

Inadequate



Avon and Wiltshire Mental Health Partnership NHS  
Trust

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

## 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)
RVN	Trust Headquarters	Bristol Central and East Crisis Team	BS2 9RU
RVN	Trust Headquarters	Bristol South Crisis Team	BS14 9BP
RVN	Trust Headquarters	Bristol Access and Triage team	BS4 5BJ
RVN3Q	Blackberry Hill Hospital	South Gloucestershire Intensive Support Team	BS16 2EW
RVN8A	Sandalwood Court	Swindon Intensive Service	SN3 4WF
RVN8A	Sandalwood Court	136 suite- Place of safety	SN3 4WF
RVN9A	Fountain Way	Wiltshire Intensive South team	SP2 7EP
RVN9A	Fountain Way	136 suite- Place of safety	SP2 7FD

# Summary of findings

RVN6A	Green Lane Hospital	Wiltshire Intensive North Team	SN10 5DS
RVN6A	Green Lane Hospital	136 suite- Place of safety	SN10 5DS
RVN3N	Mason Unit, Southmead Hospital	136 suite- Place of safety	BS10 5NB

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

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

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

# Summary of findings

## Ratings

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

### Overall rating for the service

Inadequate



Are services safe?

Inadequate



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Inadequate



Are services well-led?

Requires improvement



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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

We rated mental health crisis services and health-based places of safety as **inadequate** because:

- During this most recent inspection, we found that the service had taken steps towards addressing the issues that had caused us to rate it as inadequate following the May 2016 inspection and had more work planned. However, at this most recent inspection, we also identified some new issues of concern. We judged that the trust had taken sufficient action to lift the warning notice from the 2016 inspection and we have issued requirement notices regarding issues where the trust must improve, these are detailed at the end of the report.
  - The trust had addressed some ligature risks at the places of safety however in Devizes and Mason unit, we saw examples of ligature points that either did not appear to be mitigated or had not been identified by a local assessment. There were problems with damp in a kitchen at the Devizes place of safety and the effectiveness of the alarm system in Salisbury.
  - There were significant problems accessing beds for people requiring admission to hospital. Some patients waited 32 to 50 hours after being assessed in the place of safety before admission to hospital. This put pressure on the capacity in the places of safety and could be a factor in levels of restrictive interventions. This also put pressure on the crisis teams who had to deal with a high level of acuity of risk in the community. A patient under the care of community mental health services had waited five weeks for admission to hospital as an informal patient. We identified this information as a complaint was made but the trust did not monitor this.
  - 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 at 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. There were significant problems with the availability of section 12 approved doctors. There were times when the AMHP services were delayed in attending due to the need to attend when the doctor was available or due to problems with their own capacity to respond. Overall 61% of people waited more than 12 hours to be seen for assessment. This was an increase on the level of people waiting 12 hours or more than at our inspection in May 2016.
  - The trust was not routinely monitoring how often people were taken to the emergency department due to a lack of capacity at the place of safety. The impact and frequency of people being diverted long distances across the trust when the local place of safety was full and then being returned to their local place of safety in order to be assessed was not routinely being monitored.
  - There had been a significant increase in the level of prone restraint at the Mason unit, when compared to data provided by the trust at our inspection in 2016. The trust did not provide specific restraint, rapid tranquilisation or seclusion data for the Wiltshire and Swindon places of safety.
  - The level of suspected suicide and unexpected death for this core service had increased since our inspection last year.
  - Staff recorded assessments of physical health on all patient notes that we looked at in South Gloucestershire. In the remaining crisis teams, staff did not consistently record this information.
  - There were some gaps and deficiencies with the quality of crisis plans and care plans in the crisis teams and some examples of limited discharge summaries.
- However:
- We observed the staff in all of the teams to be caring, compassionate and kind.
  - The trust had put governance systems in place to monitor and address the complex issues affecting the use of the places of safety more effectively.

# Summary of findings

- The trust had been involved in extensive inter-agency work to try and address some of the problems affecting the use of section 136. The trust had supported street triage and control-room triage initiatives.

# Summary of findings

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

### Are services safe?

We rated safe as **inadequate** because:

- In the South Wiltshire Intensive team we found a sharps box stored in a way that presented a risk of a needle stick injury to staff.
- At the Devizes place of safety, there were potential ligature points that had not been identified by the ligature assessment, damp in a kitchen area on the ward and no clock for patients.
- Staff had not conducted regular checks on the emergency equipment, the kitchen fridge temperature and fire extinguisher at Devizes place of safety.
- Personal alarm systems were not adequate at the Salisbury place of safety. Staff told us that this made them feel unsafe. At the 2016 inspection of the Salisbury site, concerns had been raised with the trust about the alarm system. There had been a serious assault on a member of staff in the Salisbury place of safety since the last inspection and the alarm had not worked when staff tried to use it to summon help.
- A bedroom door on Mason unit had standard door hinges. This could have been used as a ligature anchor point. This was in a blind spot and did not have convex mirrors positioned to aid staff in mitigating this. The Mason unit had an ongoing problem with interruptions in the water supply.
- Staff told us they had regularly been working alone in the Salisbury place of safety. These staff were not always trained in the prevention and management of violence (PMVA) and the personal alarm system was unreliable. Bank or agency staff who were new to the place of safety would also be asked to work there alone on their first shift. Some staff told us they did not feel safe and that sometimes their colleagues might miss looking through the viewing panel into the place of safety when undertaking ward observations. Staff told us that they had raised these concerns with managers. This was raised with the trust on this inspection and they directed that two staff needed to staff the place of safety. The local policy indicated that staff in the suite should be PMVA trained, however the ward was not always able to facilitate this.
- During the week of our inspection two out of the last six people admitted to the Salisbury place of safety did not have risk assessments. The trust told us that they would monitor this centrally going forward.

Inadequate



# Summary of findings

- One psychiatrist was working across two Bristol crisis teams due to a vacant post, and no locum doctor had been employed. Some crisis teams were operating with a high level of staff vacancies.
- We did not find crisis plans on many of the crisis teams' case records. We found some examples of risk assessments not being updated by crisis teams. There was a lack of monitoring of the medicines held or prescribing in the North Wiltshire intensive team. Medicines management was poor in the North and South Wiltshire Intensive teams. We found loose medicines with no record of where they were from and sporadic checks. 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.
- We identified at the last inspection in May 2016 that the Wiltshire and Swindon operational policy required updating to reflect that an individual must be able to give verbal consent to receive oral medication, however, the Wiltshire and Swindon place of safety protocol did not refer to this issue.
- There had been a significant increase in the level of prone restraint at the Mason unit, when compared to data provided by the trust at our inspection in 2016. The trust did not provide specific restraint, rapid tranquilisation or seclusion data for the Wiltshire and Swindon places of safety.
- The level of suspected suicide and unexpected death for this core service had increased since our inspection last year. In the year to March 2016 the trust had reported six deaths however in the year to May 2017 there were 18 deaths. The trust provided us with updated incident data following the 2017 inspection which indicated a suspected homicide by a patient in one of the intensive teams shortly before the inspection, however this was not raised by the trust or the team at the inspection.

