were encouraged to report incidents by their line managers.

## Safeguarding

- Across all services, generally we found safeguarding systems and processes were understood by staff to keep people safe. Safeguarding concerns were recognised and reported promptly to ensure patients were protected at a local level.
- Bristol City council safeguarding team were leading on the issue of the sudden closure of Laurel ward (older adults). It had expressed concerns about the lack of an impact assessment on the patients from this ward as a result of the closure.

## Seclusion

- All acute wards had access to an extra care area and/or seclusion room to help support patients who were significantly unwell and required nursing in isolation. During the inspection in May 2016, we found that some

## Are services safe?

seclusion suites were not meeting the privacy and dignity needs of all patients due to the manner in which access to toilet facilities was arranged. We had found that on Elizabeth Casson, Oakwood, Lime and Hazel ward and where it was not safe for seclusion to be ended, patients were being given disposable aids for toileting. When we visited in June 2017, alterations had been made to the seclusion room at Oakwood and toilet facilities had been added. In addition, the trust had conducted a seclusion review, which included centralising seclusion facilities. The plan was to further develop these facilities over the coming months. There was still further work to be undertaken on Silver birch ward to minimise the impact on patient's privacy and dignity. This was due to accessing a seclusion facility on another ward, as it did not have its own dedicated one.

### Assessing and monitoring safety and risk

- Overall across the service, staff updated risk assessments regularly and following incidents. We found the risk assessment tools were standardised and available for use on the trust's electronic records system.
- Where wards had blanket restrictions in place, these related directly to risks to patients. An example on the acute wards was staff would not allow plastic bags on the wards due to health and safety issues.
- In 2015, the trust introduced a programme to reduce restrictive interventions through the Safewards

initiative. All inpatient wards engaged with the programme and an Involvement worker had been employed to support the programme in practice. The 10 interventions are designed to minimise the use of restrictive practice, including prone restraint. An evaluation of Safewards in practice had commenced to assess the engagement level of all wards and develop a delivery plan to support engagement and good practice.

- Medicines management within the community adult teams still required a safe medication disposal system.

### Duty of Candour

- The Duty of Candour (DOC) became a statutory requirement for all CQC registered trusts in November 2014. The DOC places a requirement on providers of health and adult social care to be open with patients when things go wrong, ensuring that honesty and transparency is standard practice. The trust's DOC policy and 'being open' procedure, were ratified in 2016.
- The trust understood and applied the duty of candour appropriately. This was evident in the majority of local teams where staff received training at corporate induction to enable them to follow the trust's policy and expectations. We reviewed seven complaint responses and all were appropriate and gave explanations and apologies where necessary.

# Are services effective?

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

## Summary of findings

At our last inspection in May 2016, we rated effective as good overall. However, at this inspection we have rated three of the core services as requires improvement, so this rating has now changed to requires improvement overall.

## Our findings

### Assessment and delivery of care and treatment

- Care plans and care records were generally of a good standard across the trust. However, on the Daisy unit staff had not provided care plans to residents and they were not in an accessible format.

### Best practice in treatment and care

- Care and treatment was being delivered in accordance with national guidance and standards. The trust participated in 20 national clinical audits which looked at various areas including; safeguarding knowledge of staff, pharmacy interventions, clozapine prescribing practice.

### Skilled staff to deliver care

- Staff were encouraged to develop their skills and knowledge. Staff were able to attend training courses if these had been identified as a development opportunity, and often these were funded by the trust.
- The trust's target rate for staff receiving an appraisal was 95%. As at 18 April 2017, the overall appraisal rates for all permanent staff (clinical and non-clinical) staff ranged from 87% to 90% at the trust-wide level.
- The trusts clinical supervision compliance rates for non-medical staff from 1 April 2016 to 31 March 2017 were 83% with a target rate is 85% compliance. Medical staff had exceeded the target with 88% compliance.

### Multidisciplinary and inter-agency team work

- Services demonstrated strong multidisciplinary working, both internally and externally. However, the Daisy unit did not have an occupational therapist and activities lacked a therapeutic focus.

