

Avon and Wiltshire Mental Health Partnership NHS Trust

Community-based mental health services for adults of working age

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RVN1H	Trust Headquarters	North Assessment and Recovery Team	BS10 5PY
RVN1H	Trust Headquarters	Central and East Assessment and Recovery Team	BS2 9RU
RVN1H	Trust Headquarters	South Assessment and Recovery Team	BS14 9BP
RVN1H	Trust Headquarters	Bristol Crisis Team	BS4 5BJ

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Avon and Wiltshire Mental Health Partnership NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Avon and Wiltshire Mental Health Partnership NHS Trust and these are brought together to inform our overall judgement of Avon and Wiltshire Mental Health Partnership NHS Trust.

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

On 8 and 9 December 2015 we inspected the crisis, assessment and recovery services that the trust delivered to adults of working age in response to a number of concerns.

The local commissioning group and local safeguarding adults team told us they were also concerned about the poor performance of services and that patients may be at risk.

Assessments were not always carried out in a timely way, there were over 500 patients waiting for assessment at the time of our inspection. A small number of these patients had been waiting several months. Some patients did not have risk assessments or risk assessments were not linked to patients' care plans. We found that patients' care needs were not always met in a timely way, that some patients did not have care plans whilst others had plans of poor quality. In some cases care plans were out of date.

There were not enough qualified nursing staff to provide care for complex patients, the current model underestimated number of qualified staff needed. Qualified staff needed to devote large amounts of time to supporting recovery navigators (support workers not qualified in mental health nursing) in addition to carrying a caseload which was larger than that planned in the new model.

Recovery Navigators were supporting complex people. Recovery navigators often had no experience of working within the NHS and didn't understand how to work with such complex patients. There was a 30% turnover of recovery navigators which meant some people had not had a consistent worker. The majority of recovery navigators were new in post.

There were inadequate governance systems in place. Not all the assessment and recovery teams had a system in place to ensure all referrals were tracked and there was no effective system in place to identify, track and follow up safeguarding concerns. The trust were aware of the

difficulties within the service. No effective measures had been put in place to address the issues. The lack of a service manager for the assessment and recovery teams meant there was nobody with overall responsibility for the systems and processes within these teams. Senior managers were aware of the problems but there was no effective strategy in place to tackle them.

Systems in place to audit electronic care records had not identified the poor quality of these records.

We returned to the trust on 17 February 2016 to check that the actions specified in the section 29a warning notice had been completed. We only checked the trust had completed the specific actions required by 1 February 2016.

We found that there was now an effective system in place to monitor referrals. The provider had established a tracking tool and escalation process to monitor the waiting lists and times for referral to assessment and referral to treatment. Individual teams now had information about all patients on the waiting list, how long they had been waiting, and reasons for any wait over four weeks. Staff updated the tracking system daily.

The trust had provided extra staff resources to address the waiting lists and manage the service. The trust had reached agreement with the Clinical Commissioning Group (CCG) to undertake a skill mix review to ensure there were enough qualified staff to assess and care manage patients.

The service had revised its governance structure within Bristol to focus on gaining detailed assurance that all teams were delivering safe and effective care in a timely manner. The trust had introduced new governance groups across Bristol.

The service had established a safeguarding tracking system and was in the process of rolling out additional training to all staff over the next two months.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

At our inspection on 8 and 9 December 2015 we found that the Bristol community assessment and recovery services were not safe:

- There were not enough staff of the right grades and experience to support complex patients
- Risk assessments were not always completed or updated
- Patients were not always seen within the two week target and there was no system in place to monitor the health of patients on the waiting list
- There was no system in place to ensure patients who missed assessment appointments were followed up
- The crisis team did not always make timely safeguarding referrals for patients or their children who were at risk.

However, patients who were seen regularly by members of staff had a good response if their health deteriorated. Staff were able to arrange an appointment with a psychiatrist for review. The crisis team had a good handover system to discuss and communicate patient risks amongst the team. Agency staff were employed on contract to provide some continuity of care.

We returned to the trust on 17 February 2016 to check that the actions specified in the section 29a warning notice had been completed. We only looked at the specific actions required to be completed by 1 February 2016.

The trust now had an effective system in place to monitor referrals. The waiting list had been reduced.

Are services effective?

We found that the Bristol community and assessment teams were not effective.

- Initial assessments were time limited and were not sufficient enough to complete a full assessment of patients needs
- Care plans were out of date, incomplete and did not contain patients views. Some patients had no care plans at all.
- Recovery navigators did not receive the correct training and or have the right experience to support complex patients.

However, we found that the trust had put a good system in place to support recovery navigators. There was evidence of good multi-disciplinary working and liaison with GPs and other services.