However:

- The trust had taken action to address many environmental issues identified at the last inspection in Swindon, Devizes and Mason unit place of safety. The Mason unit had good staffing levels and used regular bank staff to cover shifts when required. Risk assessments at Mason unit were good. Mason unit staff were experienced and well-supported in looking after young people under 18 in the place of safety.
- The crisis teams had good lone working protocols. In the crisis teams, we saw examples of letters to families after an incident.



# Summary of findings

## Are services effective?

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

- Some care plans in the North Wiltshire team were very brief, consisting of one line, and were medication orientated. Some people who used services did not have care plans and it was not always possible to tell if staff had given service users a copy of their care plans.
- Staff recorded assessments of physical health on all patient notes that we looked at in South Gloucestershire. In the remaining crisis teams, staff did not consistently record this information.
- Risk was not always discussed at every intensive/ crisis team handover meeting. Following the last inspection we recommended that the trust should ensure good practice for handovers was shared to improve consistency.
- There were significant problems getting section 12 approved doctors to attend assessments in the places of safety.
- Some people were being taken to the emergency department when the places of safety were full (as opposed to being taken there for physical health reasons).
- Training in the Mental Health Act and Mental Capacity Act was provided by e-learning and was not mandatory for band 2-4 clinical staff. Staff in the crisis teams were not always clear about consent to treatment and capacity was not always well recorded.

However:

- All places of safety had started using the same paperwork and had introduced care plans. Complex care and multi-agency meetings took place in line with the crisis care concordat.
- The trust had been involved in an inter-agency approach to addressing the frequency of detention under section 136. This included trust staff working in control room and street triage. This was a joint venture with the police. The control room triage had been very successful in Wiltshire in reducing the numbers of detentions under section 136. Staff told us that relationships had improved between the different agencies delivering crisis care. People were no longer being taken to police cells as a place of safety unless there were valid reasons.

## Requires improvement



# Summary of findings

- The trust had begun collecting and analysing more data regarding the operation of the places of safety. The trust had undertaken a thematic review of incident data for the places of safety from October 2016 to March 2017.
- 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. 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.
- The crisis teams had exceeded the national priority target to gate-keep 95% of admissions for the previous 15 months.

## Are services caring?

We rated caring as **good** because:

- 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.
- We saw evidence of patients' involvement in care plans in care records. Patients were involved in interviewing staff. Advocacy was available in all areas. Teams sought feedback via a 'friends and family' questionnaire.

Good



## Are services responsive to people's needs?

We rated responsive as **inadequate** because:

- The trust did not monitor its response times to the crisis lines out of hours. Some staff reported possible delays in answering at night due to assessing other patients or being in the 136 suites. Service users in some teams reported that they found it difficult contacting some crisis teams out of hours, and waiting for call-backs. This was also an issue at our inspection in May 2016.
- Service users told us that there were delays in being given care plans, several told us that they were not sure how to complain. Some service users and carers told us of problems with communication such as being informed of their relative's admission to hospital or appointments not being kept.
- Staff in the crisis teams would 'cold call' patients that were not engaging but we found this was not always the case in the South and North Wiltshire Intensive teams.

Inadequate



# Summary of findings

- The quality of discharge summaries from the crisis teams was inconsistent.
- Significant delays remained in people being seen for assessment in the places of safety and waiting for transfer to a hospital bed following assessment. The majority of people (55%) waited 12-24 hours before being assessed in the 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, and considered this may have an impact on levels of seclusion in the places of safety.
- There could be very significant delays following assessment, if the person needed to be admitted to a mental health hospital bed. The trust's data showed that 58% of those needing admission had a delay in discharge from the place of safety recorded due to identifying a bed. We saw eight cases recorded where the person had waited between 32 and 50 hours after their assessment before their detention at the place of safety ended due to identifying a bed. AMHPs told us that they often had to wait for a daily trust wide bed discussion in the middle of the day before it was known if beds were available. Bed managers told us that demand was very high and they could not find beds for people being recalled from a community treatment order. We saw that a complaint was made that a patient had waited several weeks for a bed for an informal admission, and that a patient had become distressed and been sedated whilst waiting 37 hours in the emergency department for a mental health bed.
- Data provided by the trust showed that on average eight people per month were taken to Wiltshire places of safety when the Mason unit was full. The data also showed that this would typically add 15 hours delay and involve them being transferred back to Mason unit before they were assessed. Whilst there was a multi-agency agreement that was adhered to by the local authorities regarding responsibility for assessment in Mason unit this had not been extended to cover the issue of people who were taken out of area to the Wiltshire and Swindon place of safety suites.
- A window in the seclusion room at the Mason unit that overlooked the path running behind the building had been replaced with clear glass, this compromised patients' privacy and dignity.

However:

# Summary of findings

- All the intensive teams had capacity and systems to see people within urgent and routine target times and had met these targets over the previous year.
- The trust had been engaged in multi-agency work and had developed an action plan to try and address some of the reasons for delays

## Are services well-led?

We rated well led as **requires improvement** because:

- The Wiltshire South intensive team had one band 7 manager, whereas the other teams had two band 7 staff sharing this role. This put that team under pressure to function with less resources.
- The trust had begun collecting and analysing more data regarding the operation of the places of safety. The trust had undertaken a thematic review of incident data for the places of safety from October 2016 to March 2017. The trust were not routinely undertaking analysis of the level of people who needed to be turned away from the places of safety due to a lack of capacity.
- Although teams told us that they regularly audited care records we found these audits had not always picked up gaps in recording such as a lack of crisis plans in the crisis teams, the quality of care plans and assessment and recording of physical health needs.
- At our inspection in May 2016, data showed that there were serious issues with the capacity and service delivery within the Bristol place of safety and the governance structures were not in place within the trust to ensure effective escalation to the executive team. At this inspection we saw that complex issues and delays persisted, the trust had put governance systems in place to monitor issues more effectively however there was limited evidence that this was having an effect. The number of people detained for over 72 hours had reduced, however otherwise delays for assessment had increased since our inspection in 2016. Overall 61% of people waited more than 12 hours to be seen for assessment. This was an increase on the level of people waiting 12 hours or more than at our inspection in May 2016. We did not always see the trust analysing trends such as this.