### Consent to care and treatment and good practice in applying the MCA

- Most services were recording capacity and consent well.
- Training in consent and the Mental Capacity Act was predominantly through e-learning. The e-learning program was a package bought from an external provider which covered the principles of the Mental Capacity Act in detail

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

- The trust has started the process of reviewing and strengthening their governance around the Mental Health Act 2005 (MHA), their aims for the review include improving assurance, identifying and resolving recurring trends and ensuring the principles of MHA are embedded in their policies and procedures. The trust told us that they have started to introduce new systems to address some of the ineffective governance systems in place. This work will be co-ordinated by both the associate director of statutory delivery and the newly appointed role of professional head of mental health.
- The trust had re-established their Mental Health Act legislation committee (MHAL) after a break since 2015. The first meeting was held in March 2017. This group was attended by representatives for medical staff, operations and approved mental health professionals (AMHPs) meeting on a quarterly basis. The group aimed to provide high level scrutiny and challenge to ensure a change of culture in relation to MHA is embedded across the trust. The Director of Nursing and Medical Director had not yet attended the two meetings held so far. The MHAL has already developed a very challenging two year plan to address issues identified to date. There was evidence that some of the work outlined in the plan was already underway.

## Are services effective?

- The trust told us that it planned to re-focus the direction of the MHA team to provide better oversight, scrutiny and governance. For example, it had already started by conducting an audit of MHA in all the inpatient wards. The audit focussed on the practical application of the Act rather than the implementation of its principles. However, currently there was no implementation date in place for a continuous programme of auditing the MHA and its implications. The MHA team report would also be changed; it would focus on thematic learning, analysis of data and outcomes of mental health act reviewer visits. The plan was for the report to be presented to the MHAL rather than the matrons meeting to inform their discussion.
- The trust were planning to implement a new process for dealing with provider action statements (PAS); reports required by CQC in response to Mental Health Act reviewer visits. These reports ask a provider who have detained patients on their wards to address any identified action required during a visit. Previously the trust was not providing PAS to CQC in a timely manner, with several outstanding for a significant amount of time. This was previously raised with the trust and remained an issue up to and including our inspection, there were five PAS outstanding for more than four months. Currently, ward managers are co-ordinating the provider's response to the visit reports without support from the trust. The new process described will involve the MHA manager co-ordinating the trusts response to CQC and analysing reports to identify recurring themes and issues. These will be raised to the mental health act legislation committee and the MHA manager will identify any additional training needs for staff based on identified outcomes.
- Other examples of the work underway in the new MHA plan include the MHA legislation committee reviewing all trust policies and procedures to ensure they reflect the principles of the MHA Code of Practice revised in 2015. The trust are also planning to amend RiO to increase functionality and streamline current administration processes relating to MHA.
- The trust was currently meeting its MHA training target of 85%. The training was delivered to staff every three years via an online training package. The training package was under review and due to be redesigned, underpinned by the Human Rights Act. There also have plans in place to commence the Bevan Brittan training programme, a high level training course to cover subjects such as how the Human Rights Act underpins MHA, Mental Capacity Act and emerging case law.

# Are services caring?

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

## Summary of findings

At our last inspection in May 2016 caring was rated as good and this has not changed.

## Our findings

### Kindness, dignity, respect and support

- We received positive feedback from patients about the care provided within the trust.
- We observed that staff treated patients with compassion, dignity and respect, and provided genuinely person-centred care.
- Staff in took the time to interact with patients and involved them in their care. They ensured patients understood their care and treatment options and supported them to make decisions about their own care.

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

- Although some of the environments in wards for older people did not promote privacy or dignity, the trust and ward staff were aware of these challenges and staff did their best to overcome them.

- In the Friends and Family Test, which asked service users whether they would recommend the services they have used; giving the opportunity to feedback on their experiences of care and treatment. The trust scored similar to the England average over the six month period (August 16 to January 2017) fluctuation no more than 3% above or below in any of the six months. The score of 88% of patients recommending the trust was achieved in three of the six months in the period between October 2016 and December 2016 whilst September had the highest score in the period with 89% recommending. The percentage of patients who would not recommend the trust was similar to the England average, averaging 1% less over the period.
- The staff Friends and Family Test (FFT) was launched in April 2014 in all NHS trusts providing acute, community, ambulance and mental health services in England. It asks staff whether they would recommend their service as a place to receive care, and whether they would recommend their service as a place of work. The percentage of staff who would recommend the trust as a place to receive care was worse than the England average – 77% compared to 80%. The percentage of staff who would not recommend the trust as a place to receive care is similar to the England average – 7% compared to the England average of 6%.