Summary of findings

Are services caring?

We found that staff within the assessment and recovery teams and crisis teams were caring.

- Staff were committed to providing the best care they could.
- Families were able to attend assessments.
- Patients were involved in reviews of their care but this was not reflected in care plans.

However, we found that patients' views were not always recorded in the majority of care plans we looked at.

Are services responsive to people's needs?

Bristol community assessment and recovery teams were not responsive.

- In the north and central teams over half of the patients referred waited more than two weeks to be assessed. For over a third of patients it was over four weeks
- Patients who cancelled or missed an appointment were not always followed up by community teams.
- Premises at Brookland Hall and The Greenway centre were cramped and noisy with limited access to desk space for staff.

However, the crisis team responded within four hours for urgent referrals. Only 5% of patients waited over four weeks to be seen by the south team. There was evidence of learning from complaints in the crisis and recovery teams.

We returned to the trust on 17 February 2016 to check that the actions specified in the section 29a warning notice had been completed. We only looked at the specific actions required to be completed by 1 February 2016.

The trust had provided extra staff to clear the waiting list. The trust now had a system in place to identify how long each patient had been waiting. Staff were able to identify patients needing assessment and allocation and ensure they were followed up as appropriate.

Are services well-led?

Bristol community assessment and recovery teams were not well led.

- Senior manager and the trust board were aware of the problems within the assessment and recovery teams but had not put in effective systems to address issues and improve services
- There was no effective system in place across all the assessment and recovery teams to manage the waiting list.

Summary of findings

- There was no system to learn from serious events.
- Staff morale was poor with high staff turnover.

However, senior staff told us that they had been well supported by the managing director of Bristol services. The trust had provided and additional two senior practitioners to work in the central team.

We returned to the trust on 17 February 2016 to check that the actions specified in the section 29a warning notice had been completed. We only looked at the specific actions required to be completed by 1 February 2016.

We found that there was now an effective system in place to monitor referrals. The trust had revised its governance structure within Bristol to focus on gaining detailed assurance that all teams were delivering safe and effective care in a timely manner. The trust had introduced new governance groups across Bristol.

Summary of findings

Information about the service

Avon and Wiltshire Mental Health Partnership Trust provide crisis, assessment and recovery services as part of the Bristol Mental Health partnership.

Our inspection team

The team comprised two CQC inspection managers, four CQC inspectors, a clinical governance specialist, a crisis team specialist nurse, two social workers, a nurse and an assistant inspector.

Why we carried out this inspection

We carried out this inspection in response to a number of concerns from a whistleblower, Bristol Clinical Commissioning Group, Bristol safeguarding adult team and information CQC had received about a number of serious incidents.

How we carried out this inspection

Before the inspection visit of 8 and 9 December 2015, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit on 8 and 9 December 2015, the inspection team:

- visited the crisis team base at Callington road Hospital and spoke with crisis team staff based within the three assessment and recovery teams
- visited the South, North and Central and East assessment and recovery teams
- looked at 110 electronic patient records
- spoke with 50 staff across the four teams
- interviewed the managing director, head of profession and practice and the medical director for Bristol services

- interviewed senior members of the organisation including the director of nursing and the chief executive
- attended the crisis team handover meeting.

We also looked at a range of policies, procedures and other documents relating to the running of the service.

Before the inspection visit on 17 December 2016 we looked at the report of actions sent to us by the trust.

At our inspection of 17 February 2016, the inspection team:

- spoke with nine members of staff
- looked at the new policies and procedures introduced to manage referrals
- looked at 35 electronic patient records to check waiting times, this included the records of patients we had identified at the inspection in December 2015.

Summary of findings

Areas for improvement

Action the provider **MUST** take to improve

We issued a Section 29A warning notice on 31 December 2015 which told the trust they must make significant improvements to the following areas:

- Care and treatment was not always provided in a timely way
- There was a lack of safe care and treatment
- There was a lack of governance systems in place to manage the quality and effectiveness of the service

- Staff providing care to patients did not always have the competence or experience to provide care safely
- Staff did not always take steps to safeguard patients from abuse
- The premises and equipment were not suitable at Brookland Hall and the Greenway Centre.

Significant improvements are required to the quality of the healthcare provided by the trust by way of having effective systems in place that address the points above.

Avon and Wiltshire Mental Health Partnership NHS
Trust

Community-based mental health services for adults of working age

Detailed findings

Name of service (e.g. ward/unit/team)

Name of CQC registered location

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

Our findings

Safe staffing

We inspected three Bristol assessment and recovery teams (north, central and south), the Bristol crisis team and the triage team. The triage team was the single point of access for referrals to the crisis and community teams. Referrals were initially followed up by the triage team and allocated to the appropriate community or crisis team.