## Requires improvement



# Summary of findings

- The lack of availability of beds put significant pressure on the operation of the places of safety and had an impact on the acuity of risk that the crisis teams were dealing with. The trust planned to set up a trust-wide bed management team to provide a more co-ordinated approach.

However:

- The trust had been engaging in multi-agency work and had developed an action plan to address some of the reasons for the delays. The trust planned to employ more section 12 doctors.
- Managers were supportive of their teams' development. Staff expressed confidence that they could raise issues.

# Summary of findings

## Information about the service

In February 2014, the publication of the Crisis Care Concordat placed mental health crisis care under the national spotlight. The Concordat committed its signatories to working together to improve the system of care and support, so that people in crisis are kept safe and are helped to find the support they need. The trust have a range of different teams that work together to meet the needs of people who present in crisis; for example, intensive teams, health-based place of safety, street triage, control room triage, mental health liaison and primary care liaison teams. During this inspection, we focused on the intensive services and the health-based places of safety, although we also describe how these services work with others.

Crisis and home treatment teams within the trust were called “intensive services” in all areas except Bristol. The intensive services teams provide home based interventions to people experiencing a mental health crisis, who may or may not already be working with the mental health services. For most patients this was usually up to four to six weeks.

They are also responsible for gatekeeping of inpatient beds and facilitating early discharge from wards for people over the age of 18. There was no upper age limit, but the service did not cater for people with dementia except in exceptional circumstances.

The trust had seven intensive services;

The Bristol Crisis and Intensive Home Treatment Service, which was made up of three “spokes” and a “hub”.

The South Wiltshire Intensive Team.

The North Wiltshire Intensive Team.

The South Gloucestershire Intensive Team.

The Swindon Intensive Team serves Swindon and agreed North Wiltshire specific area.

The North Somerset Intensive Team serves.

The Bath and North East Somerset Intensive Team.

We inspected two of the Bristol spokes (Central and east, serving Bristol city centre, and Bristol South), the Bristol triage service, the North and South Wiltshire teams, South Gloucestershire, and the Swindon team.

Section 136 of the Mental Health Act allows for someone believed by the police to have a mental disorder, and who may cause harm to themselves or another, to be detained in a public place and taken to a safe place where a mental health assessment can be carried out. Police can also take people who are detained under section 135 to a place of safety. Section 135 can be used by mental health professionals to take someone to a place of safety for a mental health assessment.

A place of safety could be a hospital, care home, or any other suitable place where the occupier is willing to receive the person while the assessment is completed. Police stations should only be used in exceptional circumstances.

Health-based places of safety are most commonly part of a mental health unit on a mental health hospital or acute hospital site, or part of an accident and emergency department in an acute hospital. The trust provides seven health-based place of safety across four locations within its geographical area to adults of all ages with no upper limit.

Wiltshire and Swindon places of safety are based within grounds of mental health hospitals, offering single occupancy at each facility: Fountain Way Hospital, Salisbury; Green Lane Hospital at Devizes and Sandlewood Court at Swindon. Young people under 18 years old can be assessed under a section 136 at the allocated places of safety at Fountain Way Hospital, Salisbury and Sandlewood Court at Swindon. They are served by three clinical commissioning groups (CCGs), North Wiltshire, South Wiltshire and Swindon, and Wiltshire police force.

The Mason Unit place of safety in Bristol has capacity for four patients. It covers a wide geographical area commissioned by four clinical commissioning groups (CCGs), covering Bath and North East Somerset, North Somerset, Bristol and South Gloucestershire. It is served by the Avon and Somerset police force. Mason Unit can

# Summary of findings

accept one young person aged 16 and 17 at any time and one under 16 at any one time. If an under 16 year old is

detained at the suite, the CCGs have agreed one space will be closed on the unit to ensure a safe environment for the under 16 year olds, separated from other adult detainees.

## Our inspection team

Team leader: Karen Bennett-Wilson, Head of Hospitals inspection.

The team that inspected mental health crisis services comprised of: one CQC inspector, one inspection manager and three specialist advisors.

The team that inspected health based places of safety comprised of: a head of hospital inspection, a CQC inspector and two Mental Health Act reviewers.

## Why we carried out this inspection

We undertook this announced comprehensive inspection to find out whether Avon and Wiltshire Mental Health Partnership NHS Trust had made improvements to their mental health crisis services and health-based places of safety since our last comprehensive inspection of the trust in May 2016.

When we last inspected the trust in May 2016, we rated the service as **inadequate** because we were concerned that in the places of safety people waited a long time for assessment and were taken to a police station too frequently. We were concerned that the trust did not have effective systems to assess gaps in service provision and that care and treatment was not always provided in a safe way.

Following the May 2016 inspection we issued a warning notice. The warning notice was served under Section 29A of the Health and Social Care Act 2008 in June 2016.

The warning notice required the trust to make significant improvements to the quality of the healthcare provided, this meant effective systems must be in place that address the following points:

1. There was a lack of effective operation of governance systems and process in place to ensure care was provided in a safe environment, including the provision of premises and equipment that were safe and suitable.

2. There was a lack of effective operation of governance systems in place and to assess, monitor and improve the quality and safety of services (including the quality of the experience of service users in receiving those services), which arise from the carrying on of the regulated activity.

3. Care and treatment was not provided in a safe way, including ensuring such arrangements respond appropriately and in good time to people's changing needs

We also told the trust it must make the following improvements to 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

# Summary of findings

- 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 update the Wiltshire and Swindon health based places of safety operational policy to reflect the changes made to the MHA Code of Practice.

And that it should make the following improvements:

- The trust should review out of hours crisis arrangements to ensure consistency across all the teams and localities
- The trust should ensure good practice is shared more effectively and consistently with use of handover templates and caseload monitoring information such as whiteboards across all teams and localities
- The trust should ensure that governance systems accurately record staffing establishment and use of agency across all teams and localities

## How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from staff at focus groups.

During the inspection visit, the inspection team:

- visited six intensive teams and the Bristol triage team
- visited all four of the health-based places of safety at the hospital sites, looked at the quality of the environment and observed how staff were caring for patients at each
- spoke with 15 patients who were using the service and 6 carers
- spoke with the 15 managers or acting managers for each of the teams and two service managers

- spoke with 37 other staff members; including doctors, psychologists, nurses and social workers
- interviewed the associate director involved in service improvement for these services
- spoke with three police representatives with mental health lead responsibilities for Avon and Somerset and Wiltshire police forces
- held engagement events that invited approved mental health professionals (AMHPs) to discuss local service provision
- sought feedback from other teams that support the crisis services, for example, mental health liaison teams at the acute hospitals, and emergency department staff
- looked at 59 care records
- observed 7 handover meetings, a complex case meeting, and the triage morning discussion
- carried out specific checks of the medication management at all of the intensive teams, health-based places of safety and the Bristol triage team, including reviewing 10 prescription cards
- looked at a range of policies, procedures and other documents relating to the running of the service.