# Are services responsive to people's needs?

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

## Summary of findings

At our last inspection in May 2016 responsive was rated as good and this has not changed.

## Our findings

### Access and discharge

- Across services, we saw good support given to patients with complex needs. In particular, within the older adult wards we saw good physical healthcare provision.
- CAMHS services had been through a prolonged period of uncertainty and considerable change. This had still not been fully resolved at the time of our inspection. Some staff were still unsure as to whom they actually worked for and which organisation was responsible for them. Staff vacancies were running at about 12% across the services we inspected, and a consequence of this was increasing caseloads and waiting lists for community services. In the Riverside unit, the model of care and the building environment was in need of further development to meet the needs of children requiring inpatient care. The service could not accommodate children and young people with a high level of care or treatment needs.
- We found that the majority of people who had been assessed and needed admission had a delay in discharge from the place of safety recorded due to identifying a bed. AMHPs also told us that there were still significant issues identifying beds, and that bed managers would often prioritise a patient in the community in need of admission.

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

- The trust had a budget for translators and information to meet the needs of the local population. A wide variety of languages were accessed which included Polish, Somalian, Spanish and British Sign Language.

### Listening to and learning from concerns and complaints

- We found information about how to raise a concern or make a complaint was readily available to patients across all the services. Although there was a trust wide complaints and concerns policy this was due for review on the week of the inspection.
- Learning from complaints was considered and discussed in team meetings. There was a robust investigation process in place and a formal action plan was completed for every complaint, along with a suitable reply.
- There were multiple examples of the trust learning from complaints at both a local and trust wide level. For example, on older person's inpatient wards communications with carers had been improved over transfer and discharge arrangements for patients.
- The appointment of a new manager overseeing complaints was beginning to strengthen the reporting process, but further work was required to enable the trust board to receive information on trends and themes. There was an annual report prepared by the PALS team looking at the overall issues with statistical detail about the types and nature of complaints along with outcomes and whether they had been upheld.



# Are services well-led?

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

## Summary of findings

At our last inspection in May 2016 well led was rated as requires improvement and at this inspection we rated it as Good.

## Our findings

### Vision, values and strategy

- At the time of the inspection the trust had adopted a new mission/purpose statement: 'Working together to live our best lives.' It was in the process of developing a new strategy, with three main principles - to support staff, work for patients, and be sustainable. The trust recognised this would take time to develop and embed but also realised it was a strategic risk if it failed to explain and achieve buy in to the strategy effectively.
- The trust board had commenced the process of revising the strategy to take account of new policy direction (Five Year Forward View for Mental Health) and the priorities of the two local sustainability and transformation partnerships. In addition, the trust had reported a significant overspend during the last financial year (2015/16). It was planning to undertake challenging work with all its commissioners to address this over the next two years. This was planned to ensure the trust had the resources to meet its commitments in line with the quality strategy. This was occurring during the inspection period and plans had not been finalised. The existing strategy involved four key components – Our Purpose, Our Vision, Our Priorities and Our Values.
- As previously reported the trust's priorities were:-
  1. We will deliver the best care
  2. We will support and develop our staff
  3. We will continually improve what we do
  4. We will use our resources wisely
  5. We will be the future focused
- The values were:-
  1. P – Passion. Doing our best, all of the time

2. R – Respect. Listening, understanding and valuing what you tell us
  3. I – Integrity. Being open, honest, straightforward and reliable.
  4. D – Diversity. Relating to everyone as an individual
  5. E – Excellence. Striving to provide the highest quality support.
- Staff we met on this inspection were aware of the trust's vision, priorities and commitments and we saw information displayed in every location. Information surrounding the trust's current vision and strategy was also displayed on the trust intranet page. There was some confusion amongst staff over the future strategic direction of the trust. This was commented on during our initial staff focus groups and attributed by staff to the overspend, and a lack of clarity about the trusts future strategic direction.