The triage team had three nursing staff, one of which was agency who had been in post over a year, and one administrator. The original plan had been to staff the triage team with existing crisis staff but the crisis team did not have enough staff. Managers could move staff between the crisis and triage teams if required. The crisis service manager showed us their proposed new staffing model, which included additional staff agreed by commissioners for the triage team.

The trust's Bristol risk register dated 1 December 2015 stated, 'The capacity within the recovery teams has led to a variety of concerns with case planning and case load management'. The risk register further stated, 'Use of agency staff where available however there is a clear lack of agency available to support need.'

Within the assessment and recovery teams registered nursing staff were under pressure as they had higher than expected caseloads and there was a rapid turnover of recovery navigators. There had been a 30% turnover of recovery navigators and a reduction in the number of registered nursing staff to eight per team since the implementation of the new model last year. The new model intended that qualified members of staff would have lower caseloads. This had not happened. The trust's Bristol risk register updated 1 December 2015 stated, 'Risk upgraded as significant concerns regarding staffing. Continued challenges with recruitment and not all recovery navigator posts filled meaning that the necessary shift in caseloads has not taken place at the pace needed'.

We spoke with 50 staff across the crisis and assessment and recovery teams. All staff expressed concerns about staffing levels and staff turnover. Staff told us this had impacted negatively on staff stress, caseload size, and consistency of care for patients and service delivery. Information provided by the trust showed that one impact on care delivery was the large number of patients awaiting assessment. At the time of our inspection figures from the trust showed that 548 patients were awaiting assessment and that 211 of these had been waiting over four weeks.

There was significant use of agency staff over the last eight months, apart from in the north team. Trust figures showed agency use as:

- in the central team agency use had increased from 22% in April 2015 to 65% in September 2015, reducing slightly to 59% in November 2015
- south team had used between 11% and 42% over this period with agency usage in November 2015 at 33%.

The assessment and recovery teams employed regular agency staff to cover staff shortages. Three members of agency staff carried out the assessments in the central team. Agency staff told us that they had originally been employed to complete assessments but now also had caseloads. Some of the people who have been allocated had been on the team caseload for a year or longer, without any intervention. One member of agency staff gave two examples of where they had contacted patients to ask if they needed a service since their assessment over a year ago. One patient said, "I needed help last year. I don't need help now", which indicated the response time had been too long.

Assessing and managing risk to patients and staff

We looked at 110 electronic care records across four services.

The crisis teams used a red, amber, green (RAG) rating screen to assess and identify risk. Red for high risk, amber for moderate and green for low. We saw the crisis team caseloads had these risk ratings allocated to each patient on the handover caseload sheet. We observed handover meetings for the crisis team, which was led by the shift co-

Are services safe?

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

ordinator, and the caseload document was updated as individuals were discussed. Information was cross referenced with the electronic patient record and planned activities were delegated to different members of the team.

However, we noted that the central crisis team did not clearly discuss individual patient risks and there was a lack of clarity about why care plans were in place. For example, two members of staff needed to visit one patient. Another patient needed a male member of staff to visit. Neither patient's record contained information about why this was necessary on either the caseload document or the electronic patient record. This meant that staff unfamiliar with these patients would not have all the information about the patients' needs and risks.

Records we looked at across the four teams showed that of 110 patients 15 had no current risk summary. Staff had not always updated summaries following an incident, or reviewed risk regularly. This meant that due to the high turnover of recovery navigators and the use of agency staff the trust could not ensure patients were always supported by staff with which they had developed a therapeutic relationship. The lack of risk assessments meant that staff might not recognise that patients were deteriorating and that they were potentially a risk to themselves or others.

Over the four teams, we visited 2405 patients who were in receipt of a service. Electronic care records we looked at showed that patients seen regularly by a member of the team had a quick response when there was deterioration in their health. Records showed that patients could access a medical review with a psychiatrist if necessary, for example, for a medication review. Staff were able to discuss concerns about patients with more senior members of the MDT.

Assessment and recovery teams did not always assess patients within the trust's target of two weeks for non-urgent referrals. The trust figures for waiting times on the 8 December 2015 showed that:

- There were a total of 548 patients on the waiting list
- 325 (59%) of patients had been waiting more than two weeks to be assessed
- 70 patients out of 83 referred to the south team were seen within two weeks
- 130 patients referred to the north team, 78 patients referred to the central team and three patients referred to the south team waited over 4 weeks to be seen.

The manager in the north team told us that 283 patients had been assessed but not allocated to a member of the assessment and recovery team. Some patients were awaiting allocation and others discharge but there were no clear figures available to identify what proportion of these patients were awaiting allocation.