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

- Service users and carers that we spoke with in relation to the Bristol south crisis team were very positive

about the service they received. Some service users and carers that we spoke with in relation to other teams told us that there was room for improvement in the service they had received.



# Summary of findings

- Service users and carers told us that they had not found it difficult to contact the Bristol crisis teams. However many service users and carers told us they found it very difficult to reach other crisis services after hours. They did not usually get an immediate response when they called and often had to wait for a call back. People told us this was frustrating.
- One service user told us that there was a lot of repetition of things already discussed at previous meetings and that the staff handover of client casework could be better. Service users told us about two occasions where appointments had not been kept.
- All of the service users and carers mentioned that they had had care plans. Some had experienced a delay with this, and in some cases it took a few weeks before a care plan was in place.
- Some service users told us that they did not always feel involved in the planning of care, and that there were limited options for treatment.
- Carers told us they felt involved with the care planning and delivery of care. They reported receiving regular updates on the progress of treatment. However, one carer told us that when her family member was admitted to hospital she (as next of kin) had not been notified until after discharge.
- Some service users and carers mentioned that they were given the opportunity to feedback about the service either face-to-face, or over the telephone.
- One carer told us that he felt that his partner had been discharged too quickly from the service. Others felt that the discharge process had been satisfactory
- All service users and carers mentioned that the information they had received was accessible and easy-to-understand.
- Several service users mentioned that they did not know how to complain, other than to contact the care coordinator or team's direct number. One service user commented that he would not feel confident in making a complaint directly to a team.
- Some carers mentioned that they had been offered an assessment of their own physical, caring and mental health needs. Another carer told us that the South Gloucestershire team was very approachable, and if she needed any help, she would feel confident of asking for help.

## Areas for improvement

### Action the provider MUST take to improve

- The provider must ensure that where there are problems 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 staff effectively monitor fridge temperatures, emergency medical and fire equipment at the Devizes place of safety.
- The provider must ensure that at all crisis/intensive teams there is sufficient monitoring of the medicines prescribed and held in the services by both the staff in the service and the trust pharmacy department.
- Should ensure that sharps boxes are not stored in a way that presents a risk of needle stick injury and the possibility of staff contracting a blood borne virus.
- 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 the senior managers in the trust clarify procedures and joint working arrangements with local authorities for assessments in each place of safety and reduce the level of transfers between places of safety.

# Summary of findings

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

- The provider should ensure that privacy and dignity is not compromised at Mason unit seclusion suite via the external window.
- The provider should ensure that damp is addressed in the kitchen at the Devizes place of safety.
- The provider should ensure that local guidelines are followed so that the places of safety are staffed with staff trained in prevention and management of violence (PMVA).
- The provider should ensure care plans in all intensive/ crisis teams are holistic.
- The provider should ensure that all crisis teams have a good understanding of identifying safeguarding issues.
- The provider should ensure that risk is always discussed at intensive/ crisis team handover meetings and that good practice for handovers is shared.
- The provider should ensure all teams take a proactive approach to assessing, monitoring or care planning for general physical health of patients on their caseloads.
- The provider 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 provider should ensure crisis teams pro-actively follow up patients that can't be contacted.
- The provider should ensure that compliments and complaints are discussed and reflected on in all crisis team meetings.
- The provider should ensure that they monitor response times to callers to the crisis teams out of hours.
- The provider should ensure that learning from incidents is shared in all crisis teams.
- The provider should ensure that all service users are given information on how to complain.

## Avon and Wiltshire Mental Health Partnership NHS Trust

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

### Detailed findings

#### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Bristol Access and Triage team	Trust Headquarters
Bristol South Crisis Team	Trust Headquarters
Bristol Central and East Crisis Team	Trust Headquarters
South Gloucestershire Intensive Team	Blackberry Hill Hospital
Swindon Intensive Service	Sandalwood Court
North Wiltshire Intensive Service	Green Lane Hospital
South Wiltshire Intensive Service	Fountain Way
Mason unit- Bristol 136 suite- place of safety	Mason unit –Southmead Hospital
Bluebell unit – Devizes 136 suite place of safety	Green Lane Hospital
Salisbury 136 suite - place of safety	Fountain Way
Swindon 136 suite – place of safety	Sandalwood Court

# Detailed findings

## Mental Health Act responsibilities

- Staff accessed Mental Health Act training as e-learning rather than face-to-face training. This training was only mandatory for qualified staff such as registered nurses. In many teams, health care support workers were not accessing this training even though their roles involved providing care to people detained under the Mental Health Act, or monitoring risk for those on leave from hospital.
- 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 in accordance with the MHA Code of Practice.
- 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.
- The trust had been involved in a considerable amount of inter-agency work around section 136 and the places of safety in response to issues raised at the last inspection.

## Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff accessed Mental Capacity Act training as e-learning rather than face-to-face training. This training was only mandatory for qualified staff such as registered nurses. In many teams or places of safety, health care support workers were not accessing this training even though their roles involved providing care to people who used services and may lack capacity.
- Records indicated that staff in the crisis teams were not always clear about consent to treatment and recording an assessment of capacity

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

## Our findings

### Safe and clean environment

#### Mental health crisis services

- The majority of the crisis/intensive teams' work took place in people's own homes, GP surgeries or clinic rooms. Interview rooms in the buildings used by the intensive teams were either fitted with fixed alarms, or portable alarms were used. These areas were clean and well maintained in all the locations.
- At Bristol Crisis South and Bristol Crisis Central and East teams, interview rooms were fitted with alarms and staff had a response plan. In Salisbury and Swindon, staff used personal alarms and staff from the ward would respond. Staff that used portable alarms showed us where they were kept. There were no interview rooms in Devizes, South Gloucestershire or the Bristol Triage service. The teams without interview rooms were able to use book rooms on trust sites or at GP surgeries, or could meet service users in community settings as an alternative to home.
- In all sites, there were appropriate facilities for staff to wash their hands. Staff adhered to infection control procedures.
- Clinic rooms were clean but mainly used for the storage of medication. GPs monitored the physical health of their patients. However, in Salisbury there were seven full sharp boxes. One large full sharp box was on a very high shelf and had not been closed and sealed. This presented a risk of needle stick injury and possibility of staff contracting a blood borne virus.

#### Health-based places of safety

- Shortly before our last inspection in May 2016, the trust had relocated the place of safety suite in Devizes into a unit that had previously been a small ward on the Green Lane hospital site. There were plans to develop this suite into a five-bedded place of safety unit and to close the one-bedded place of safety units in Salisbury and

Swindon. When we visited in June 2017, work was still underway to convert the Devizes place of safety into a five-bedded unit and it was still operating as a one-bedded unit in part of the ward.