### Good governance

- The new chair of the trust had introduced a significant change in the mode of reporting to the board from its sub-committees, which was structured around the provision of assurance and escalation of risks. Board sub-committees stated explicitly whether or not they were assured in relation to a range of risks which the board had agreed to monitor. If not assured, they were required to state what actions were resulting, and which risks needed to be escalated to the board for discussion and resolution. Executive directors described how this was underpinning an accountability culture. Also, how it was leading them to consider what sources of assurances they were drawing upon, and whether they were fit for purpose.
- Sub committees of the board were:
  1. Audit and risk - to assess whether the trust's systems and processes for governance, risk management and internal control are fit for purpose, and are being applied appropriately and effectively; and, to report to the board on its findings
  2. Nomination - to conduct the formal appointment to, and removal from office of board directors

## Are services well-led?

- 3. Remuneration - agree policy and frameworks for executive and senior officer remuneration:
- 4. Finance and planning - to provide specialist financial, performance management and commercial scrutiny and oversight
- 5. Quality and standards - to oversee the provision of safe high quality patient care and comply with all relevant legislation, regulations and guidance, and that meets the expectations of service users
- 6. Charitable funds - to monitor the application of all charitable funds in accordance with the Charities Acts, external guidance and applicable legislation, and to ensure that decisions on the use or investment of such funds are compliant with the explicit conditions or purpose for each donation.
- The trust had made some changes and improvement to its risk processes since last year's inspection. It had done away with a separate strategic risk register and now had a corporate trust wide risk register and board assurance framework. It had decided to abandon the previous variety of risk matrices designed to accommodate differing risk appetites. These changes were the product of a recent dedicated board seminar. However, senior staff told us that there was still some way to go before the trust had a fully implemented risk management system, with appropriately trained staff in post to administer it.
- The trust was going through a management restructure at the time of the inspection. Previously, services were organised into seven directorates which were either aligned to the one of the six local authorities or specialist services. Each directorate had a management triumvirate consisting of a clinical director, managing director and a service lead. The new structure was to be based on two geographical patches based on the sustainability and transformation plans, and one for specialist services. These would be led by one clinical director supported by a range of senior managers aligned to a local authority.
- At a directorate level scrutiny took place through monthly quality and performance review meeting led by members of the triumvirate management team. These meetings had a standard agenda which included quality assurance, quality improvement, strategic issues and performance. The directorates also had their own internal quality assurance groups which were the main links back to wards and teams.
- The trust had recognised the importance of developing a strong programme of quality assurance. This included a system of internal inspection, clinical and patient led audits, using learning from serious incidents and complaints and assuring compliance against NICE clinical guidelines. At the time of the inspection the trust were using a new quality improvement plan to capture this information and roll it out to operational areas. We spoke with managers about the effectiveness of this work, but not all were clear about how their respective teams would use it. Our specialist advisor reviewed it and felt it lacked clear instructions on either how it was to be used or what it was intended to achieve.
- It was positive to see that each of the wards and teams had access to a range of management information, which was available in the trust intranet, displayed in an accessible format. However, this did lack detail about significant trends and areas for improvement. Directorates were able to keep their own risk register and these were brought together to influence the trust wide risk register.
- Commissioners in the local clinical commissioning groups (CCGs) felt that the trust was responsive to the previous May 2016 CQC inspection. The CCGs felt there had been progress in their relationship with the management triumvirates and the executive team. However, they felt there were still areas of improvement required, such as timely responses to serious incident reports and quality impact statements for the recent skill mix reduction on inpatient wards. Wiltshire CCG in particular, were concerned about the workforce challenges the area faced and what specific plans the trust have to address these.