The trust had no system in place to monitor the health of people who had not been seen or were awaiting allocation. Triage staff told us they tried to call patients who were awaiting assessment but did not always have capacity.

The time lapse between triage and assessment increased the risk to staff. Staff visited alone unless specified otherwise. The time lapse meant the risk could have changed or increased and staff would be unaware of this.

Records for one patient in the central team showed their recovery navigator, who left in February 2015, had been the last member of staff to see them. In April 2015, the patient rang the crisis team in distress. They were reviewed and in July 2015, a decision was taken to allocate a new recovery worker. The new worker arranged to visit in November 2015.

Another patient had waited 148 days for assessment and a further 79 days before their notes stated, 'to be allocated a recovery navigator'. At the time of our inspection on 7 and 8 December 2015, this had not happened. A third patient referred on 19 June 2015 missed an assessment appointment in August 2015. The electronic patient record showed that the triage team had not reviewed them or arranged a further appointment during this time.

The central team had not assessed a fourth patient referred on 07 May 2015. A fifth patient referred on 27 January 2015 had been unable to attend an assessment appointment due to their child being sick. The service had not offered a further appointment. This patient's GP followed up in September 2015 but nothing further had happened until 1 December 2015 when the crisis team contacted the triage service. The central team offered the patient an appointment for a telephone consultation on 23 December 2015.

The triage team had not reviewed any of the above patients to monitor their health in order to ensure they did not need a service urgently or to check that their risks had not increased. The trust could not be sure that patients waiting assessment and allocation were safe and that any risk of harming themselves or others had not increased.

Are services safe?

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

The minutes from the trust's quality and standards meeting in November 2015 identified the risk associated with unallocated cases in Central Recovery. The meeting minutes stated that the electronic care records system could not flag up how long patients had been waiting and who was awaiting allocation to a care coordinator and that the trust was looking at a system to manage this.

Staff in the crisis team told us about the impact the lack of staff within the community teams had on their capacity to focus safely on crisis work. Crisis team staff told us that the community teams who did not always have enough time to work effectively with patients they transferred. This meant individuals either stayed on the crisis team caseload longer than necessary, or frequently re-presented in crisis. One member of staff told us about a patient this had happened to and the crisis team saw the patient.

Staff had received training in safeguarding but we identified a number of cases where the crisis team had not taken appropriate action. The crisis team should have referred six patients, or their children, to local authority safeguarding services but this had been delayed or had not happened. We raised this with the crisis team service manager who reviewed these cases.

We reviewed 12 serious incidents across the crisis team and assessment and recovery teams. Of the 12 we found that five identified issues with either care planning and/or risk assessment. However, we found no evidence that this had led to improvements in care planning and risk assessing across teams.

We returned to the trust on 17 February 2016 to check that improvements had been made. The trust now had an effective system in place to monitor referrals across all the assessment and recovery teams. Staff were able to identify how long all patients referred had been waiting for assessment. The trust now had a system in place to ensure patients were allocated to a care coordinator.

We looked at the electronic records of all patients we had identified at the visit in December 2015 as either waiting several weeks to be assessed or allocated. Staff had ensured all these patients had been followed up and appropriate actions taken.

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.

Our findings

Assessment of needs and planning of care

Over all four teams inspected, we looked at **110** electronic care records

Individual patient records we reviewed contained a basic assessment of patients' needs. This had been carried out in their assessment appointment, which usually took place over an hour. The presenting situation in the core assessment was completed but for the majority of records we reviewed other sections of the core assessment such as mental health history, social circumstances, substance misuse history and other sections of the assessment were not completed. We did not find evidence that any further assessment, apart from the medical assessment, took place following the half hour assessment. Staff told us that half an hour was not sufficient time to complete an initial assessment.

30 of the 110 records we looked at contained no care plan, an out of date care plan or a care plan from a previous episode of treatment. Care plans were brief and did not always contain patients' views or preferences. Care plans did not contain goals that were specific, measurable, attainable, realistic and time limited. Goals were not specific and care plans did not contain any information about how they would be reviewed and progress assessed. Some plans were from previous episodes of care or had been written over three years previously. These plans had been marked as 'updated' on the electronic system. However, there was no evidence in reviews that staff reviewed all the goals and that the needs were still current. Staff consistently told us that some care plans and risk assessments would not be up to date due to the current work pressures.

In Bristol crisis (north spoke) of five cases reviewed only two patients had a care plan and a further two patients had no risk assessment or care plan.

In Bristol crisis (central spoke) of 14 care records reviewed three patients had no risk assessments, three patients had no care plans and a further three patients had neither a care plan nor a risk assessment.