- At our last inspection in May 2016, we raised concerns relating to ligature risks in Devizes. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. When we visited in June 2017, we saw an up to date ligature assessment. Some items had not been recorded on the ligature assessment such as two fire alarms, plates around alarm indicators which were not flush with the ceiling or walls, a drainpipe in the garden and an ensuite toilet with standard taps that was not being used and was to be kept locked at all times. When we raised this, the managers advised that they would update the risk assessment, as they had put some things back up following decoration, and that they had not considered that some other items needed to be included. We saw a ligature assessment at another trust place of safety site that did include similar items. Staff told us that there was advice on the trust's intranet on completing a ligature assessment but not a training session.
- The trust had completed some ligature reduction work in Devizes and they had more planned such as removing a door restrictor. However, target dates for this were not recorded on the ligature assessment sheet. At our last inspection in May 2016, we had identified a bathroom containing a toilet that had multiple ligature risks in Devizes, this meant there was a need to watch people while using the bathroom or toilet. When we visited in June 2017, we saw that the bathroom had a reduced ligature shower installed. The bathroom door had no viewing panel and the trust's action plan appeared to suggest that this door did have an adjustable viewing panel. All staff we spoke with knew where the ligature cutters were kept.
- At our last inspection in May 2016, we noted that to enter the Devizes place of safety, emergency response staff from the acute ward had to come outside from a different building, through two sets of locked doors to enter the place of safety. We were concerned that timed

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drills had not been carried out. When we visited in June 2017, we saw an incident record to confirm a timed drill had taken place in March 2017. Staff from the acute ward had taken less than a minute to respond. We noted that if three members of staff needed to respond from the acute ward, they would all need to enter the building together as only the security nurse on the acute ward held the key fob to enter the place of safety.

- In Devizes, we saw a fire extinguisher that staff had not had tested as scheduled in February 2017. We brought the fire extinguisher to the manager's attention and she advised us the following day that she had arranged for this to be tested. The patient garden had a single storey roof that was a potential absconding risk for patients. The manager advised us that the trust planned to install anti climb guttering on the roof. However, until the work was done, staff escorted patients in the garden.
- The environment in Devizes was clean and tidy and staff told us they completed a weekly environmental check. However, a kitchen area on the ward smelt strongly of damp and staff showed us damp on the wall under the sink. Staff used this kitchen for the preparation of patient snacks such as toast. There was a fridge in this kitchen in which items such as desserts were kept for patients. However, the staff had not monitored the temperature of this. Water was only available in parts of the place of safety due to an issue that had been ongoing for two days. The manager advised us that a specialist plumber was due to attend the unit.
- At the last inspection in May 2016, we were concerned that the Devizes place of safety did not have equipment staff could use in an emergency. When we visited in June 2017, the clinic room contained emergency equipment such as a first aid kit, oxygen and ligature cutters. We saw the weekly checklist kept in the room for checking the resuscitation equipment, and noted that there were gaps of four weeks and two weeks in April and May 2017. Staff told us that as the suite only operated when a person was detained they continued to store medicines in the clinic room on the acute ward. Staff told us that it was intended to store medicines in the clinic room once it was operating as a five-bedded unit in future.
- Mason Unit was a four-bedded unit within the Southmead acute mental health in-patient facility in Bristol. It opened as a place of safety in 2014. There was an on-going environmental issue with legionella identified in the water at the building where the Mason unit was located. The trust was aware and implemented the recommended monitoring and management procedures (including restrictive admissions). At the May 2016 inspection, the local management team told us that the trust would not remove known ligature risks until this issue had been resolved and they knew the full extent of work required as a result.
- At the inspection in May 2016, we were concerned that the seclusion room at Mason Unit did not have full line of sight and the ensuite toilet did not have anti-ligature tap fittings. The mirror was removable from the wall fitting. The door handle from the seclusion room to the ensuite was not an anti-ligature fitting. The ensuite facilities in the bedrooms were not anti-ligature and the beds could potentially be stood up on their ends and used to barricade the door or as a high ligature point. When we visited in June 2017, we saw that the trust had addressed these issues.. We saw a patient had damaged the seclusion room on the morning of our inspection but the manager had contacted the trust to fix this.
- When we visited in June 2017, we saw that some ligature risks remained on the main ward area as the bedroom doors had standard door hinges. Managers had identified this on the risk assessment as a trust wide issue. The manager was not aware of plans to change the door hinges. We saw one bedroom door that was not in line of sight of the ward with the doorway located in a recessed corner. This area did not have a viewing mirror. We asked for ligature incidents on the ward. There had been an incident in September 2016 where a patient had tied a ligature from a bedroom doorway. It was only on approaching the doorway for observations that a member of staff had noticed that a patient had draped a sheet over the outside of the door. We saw that there had been 26 other ligature incidents on Mason unit in the previous year, however these had not involved a ligature point.
- At Mason unit there was a problem with the water supply, which failed regularly and could put one or more showers out of action. Managers had reported this two months prior to the inspection but it remained a problem.
- During our inspection in May 2016, the ensuite shower at the Swindon place of safety suite was identified as a

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potential ligature point When we visited in June 2017, the trust had replaced this with a reduced ligature point shower. The lounge area taps, cupboard and door handles were not of an anti-ligature design. Staff told us that this area was always under staff supervision and staff always accompanied patients using it. . There was no access to outside space.

- The Salisbury place of safety suite was on the Fountain Way acute mental health hospital site. The entrance to the suite was located in a corridor between the acute ward and the psychiatric intensive care unit. In order to respond to the Salisbury place of safety, staff from the acute ward had to go through two sets of locked doors that staff had to open with a key rather than a form of swipe access. Some staff we spoke with expressed concern this could potentially add some delay to assistance reaching them, although did not have specific examples where this had been the case.
- Staff that we spoke with at the site told us of longstanding problems with the 15-year-old personal alarm system. They reported a delay of a few seconds after pulling the alarm before it would start working. Staff told us the system was prone to regular failure across all the wards on the site. A computer maintenance company had to attend the site to rectify this. Staff reported that this took several hours at times. During this time, staff would rely on mobile phones or personal attack alarms. Staff also told us that despite daily testing of all alarms, individual alarms would regularly be faulty, with approximately five or six a month being returned to the supplier.
- At our last inspection in May 2016, we identified the alarm system at the Fountain Way site as a problem. Staff told us of an incident in the place of safety since the last inspection when a member of staff had been seriously assaulted when the alarm system had failed to work. Ineffective alarm systems raised the risks to patients, staff and visitors in the event of an incident where assistance is required. At this inspection in June 2017, we raised these issues with the trust and they informed us that they planned to install a new alarm system by the end of October 2017.