### Fit and Proper Person Requirement

- The trust was meeting the fit and proper persons requirement (FPPR) to comply with regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This regulation ensures that directors of health service bodies are fit and proper persons to carry out their role.
- The trust had a fit and proper person policy and procedure in place.
- We examined six files and found no significant systemic weaknesses or any issues with the quality of due diligence across those appointments. However, there was no evidence from the files, those declarations of interest had been used to check on whether a proposed



## Are services well-led?

appointee's behaviour or track record regarding outside interests raised any character concerns. The acting company secretary explained that these were in fact used but accepted that this was not clear in the files and would make changes to make this clear.

- All the records included all the necessary information. This included a photo identification, completed disclosure and barring (DBS) checks, a self-declaration on occupational health, certificates to prove professional qualifications and competencies, insolvency and bankruptcy checks, a full record of employment history and references.

### Leadership and culture

- The trust had a relatively new senior leadership team, with a range of appointments made over the last 12 months. This included a new chair, medical director, finance director, operations director and a couple of non-executive directors. A new appointment to the director of human resources role was due to commence in post shortly after the inspection.
- Senior managers we spoke with felt that the new chair had started to set a new culture for the trust board. They also felt the chief executive was open and approachable. She had generated a weekly update for all staff in which she invited comments and where feedback was acted on. There was also more visibility of executives visiting services and taking on a link role with each of the localities.
- The trust understood and applied the duty of candour appropriately. We looked at six closed complaint files and assessed them against the CQC's standard for complaints management. All were closed on time and met all requirements effectively. There were good final responses in all cases. There was evidence of thorough investigations, compassionate apologies, concerns addressed, all referenced the parliamentary health services ombudsman appropriately and one had a learning plan on record. However, the chair accepted that complaint information and learning was given closer attention at the board quality and standards committee, rather than the trust board.
- The trust just had just completed an external financial review, in collaboration with NHS Improvement. This was aimed at highlighting key areas for consideration in addressing the financial recovery. However, the scale of

the financial improvement plan would have a potentially significant impact on the way the trust currently operates. The trust is currently in segment 3 of support from MHS Improvement.

- In the NHS staff survey 2016, the trust were better than average of other mental health trusts for one key finding around the percentage of staff experiencing physical violence from staff in the last 12 months. However, the trust reported results worse than average for 15 key findings, this included equal opportunities and career progression, reporting errors, near misses or incidents witnessed in last month, staff feeling unwell due to work related stress, communication between senior management and staff, role makes a difference to patients/service users, staff experiencing harassment, bullying or abuse from patients, staff reporting the most recent experience of harassment, quality of appraisals, quality on non-mandatory training, learning and development, staff confidence and security in reporting unsafe clinical practice, organisation and management interest in and action of health and wellbeing, staff recommending the organisation as a place to work or receive treatment, staff satisfaction with resourcing and support and staff who are satisfied with the quality of the work and care they are able to deliver.
- The percentage of staff who would recommend the trust as a place to work was close to the England average – 66% compared to the England average of 64%. The percentage staff who would not recommend the trust as a place to work is similar to the England average – 17% compared to the England average of 18%.
- The trust's Annual Equality Data Monitoring Report 2016 on the diversity of their workforce stated that there was 40% representation of women in senior and very senior management roles. Although Black and minority ethnic (BME) workforce representation had dropped by a percentage point in 2016 to 11%, the trust had a balanced BME/white workforce in terms of proportional representation to the overall working age population.

The trust acknowledged that more work was needed around encouraging disability declarations.

- In terms of the overall workforce in 2016, black and minority ethnic (BME) employees accounted for 12% of the workforce. BME representation at board level was lower, however, at 8%.

## Are services well-led?

- From the first quarter of the financial year there had been 15 cases where staff members had been involved in a disciplinary case. Of those 15 cases six of them have resulted in staff being suspended with three cases where the police have been involved.
- The trust had a range of issues being developed to maximise the levels of engagement with the workforce:
  1. Staff charter to be developed.
  2. Workforce strategy to be developed. The strategy aimed to respond to current opportunities and risks and take account of the clinical strategy.
  3. Staff engagement/experience groups to be established in each locality and feed into trust wide staff experience group.
- The trust had an established joint negotiation and consultation committee, which met bi-monthly with locally recognised union representatives. A range of staff issues were discussed and formally recorded. We met with two representatives of this group during the inspection. They spoke positively of the professional relationship with senior management, but recognised the next year would provide significant challenges.