Of the six records reviewed in the Bristol crisis (south spoke) two patients had no care plan, three patients had no risk assessment and one patient had no care plan nor risk assessment.

We reviewed 27 care records in Bristol south assessment and recovery team. Three patients had no care plan at all. Nine patients had care plans that related to previous episodes of care but not their current episode with recovery team. Some patients had care plans that the recovery team had not completed; for example, the care plan was for an in-patient stay, and did not address current needs and risks.

In Bristol central and east assessment and recovery team, we looked at 49 electronic care records and found that some patients' care plans were marked as 'updated' when the recent review provided no evidence that all areas of the care plan had been reviewed. Care plans in central and east were of poor quality and generic. Staff responsible for updating patients' care plans did not always link risk to care plans and did not always update care plans following significant incidents. We found seven patients who had no care plan. Staff told us that some care plans and risk assessments were out of date and that this was due to lack of time to update them.

The lack of comprehensive and up to date care plans meant that there was a risk that patients would not get the care they needed. Due to high turnover of recovery navigators and use of agency staff, the trust could not ensure patients were always supported by staff with which they had developed a relationship. For example, six different recovery navigators had supported one patient. We looked at this patient's records and saw that staff had not updated care plans and the risk summary following a recent episode of self harm. There was no information in their care plan about how to identify when their mental health was deteriorating and how to support them with this.

Patients' preferences were not always recorded in their care plans. This meant that the trust could not be sure that patients were consulted about, or involved in the planning of their care.

Electronic records we looked at in the assessment and recovery teams showed that, where required, doctors

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.

carried out a comprehensive medical assessment following initial assessment. We saw that a letter was sent to the patient's GP with details of the medical assessment and outcome.

Staff were experienced and qualified.

Qualified nursing staff employed by the trust were experienced in working with patients with mental health problems. Recovery navigators were employed by three voluntary sector partners, one of whom told us there was a 30% turnover of recovery navigator staff. The experience of recovery navigators varied, for example, some were psychologists or social workers whilst others had limited experience of working with patients with complex needs.

The trust had no input to the recruitment of recovery navigator staff and was not responsible for their training. The terms of the Bristol Mental Health partnership specified that recovery navigators were employed by voluntary sector agencies who were responsible for recruitment, induction and training. This meant that the trust could not ensure new recovery navigators understood the trust's risk assessment and care planning procedures and understand how to deliver safe and effective care. The trust was not able to assess the competency of recovery navigators before allocating patients to them.

In response to the need for consistency and to support new recovery navigators to understand their role, the trust had introduced their own induction. However, due to staffing pressures recovery navigator staff did not always complete this induction before taking patients onto their caseload.

Recovery navigators told us that they had not received specific training on care planning, risk assessments and medications awareness. These were "learnt on the job". Recovery navigators told us they were expected to cover the duty phone and that this was not in the job description. The duty phone was also "learnt on the job". Covering the duty phone involved taking calls from patients and making decisions regarding advice, support, or transferring the call to a more senior clinician. This meant there was a risk that recovery navigators would not be able to provide the correct advice or support. The trust could not be sure that an untrained navigator would be able to assess risk correctly and escalate concerns.

Most recovery navigators expressed concerns at having complex service users with high needs on their caseloads. Caseloads ranged from 15 to 27 and could reach 30. One navigator told us, "It would not be safe or even possible to manage 30". We saw records of two incidents where recovery navigator's care coordinated complex patients. In one case inadequate medicines management had resulted in harm to the patient. In the second case, the navigator had not discussed risks with a clinician following an overdose.

Recovery navigators received monthly management supervision, which included a case review, and monthly clinical supervision. They attended weekly meetings and once a month a meeting where they could discuss their patients.

We looked at nine supervision records for recovery navigators and saw that they all received regular management and clinical supervision. Where recovery navigators were being directly supervised by any one of the three managers, records were present and up to date. However, those recovery navigators who were being supervised by a Band 6 member of staff held their own records. We asked four recovery navigators about their supervision records and they were able to produce them.

Multi-disciplinary and inter-agency teamwork

Regular multi-disciplinary team (MDT) meetings took place. In addition, there were work stream meetings where staff could discuss patients. In the central team, each work stream had a weekly assessment meeting to discuss referrals and allocations.

The crisis team had meeting structures and systems in place to provide oversight and safer working. This included twice-daily handovers with a handover sheet. There were clear email updates from the night staff, weekly MDT meetings and monthly whole team meetings.

We saw records which showed effective working by recovery navigators with other teams external to the organisation, for example social care organisations. Letters were sent to GPs informing them of changes to patients' care, for example medication changes.

Are services caring?