## Safe staffing

### Mental health crisis services

- There were 170 staff working across the crisis teams at 31 May 2017. Twenty staff had left the trust's crisis teams in the 12 months prior to 31 March 2017.
- All teams had an established staffing level. Across the crisis teams the establishment level was 111 whole time equivalent (WTE) qualified nurses and 30 WTE nursing assistants. At 31 May 2017 there were 38 WTE vacancies for qualified nurses and 10 additional nursing assistants than the establishment level.
- The number of vacancies varied across the teams. The data provided by the trust indicated that at 31 May 2017 Bath and North East Somerset Intensive team had the highest level of qualified nursing vacancies at 70%. Wiltshire Intensive North team had a vacancy rate of 51% followed by Bristol crisis central and East at 41% and finally South Gloucestershire Intensive at 14%. When we visited the teams, the South Gloucestershire and Bristol Crisis South team reported they had no qualified nurse vacancies. The highest nursing assistant vacancy rate provided by the trust was 31% for the Bristol Crisis Central and East Team. The Bristol Crisis South and Swindon Intensive teams reported no nursing assistant vacancies.
- The trust had reported the establishment and vacancy figures for the Bristol triage service as zero, which appeared to be an error. When we visited this team, they reported that there were eight band 6 posts, two of these had substantive staff in post, three of these were filled with long term (some for two years) bank or agency staff and the remainder were filled by more general bank and agency staff. The team also had three nursing assistant posts, one with a substantive member of staff and two with long term bank or agency staff. Staff turnover in the team had been 10% in the year prior to the inspection. The manager explained that funding arrangements with the clinical commissioning group meant that the team had less flexibility to cover for sickness and leave, and funding had been reduced for administrative support. Staff reported that staffing numbers in the team seemed to have 'dwindled away' and it felt under-resourced. However, the manager told us that the team was rarely short-staffed.



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- Most teams told us that they used bank and agency staff to cover vacancies and sickness. Team managers tried to use regular bank and agency workers whenever possible. Across the trust's crisis teams, 1205 qualified nursing shifts and 2425 nursing assistant shifts were filled by bank staff and 85 qualified nursing shifts and 176 nursing assistant shifts were filled by agency staff in the 12 months prior to inspection. The Bristol Triage service and the Wiltshire Intensive North team were the teams with the highest levels of bank and agency staff usage. In the month prior to the inspection four qualified nurses from the Wiltshire Intensive North team had left to join a newly formed triage team. In the 12 months prior to March 2017 there had been 716 qualified and non-qualified nursing shifts that were not filled by bank or agency staff.
- The percentage levels of sickness varied across the teams. Bristol triage service had the highest sickness rate of 9%, Bristol Crisis North team had the lowest rate at 1%. The trust's average sickness rate was 3.9%.
- All teams had at least one band 6 member of staff on per shift. With the exception of South Wiltshire, all the teams had a band 7 clinical lead in addition to the band 7 team manager. The band 7 manager role in the South Wiltshire team was being split between two band 7 nurses from other teams. This was due to an ongoing staffing issue.
- The trust provided figures for the caseload of each team over the 12 months prior to March 2017. Each crisis team's caseload fluctuated over the year. The lowest figure for a team for a month in that period was 74 and the highest was 142.
- The Bristol triage service provided the single point of access for referrals into Bristol mental health services. This included the crisis teams, assessment and recovery teams and specialised services. This team did not carry a caseload and received about 20 referrals a day, the day prior to our visit the team had 198 open referrals.
- Bristol South, South Gloucestershire and Swindon intensive teams reported they had enough staff to safely manage their services. In Bristol Central, managers had recently increased the staffing levels due to increased activity in the service. The manager had the ability to flex the staffing dependent on demand.
- In Devizes, four of the Band six staff had left the service to join the new street triage service. This had placed pressure on the service in terms of safe staffing. The service had recruited two new staff and block booked three agency staff to meet the shortfall.
- Each team had a psychiatrist as part of the team. They were generally available Monday to Friday in working hours. In the central Bristol team, there were two part time psychiatrists and access to a psychiatrist one day a week by telephone. In Bristol South, the psychiatrist was shared with the Bristol North Crisis team due to a vacant psychiatrist post. The psychiatrist spent half the week in each team and was available for the other team by telephone when he was not with them. The trust had not employed a locum psychiatrist. The psychiatrist covering both teams reported having less time to participate fully in medical audits or service development as a consequence. Out of hours the crisis teams had access to a doctor on call.
- Staff received mandatory training, including resuscitation, risk assessment, safeguarding and medicine management. The compliance rate across the Bristol crisis/intensive teams was 73% this was below the trust target of 85%. The Bristol place of safety has achieved a 94% for mandatory training. The trust did not provide data for the crisis teams outside of Bristol.
- In Bristol, a consortium between the trust and voluntary or third sector organisations provided mental health services. There were band 4 staff in the Bristol crisis teams who were not employed directly by the trust. These staff were expected to complete the trust's statutory and mandatory training.

## Health based places of safety

- The Mason unit had a dedicated team of staff comprising two qualified nurses and two health care assistants per shift. There was a dedicated ward manager for the unit. They also had an additional staffing agreement with the neighbouring acute mental health ward, whereby staff could move between the wards dependent on need. At March 2017, 12 whole time equivalent (WTE) substantive nursing staff and 11 WTE substantive nursing assistant staff for the unit. During this time, the trust reported a vacancy rate of 36% of their total qualified nursing staff and 23% of their nursing assistant staff for Mason unit.