### Engaging with the public and with people who use services

- The trust had committed to strengthen its engagement and involvement of patients and the public in developing its services. It had recently completed the new strategy for service user and carer involvement,

which was completed by a group made up of carers and third sector partner organisations. At the time of the inspection this had just been published and was in the process of shared across the organisation.

- The trust had decided to now move the line management of involvement co-ordinators to the patient experience team to better co-ordinate the initiatives.
- The trust board recognised there was still more to be done on engagement and had this listed as a corporate risk. As an action it intended to establish an inpatient and carer's charter across the organisation, over the coming months.

### Quality improvement, innovation and sustainability

- The trust had continued to participate in a number of applicable Royal College of Psychiatrists' quality improvement programmes or accreditation schemes. These covered such areas as; the accreditation schemes for electro convulsive therapy, rehabilitation wards, home treatment service, and the quality networks for forensic mental health services, eating disorder services and perinatal services.
- The trust remained committed to participation in research and viewed it as a core activity. It benefited from a nationally well respected research and development department. During 2015/2016 the trust was involved in over 200 national studies.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	<b>Acute wards for adults of working age and Psychiatric Intensive Care Units</b>
Treatment of disease, disorder or injury	The trust must ensure that it continues with its ligature improvement plan.
	Although ligature reduction work was progressing, some areas still required completion in order to maintain patient safety.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	<b>The trust must ensure that all monitoring of medical emergency equipment, including emergency medication is undertaken in line with trust policy.</b>
Treatment of disease, disorder or injury	Hospital policy was that staff should check medical emergency equipment weekly. Beechlydene, Ashdown and Poppy wards all had gaps in their equipment checking records. Poppy ward had the most frequent and longest gaps.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance
Diagnostic and screening procedures	
Treatment of disease, disorder or injury	

This section is primarily information for the provider

## Requirement notices

The trust must ensure that patient observations are completed in line with trust policy.

Elizabeth Casson ward staff had partially completed all the patient observations, except one, prior to them having observed patients. The one patient where staff had not done this was on a different level of patient observation to the remaining seven patients. We found with this record that staff had not signed to say they had observed the patient as prescribed.

### Regulated activity

### Regulation

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

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

**The trust must ensure that where there are issues with personal alarm systems these are addressed quickly, replaced if necessary, to ensure optimum safety of patients, staff and visitors.**

We highlighted during our visit in May 2016 concerns raised by staff on Ashdown and Beechlydene units related to ineffective alarm systems. Staff we spoke with told us that although the trust were due to replace the alarm system in October 2017, the system remained unreliable therefore placing staff and patients and visitors at increased risk of harm.

### Regulated activity

### Regulation

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

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

**The trust must ensure that it revisits the learning and embeds the actions across the service from the serious incident on Lime ward and the neuroleptic malignant syndrome (NMS) related death.**

This section is primarily information for the provider

## Requirement notices

Not all staff we spoke with were able to describe how to safely respond to a patient experiencing symptoms related to neuroleptic malignant syndrome (NMS).

### Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

**The trust must ensure that it revisits the seclusion arrangements for Silverbirch and provides facilities that are safe, accessible and meet the privacy and dignity needs of patients.**

When we visited in May 2016, we found arrangements for seclusion for Silver Birch ward were not safe. During this inspection, concerns remained with regards to patients still being taken under restraint across the hospital site to Lime ward. In addition, Silverbirch ward also accessed the seclusion room on Elizabeth Casson ward, which is female PICU. This raised concerns with regards to the privacy and dignity of both male and female patients.

This is a breach of Regulation 15 (1 c and d and f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

### Regulated activity

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

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

#### **Child and Adolescent Mental Health Wards**

The trust had not ensured the safety of young people from the multiple ligature risks on the ward. Whilst the trust had plans in place to mitigate identified risk staff were not following these plans. There was no plan to address and remove the ligature risks.

This section is primarily information for the provider

## Requirement notices

The trust had not ensured the safety of their premises by mending the fence that led from the garden directly onto the car park.