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

Our findings

All the staff we spoke with demonstrated a commitment to delivering the best care they could. Most of the staff we spoke with told us they were frustrated by gaps in the systems and the difficulty of recruiting and retaining staff as this had a negative impact on the care patients received.

Electronic records showed that staff who saw patients regularly developed effective working relationships which focused on helping patients manage their lives.

There was little evidence in care plans of patients' involvement. Progress notes showed that staff talked to

patients about their current circumstances but there was little evidence of planning or discussion of treatment goals and outcomes. We saw that staff carried out reviews with patients but did not always address care plan goals.

Families and carers were able to attend assessments if the patient wished. Electronic records did not always evidence that staff had assessed carer's needs. Staff did not complete this section of the core assessment.

The crisis team had a service user reference group which the service manager attended. This enabled service users to have some input to how the crisis service operated.

Are services responsive to people's needs?

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

Our findings

Access and discharge

All new referrals to Bristol mental health came through a single access point via the triage team. The triage service screened all referrals and organised these into the same three geographical sectors as the crisis team spokes and assessment and recovery teams. The triage team clinicians contacted the person who made the referral, the patient referred and any other relevant involved parties. The team then agreed the most appropriate service and the timescale within which the patient needed assessment.

The triage team booked in assessment slots via an electronic diary, with the relevant community mental health team. If the referral was urgent, they referred the patient for urgent assessment to one of the crisis team spokes. Each community mental health team provided a number of assessment slots each week. The timescale for referral to assessment was:

- within four hours for an emergency referral
- within 72 hours for an urgent referral
- one to two weeks for a routine referral.

The triage service received a high volume of referrals, for example, the week commencing 3 December 2015, 154 referrals had been triaged and allocated. However, triage staff were not always able to allocate assessment slots to community teams due to lack of capacity. For example, on the day of our inspection, triage staff told us that there were no assessment slots available with the central community mental health team, there was one assessment slot available within the north community mental health team and there were 22 assessment slots within the south community mental health team. All of the community teams except south team already had waiting lists for assessments allocated in previous weeks.

This meant that any individuals requiring allocation to the north or central teams were unlikely to be assessed. The triage team reported they 'held' a number of individuals that were awaiting allocation for assessment in addition to continuing to triage incoming referrals. Staff raised concerns that the mental health of patients who were not

urgent at the point of referral may deteriorate due to lack of timely assessment and treatment. They would try to call individuals to keep them up to date and check on any changes in presentation.

Patient waiting times from referral to assessment differed according to which team they were allocated. The triage team allocated patients to teams on a geographical basis. The trust figures for waiting times at 8 December 2015 were:

- In the south team 70 patients had been waiting less than two weeks with three patients waiting over four weeks
- In the central team 76 patients had been waiting less than two weeks and 78 patients waiting over four weeks
- In the north team 77 patients had been waiting less than two weeks and 130 patients waiting over four weeks.

The community services public risk log, dated 28 October 2015 stated there was a 'Risk of not achieving waiting times standard, 14 day referral to treatment'. The service manager for the crisis team had added increased waiting time for patients in crisis to their concerns log on 4 December 2015.

The crisis team saw urgent referrals; however, as shown in the above figures, recovery teams did not always see non-urgent referrals within the target time of two weeks.

When we returned on 17 February 2016 we found that the waiting list had been reduced. Staff were now able to identify which patients had been waiting more than four weeks for assessment and had a spread sheet which tracked these patients. Staff had an electronic system which identified how many patients were waiting to be allocated a care coordinator. We saw that only 21 patients across all three assessment and recovery teams had waited over four weeks. We looked at records for a sample of these patients and saw that staff had maintained contact and taken any action needed.

Meeting the needs of all people who use the service

Records we looked at showed that patients who needed additional arrangements to access the service did not always have suitable arrangements put in place. For example, we looked at records for one person who was homeless and referred in July 2015. After the patient had missed their first appointment, the service did not arrange another appointment until the end of September. Staff

Are services responsive to people's needs?

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

booked the appointment to take place at the night shelter. However, the night shelter was closed at the time the appointment was booked. Records showed that a further appointment 'didn't happen' and there was no record of any further appointments offered.

One patient requested home visits due to panic attacks in June 2015. Their notes stated, 'due to be assessed on 08 June but does not seem to have happened'. A final note recorded an assessment appointment for 01 September 2015 but there were no further notes. The patient had still not been seen at the time of our inspection on 7 December 2015. Another patient requested an evening appointment but notes stated there was none available. Secretarial staff sent a letter nine days after the proposed appointment date to offer a morning appointment. There were no further notes made regarding this patient.