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- When it was necessary to cover sickness, absence or vacancies at Mason unit, the manager told us that they used two or three regular bank staff. and they rarely used agency cover. Bank staff had covered 28% of qualified nursing shifts and 38% of nursing assistant shifts in the 12 months prior to the inspection. Agency staff covered 4% of qualified nursing shifts and 2% of nursing assistant shifts in the same period.
- The average sickness absence rate for Mason unit was 4% in the eleven months to May 2017.
- The Wiltshire and Swindon places of safety were staffed by the adult acute wards. Each ward had an additional allocation of two staff members within their establishment to cover the place of safety. This was in line with Royal College of Psychiatrists' guidance. In Swindon and Devizes, the managers told us that the nurse in charge would admit the person and that a qualified nurse and nursing assistant would always be on duty in the place of safety if it were in use. Staff would usually rotate this role on a shift. In Devizes, the manager told us they would always endeavour to staff the place of safety with substantive rather than bank or agency staff.
- Health care assistants in Salisbury told us that a single member of staff would typically staff the place of safety alone once the person had been in the place of safety for an hour. Staff told us that this was not safe. Female staff told us they felt concerned being alone with a male detained person as staff knew little about the person.
- Staff also told us that they did not feel that the place of safety in Salisbury was always included on ward observations if in use, and they felt more vulnerable as there were problems with the reliability of the personal alarm system failing across the site and individual alarms regularly not working when staff went to use them. Staff told us that they had raised these concerns with local management but this staffing level was still the usual practice unless the nurse dealing with the admission decided the person needed two members of staff with them. The manager confirmed that a qualified nurse and health care assistant would admit the person detained on s136 and that subsequently one health care assistant typically staffed the place of safety unless it was judged during the admission process by the admitting nurse that two staff needed to be present. This solo member of staff would rotate on an hourly basis.
- In Salisbury, the manager told us that at times a substantive or bank or agency member of staff who was not trained in the prevention and management of violence and aggression (PMVA) would be left alone with a patient detained under section 136. He explained that this was as all staff on the ward were involved in the place of safety rota which rotated hourly. Some permanent staff were exempt from PMVA for health reasons, but not exempt from staffing the place of safety. In addition, bank or agency staff were employed to cover the two extra posts allocated to Salisbury for staffing the place of safety due to the plans to relocate the place of safety to Devizes.
- On a typical night shift the manager told us that 50% of staff who covered the place of safety in Salisbury were bank or agency staff Although PMVA trained staff were requested often the staff available did not have this training. The ward manager told us that the ward would have an establishment of seven staff for each shift and aimed to have a minimum of three PMVA trained staff on duty. Bank or agency staff who had not worked in the unit before were also asked to staff the place of safety, which could be alone, once they had been observed on duty for a while.
- We fed back to the trust at the time of the inspection that staff were sometimes working alone in the place of safety. The trust advised us that their policy required two members of staff to be present during any place of safety admission and that a more historic process had been reverted to at the Salisbury site where one member of staff supervised where this was viewed as being clinically appropriate. In response, the trust advised us that they had instructed staff to discontinue this previous practice and to have two members of staff supervising. The ward manager responsible for the place of safety in Salisbury confirmed the following week that there were two staff present. Following the inspection the trust provided the local staff induction guidelines for the Salisbury place of safety which had

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been updated to identify that two members of staff should be present throughout the person's time there. The trust also planned to monitor that two staff were on duty when the place of safety was in use.

- The issue regarding staff in Salisbury not always being PMVA trained was also brought to the attention of the trust during the inspection. The trust advised that a PMVA trained response team was available on the site. The local guidelines supplied by the trust following the inspection indicated that staff staffing the suite 'will be trained in PMVA'. This meant the practice in place at the time of the inspection did not follow local guidelines.
- The places of safety were linked with inpatient wards and could access the doctors covering these wards if required.

## Assessing and managing risk to patients and staff Mental health crisis services

- We looked at 59 care records across the crisis/intensive teams. Staff generally identified and managed risks effectively. However, in South Gloucestershire in two out of four records that we reviewed, risk assessments had not been updated when the team started working with the patient. This was also the case in one out five records that we reviewed in Bristol South and in one of 12 records that we reviewed in Devizes. The South Gloucestershire team explained there had been a short break just prior to our visit in the regular auditing of risk assessments that they normally undertook.
- We found the risk assessments to be of a good standard across the teams and saw an excellent example of risk recording in the Bristol Central team. However, on a home visit to a patient in Devizes we saw that a member of staff did not assess any thoughts of self harm or suicide with a patient for whom this was a potential risk factor.
- Most teams used a red, amber and green (RAG) rating for their caseloads. Risk assessments included risk of self harm or suicide, risk to others and neglect. All teams discussed patient risks daily and could respond quickly to increases in risk levels.
- We attended handover meetings at all intensive teams except North Wiltshire. The staff discussed the risks for each person using the service at the handover meetings. Planning of the team workload took any amended risk into consideration. However, the morning meeting in Bristol Central was quite brief and swift. The meeting that we saw didn't make reference to the RAG rating or diagnosis of the patient. This information would be helpful for staff undertaking visits following the morning handover. Several teams had weekly complex case meeting which allowed discussion in greater depth. We attended a complex case meeting in the Bristol Central team.
- The intensive teams used a number of systems to allocate and monitor workload and actions required. For example, the South Gloucestershire team used a "to do" list. All the team could access this live document. It was completed after handover and checked twice daily by the shift coordinator.
- Within the Bristol access and triage team, a qualified practitioner looked at the initial referral and allocated them according to urgency, using a mental health access trigger tool. Where staff identified a moderate to high risk at the point of triage, staff arranged a face-to-face assessment to complete the risk assessment and formulate a risk management plan. The triage team allocated these referrals to the appropriate crisis team.
- There was variation in the quality and detail of crisis and contingency plans. We saw examples of detailed and person-centred crisis and contingency plans, but also examples that were of a poor standard or not present on patient notes. We found that in 25 out of 44 records across six teams either a crisis plan had not been done, or it had been poorly done. An example of this was a young adult with suicidal thoughts with no crisis plan. In the Devizes team we found that only six out of the 17 care records that we reviewed had a crisis plan.
- Staff received mandatory training on safeguarding, and knew how and where to report safeguarding concerns. Some teams, such as Bristol South, Bristol Central, and South Gloucestershire had practitioners who had taken on a role of safeguarding lead and had a strong focus on identifying and managing safeguarding issues. All teams could access the intranet Myspace page that gave clear details of trust safeguarding leads and guidance for staff.
- However, in Salisbury, safeguarding was not as robust and it was not discussed proactively in the morning meeting. For example, staff had not considered safeguarding in a case of self-neglect when there was a younger relative in the same house despite a detailed

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team discussion on the patient's needs. We later identified this during our inspector's review of notes and we asked managers to take action. We observed a home visit and noted that staff did not routinely ask questions that would explore a patient's risk of suffering abuse due to their vulnerabilities.