The trust had not ensured there was a risk assessment in place for each young person about the application of the locked doors.

This was a breach of regulation 12 (1) 12 (2) (b) (c).

### Regulated activity

### Regulation

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

#### **Child and Adolescent Mental Health Community services**

Due to ongoing staff vacancies, sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed in each team in order to meet the demands on the service and the needs of the people using it.

Not all staff were up to date with mandatory training, necessary to enable them to carry out the duties they were employed to perform.

This is a breach of regulation 18(1) & 2 (a)

### Regulated activity

### Regulation

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

The provider had not taken sufficient steps to ensure that all persons employed for the purposes of carrying out the regulated activity were of good character.

This section is primarily information for the provider

## Requirement notices

A sizeable number of staff across the specialist community mental health services for children and young people teams did not have a valid and up-to-date criminal background check in place.

This is a breach of regulation 19(1)(a)

### Regulated activity

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

Treatment of disease, disorder or injury

### Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

#### **Long stay/rehabilitation mental health wards for working age adults**

Ensuring the privacy of the service user: People using services should not have to share sleeping accommodation with others of the opposite sex, and should have access to segregated bathroom and toilet facilities without passing through opposite sex areas to reach their own facilities.

The provider must address the breach in the guidance for same sex accommodation.

### Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

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

#### **Wards for older people with mental health problems**

Staff were not doing all that is reasonably practicable to mitigate risks to both themselves and patients. Staff did not ensure clear risk management or clearly document, review and monitor risks on all wards. Risks did not always translate to care plans.

Staff did not ensure they safely observed or mitigated blind spots on Aspen ward.

This section is primarily information for the provider

## Requirement notices

The trust provided shared dormitory accommodation on ward 4. This was not appropriate or acceptable for safe management of this client group particularly at increased risk times such as at night.

This is a breach of regulation 12 (1) (2) (a) (b) (d)

### Regulated activity

### Regulation

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

Treatment of disease, disorder or injury

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

#### **Wards for people with learning disabilities or autism**

The provider did not ensure that care plans were recovery focused and in an accessible format.

The provider did not ensure residents received copies of their care plans.

This is a breach of regulation 9 (1)(a)(b)

### Regulated activity

### Regulation

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

Treatment of disease, disorder or injury

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

**The provider did not ensure that all residents had a completed capacity assessment.**

The provider did not ensure that capacity was assessed on a decision specific basis.

This is a breach of regulation 11 (1)

### Regulated activity

### Regulation



This section is primarily information for the provider

## Requirement notices

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

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

**Mental health crisis services and health-based places of safety.**

The trust must ensure that where there are issues with personal alarm systems these are addressed quickly and replaced if necessary, to ensure optimum safety of patients, staff and visitors.

This is a breach of Regulation 12 (1) and (2 e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

### Regulated activity

### Regulation

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

**Staff were not effectively monitoring fridge temperatures, emergency medical and fire equipment at the Devizes place of safety.**

This is a breach of Regulation 15 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

### Regulated activity

### Regulation

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

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

**In the Wiltshire intensive teams there was a lack of monitoring of the medicines held in the services or prescribing by both the staff in the service and the trust pharmacy department.**

Sharps boxes were not always stored or sealed appropriately.

This section is primarily information for the provider

## Requirement notices

This is a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

### Regulated activity

### Regulation

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Records indicated that staff in the crisis teams were not always clear about consent to treatment and recording an assessment of capacity.

MCA training was not mandatory for all staff who provided care.

This is a breach of Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).

### Regulated activity

### Regulation

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Systems or processes must be established and operated effectively :

Admissions into the Health-based place of safety often resulted in a lengthy wait for assessment, a lengthy wait to return to the trust's nearest place of safety or a lengthy wait for a transfer to an appropriate hospital bed following assessment. This meant that timely assessment was not always taking place to ensure the health, safety and welfare of the service users.

The trust had yet to establish a joint agreement with the local authorities for undertaking assessments in all their places of safety when patients were being diverted to an alternative trust place of safety.

This section is primarily information for the provider

## Requirement notices

This is a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.