We noted that patients who got lost in the system were often patients who missed initial appointments or did not respond to telephone calls. There was no system in place to ensure that staff followed up hard to engage patients. Qualified nursing staff expressed concerns about not being able to provide an effective assertive outreach service. One registered nurse said there was no assertive outreach team in the area and staff in the assessment and recovery teams did not have the dedicated time that an assertive outreach team would have.

When we returned on 17 February 2016 we checked the electronic records of the above two patients and found that staff had taken action in respect of the two patients mentioned above.

Records we looked at showed that when patients needed an interpreter this was available.

All staff at Brookland Hall expressed concerns at the lack of an appropriate work environment. This affected their ability to complete work and make phone calls. It also added to stress and pressure. Staff gave examples such as not being able to access a desk or computer. Connection was often poor on the laptops and at the community centre. The community centre was cold and had limited space. Phone calls made in the main office were difficult due to noise. The duty phone was located in the main office and was often manned by the recovery navigators. We observed that by mid-afternoon, there was no space left for staff to sit, no access to computers and the office was very noisy. We observed staff standing waiting for

colleagues to vacate chairs, desks and computers. Staff told us that due to competition for computers, on occasion they had left the office briefly and been logged off by another member of staff. This had resulted in their losing work.

Staff at The Greenway Centre, the north team base, told us that the office space available was cramped and noisy and our observations during the visit confirmed this. The Greenway was a community centre where a range of activities took place, the north team had an office and interview rooms on the first floor. Staff told us that on the days when a Zumba class (an exercise class to music) took place downstairs it was difficult to work due to the noise levels. There was no separate waiting area at the Greenway Centre for patients, which potentially compromised confidentiality, as they had to share the space with people using the centre for a range of activities. Patients had complained about this and it was on the local risk register. Patients had also complained that it was cold and noisy.

Listening to and learning from concerns and complaints

We saw the complaints log for the service and the crisis service manager kept a log of informal complaints or concerns raised. We saw the crisis service manager worked hard to identify the issues and work with individuals and staff for resolution.

We saw that there was a log available of issues across the Bristol community services. This log included complaints, action taken to address them and an update on progress.

We saw examples of implementing learning from complaints. For example, following a number of complaints in relation to the crisis line about poor experience due to response and attitude from staff, the service manager had put in place the crisis line protocol. This included good practice guidelines for telephone skills, how to operate the telephones and a flow chart for call handling, for example, signposting to other services or recognising when to pass the call to a registered practitioner in the triage team.

The crisis team service manager had been attending the service user reference group for crisis services. We saw sample minutes from the meeting. There was a patient safety development plan monthly report, compiled by the patient safety team, of root cause analysis and complaints recommendations. These were discussed in the monthly community services quality meeting.

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.

Our findings

There was no operational policy for the Bristol assessment and recovery services. This meant that there was no clear framework for the delivery of services. There were no clearly defined working practices, lines of responsibility and a lack of clarity about roles and responsibilities. There was a lack of measureable outcomes and no clear strategy to inform the running, development and review of the service.

There was an operational policy in place for the crisis teams. The crisis teams were not able to achieve all off the operational standards due to resource constraints and service wide pressures. For example, the crisis team did not have sufficient staffing to make contact within two hours for people in crisis.

The trust risk report to the board for November 2015 identified a risk of 'Serious quality failure event if the Trust's quality system fails to proactively identify areas of poor practice.'

In a letter to Bristol medical colleagues dated 4 December 2015 the clinical director of Bristol community services acknowledged, 'the quality of care for our patients is inconsistent, processes and systems do not always make it easy to deliver the care we would want, and our key performance indicators are not what stakeholders had hoped for at this stage.'

Minutes from the quality and standards meeting in November 2015 noted issues with responsiveness and timeliness to patient referrals, predominantly found in Bristol. Minutes from the meeting stated these issues were being addressed in the Bristol Service Improvement Plan.

We looked at two action plans for improvement developed by the trust; one which was part of the quality performance agenda which was presented to the board and one which was agreed with Bristol clinical commissioning group. Both were lacking in details such as outcomes required, measureable progress and timescales. The member of staff responsible for the actions was not always identified. It was not clear how the trust would monitor or evaluate actions. This meant the trust could not be sure that the improvement plan was effectively addressing the concerns, or that there was effective senior oversight or management of risks. We did not find any plans that addressed all the issues in a strategic, coordinated, planned and organised way.

We looked at reviews of 12 serious incidents which had identified issues with care planning and/or risk assessment. There was no system in place to ensure that an action plan was developed and implemented to ensure future improvements in planning and risk assessing were made.

We were shown the trust assurance system where 10 electronic care records, for 10 patients chosen at random, were audited at random each month as part of the quality assurance monitoring. One of the senior practitioners carried this out. Audits of these records were used to determine the quality of the teams' care records and fed into the trust's assurance system. We saw that on their dashboard the central and east team was scoring as 'green' with records audited being judged to be of an appropriate standard. We found that the care records we viewed across all teams did not correlate to these results and that the audit system was ineffective in identifying this.

There was no effective system in place to track safeguarding referrals. Staff had not completed the north Bristol team safeguarding tracking spread sheet. This meant the trust was not always able to identify if or what safeguarding referrals had been made and outcomes. This meant there was no assurance that procedures had been followed.

Leadership, morale and staff engagement

The team manager for the central team had recently left and the trust had not yet recruited to the post. In response to the difficulties in managing caseloads and allocations, two additional senior practitioners had been seconded to the central team. The team had been divided into three work streams, each with a senior practitioner and consultant psychiatrist.

The post of service manager for the three assessment and recovery teams was vacant and being covered by the overall community services manager. This meant there was no current manager who could oversee the implementation of consistent working practices across the three assessment and recovery teams.

Senior staff told us that they found the managing director of the triumvirate very helpful, supportive and willing to listen.

Staff engagement in Bristol was one of the two highest scoring risks on the operations executive risk register. The

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risk had been identified on 1 July 2014, 18 months previously. There were broad actions in place to address engagement but did not identify how staff engagement would be measured or what it would look like. It was not clear when this would be downgraded or the risk mitigated to acceptable levels.

Staff told us that an example of poor engagement with staff was the way the trust implemented weekend working. The community services manager told us that whilst meetings and consultations with staff were being undertaken about a possible start date of October 2015 the trust had already agreed an implementation date of September 2015 with commissioners. This meant that there was not a genuine attempt to engage and negotiate with staff about a significant change to their working hours.

The board assurance framework identified bullying as one of the three most concerning areas following the latest staff survey. The trust had commissioned a survey by an external agency and 49 staff across the trust chose to participate. Bristol was one of the three hot spot areas for bullying identified by the external agency. The analysis of responses identified staff on staff bullying as the major problem with 88% of this being manager on staff. The plan to address this included teams to receive team development. Bristol had the second lowest delivery of this with only 20% of teams having received it.

Staff told us that there was a “closed culture” in the trust. Some staff had raised concerns directly with the trust and offered advice on how to make positive changes. Staff told us that these concerns were not ‘positively received’ and the trust took no apparent action in relation to them.

Staff across all four teams expressed concerns with the triage system, staffing, adequate training for recovery navigators, workload, work environment and lack of stability. All staff at the central team told us that we would find some care plans and risk assessments incomplete or out of date due to not having enough time

Recovery navigators at the central team said the job was not what they expected it was going to be, based on the advertised job. One recovery navigator said, “The job description does not bare any resemblance to the actual role”. Other navigators said the job was “miss sold” and that they were “sold a lie” by their voluntary sector employer.

Many of the staff we spoke with told us that the new model was potentially good for patients. Staff said it was positive that they were moving towards a more inclusive social model; however, the new model was under-resourced with qualified nursing staff and had been implemented too quickly.

We returned to the trust on 17 February 2016 to check that the actions specified in the section 29a warning notice had been completed. We only looked at the specific actions required to be completed by 1 February 2016.

We found that there was now an effective system in place to monitor referrals. The provider had established a tracking tool and escalation process to monitor the waiting lists and times for referral to assessment and referral to treatment. Individual teams now had information about all patients on the waiting list, how long they had been waiting, and reasons for any wait over four weeks. Staff monitored the tracking system daily.

The trust had provided extra staff resources to address the waiting lists and manage the service. The trust had reached agreement with the Clinical Commissioning Group (CCG) to undertake a skill mix review to ensure there are adequate qualified staff to assess and care manage patients.

The service had revised its governance structure within Bristol to focus on gaining detailed assurance that all teams were delivering safe and effective care in a timely manner. The trust had introduced new governance groups across Bristol.

The service had established a safeguarding tracking system and was in the process of rolling out additional training to all staff over the next two months.

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.

This section is primarily information for the provider

Enforcement actions

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

Treatment of disease, disorder or injury

Regulation

Section 29A HSCA Warning notice: quality of health care

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

Significant improvements are required to the quality of the healthcare provided by the trust by way of having effective systems in place that address the points above.

You are required to make the significant improvements to the quality of care identified above.

CQC require you to undertake an immediate review of the services' waiting lists and case load ensuring all patients are allocated to a care coordinator. We require you to develop a system to ensure all referrals are tracked and followed up to ensure patients are not forgotten. This should be completed by 1 February 2016. You are required to provide us with information on your plans to undertake this.

This should be the start of a comprehensive review of the governance, assessment and care planning in the service which should be completed by 16 May 2016.