- Teams had good lone working protocols. Shift coordinators took responsibility for contacting staff that were late back from visits. Staff had code words to use if they needed assistance whilst on visits. Staff did joint visits if necessary, or would use alternative sites for seeing patients they considered too high risk to see at home. However, in Salisbury not all staff had mobile phones. Staff were sharing phones or using their own phones. Staff who had joined the team had been waiting months for a work phone. When we raised this with senior management in the trust this situation was resolved quickly and phones arrived in the services the next day.
- The team psychiatrist, non-medical prescriber (nurse) or the person's general practitioner carried out prescribing of medicines for people using the intensive service. Most teams had a named member of staff who took a lead role in medicine management. In Bristol, South Gloucestershire and Swindon medication was kept in locked cupboards and signed for. Treatments cards were signed and up to date and all medication was in date. Controlled drugs were stored safely in line with trust policy. Teams only held small amounts of medication.
- However, medicines management practice was poor in the Wiltshire intensive teams. There was a lack of monitoring of the medicines held in the services and prescribing by both the staff in the service and the trust pharmacy department. In the stock cupboard at Salisbury, there were 10 boxes of diazepam, eight boxes of zopiclone, nine boxes of risperidone and seven boxes of quetiapine held as stock. This was a large amount to be held with no routine checks of the stock. Pharmacy visits had not recorded any checks and staff only checked the stock sporadically with no set frequency. For example, staff had not recorded checks between 4 February 2017 and 23 April 2017. Where the service held medication for patients there were discrepancies between the amounts staff booked in and the pharmacy had dispensed. For example, staff recorded that they had booked in seven days' supply when the pharmacy had dispensed 28 days. On the top shelf in the clinic room were loose medications with no record of where they were from. Medication charts for patients no longer in the crisis team were still in the medication folder. Patient named medication with no medication charts was in the medication cupboard of patients who were no longer in the service. This medication should have been destroyed. The trust formulary that was in the clinic room was not the most recent one, having been issued in 2012. Despite regular pharmacy visits these issues had not been identified.
- In Devizes, there was loose medication in the cupboard including medication in blister packs with no patient names and a loose vial of medication for injection. Medication that had been dispensed over a month before our inspection was still in the cupboard.
- The lack of medicines management led to increased risks for patients. For example, one patient was on an increasing dose over several weeks. Staff in the service used stars and X to mark the chart on a number of occasions despite these not being recognised abbreviations used by the trust. Staff and managers in the service were unable to say what they denoted. Despite sporadic compliance staff continued to take the medication to patients without alerting doctors to the patient not following the prescribed treatment plan. According to the patient's care notes, staff in the supported living where the patient resided had also been getting the same medication from the GP for the patient. Staff continued to take medication even after this had been identified until the patient was detained under the Mental Health act. Despite the patient being discharged from the service the charts and medication remained in the clinic room. Staff in the service and pharmacy checks had not identified any of the issues. One of our inspectors brought the issue to managers attention they acted to review the incident.
- Clozapine is an anti-psychotic medication that requires careful monitoring of physical health when administered due to potentially life threatening side effects. Titration is the process of determining the medication dose that reduces symptoms to the greatest possible degree while avoiding possible side effects. There was a community clozapine titration protocol available. The Swindon team undertook clozapine titration in the community. There was a

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clozapine care plan template for staff. A pharmacist visited the Swindon team daily. Support workers in the Swindon team were trained to take blood samples for testing.

## Health based places of safety

- We looked at 15 care records across the places of safety. At the Mason unit, risk assessments were comprehensive. There were a combination of paper and electronic records for patients at the place of safety. In the Wiltshire places of safety the managers explained that new paperwork had been introduced shortly before our inspection visit to standardise paperwork in the places of safety across the trust. We saw that these paper forms had a very basic risk tick box section to enable staff to indicate if the patient was believed to present a risk of harm to themselves or others. The form also directed staff to input risk assessments onto the electronic care record for patients. Our impression from talking with staff about this new paperwork was that there was some confusion regarding where they should record risks. When we asked the trust to check if risks were being assessed they reviewed the care records for the five people most recently admitted to the place of safety in Salisbury. They identified that two out of six of these patients had not had a risk assessment completed. Having identified this during the inspection, the trust informed us they would monitor compliance with completing risk assessments for patients in the place of safety.
- When a person was detained in the Salisbury place of safety suite, the staff responsible for observing the patient needed to remain there. Those staff did not have access to the electronic care record risk assessment during that time, as there was no computer terminal in the place of safety.
- All staff at the Mason unit had completed safeguarding adults and children training, and a further level 2 training in safeguarding children, to be able to manage under 16 admissions. In the event that an under 16 year old was admitted to Mason unit, one bedroom was closed to admissions in order to maintain privacy, safety and dignity for the minor who could be managed in one wing of the unit. The trust's standard operating procedure stated that the young person should be under constant supervision by staff. The manager told us there was good communication and support from the child and adolescent mental health services (CAMHS). Under-16 post admission reviews were held by Mason unit and the CAMHS lead completed an outcome form to highlight any service specific delivery issues.
- The Swindon and Salisbury places of safety were also used as a place of safety for a young person under 18. Between November 2016 and March 2017 there had been 19 occasions when a young person under 18 had been taken to Mason unit in Bristol. In Salisbury there had been three occasions in the same six months when a young person used the place of safety. The operational policy for under 18's in Wiltshire and Swindon was a multi-agency policy with Oxford health.
- Staff at the Mason Unit told us that sometimes they might need to check visually if a patient had concealed anything with which they might harm themselves when they arrived at the place of safety. The place of safety protocols that we saw did not cover the powers and responsibilities of police or trust staff to search patients on admission. The trust had a general search policy that referred to personal searches and the powers of staff if a detained patient did or didn't consent to this. Staff at the Mason unit told us that the trust's search policy was under review.
- We analysed data provided by the trust in relation to incidents of restraint, seclusion and rapid tranquilisation at the Mason unit. Between 1 April 2016 and 31 March 2017 there were 85 restraints recorded, 35 of which were prone (face down). This was an increase on the level of prone restraint from the previous year. There were 41 episodes of seclusion and 10 incidents of rapid tranquilisation. The trust did not provide specific restraint, rapid tranquilisation or seclusion data for the Wiltshire and Swindon places of safety. Staff at the Swindon place of safety told us that they rarely used restraint.
- At the last inspection in May 2016 we identified that there had been no reviews undertaken into the use of restrictive interventions within the places of safety. At this inspection in June 2017, the trust had provided a spreadsheet with incident data from October 2016 to March 2017. This was 'raw data' with descriptions of the circumstances that had been recorded on the incident

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forms. The cause' column on the spreadsheet recorded the reasons for the restraint. The trust's quality improvement plan indicated that they were exploring audit tools.

- At the last inspection in May 2016 we identified that the Mason unit was the only place of safety to have specific guidance on prescribing and administering medication before a Mental Health Act assessment. We identified at the last inspection that the Wiltshire and Swindon operational policy required updating to reflect that an individual must be able to give verbal consent to receive oral medication, and staff could only administer any other use of medicine under common law. At this inspection, we found that the trust's place of safety policy referred to detention under section 136 and consent to treatment. However, the Wiltshire and Swindon place of safety protocol did not refer to this issue.

## Track record on safety

- There were 29 serious incidents involving the intensive teams between 1 June 2016 – 31 May 2017. Of these, four were suspected suicides of current patients, seven suspected suicides of discharged patients, seven unexpected deaths from natural causes, an accidental death of a patient, a suspected homicide by a patient and medication and staffing issues. The level of suspected suicide and unexpected death for this core service had increased since our inspection last year. In the year to March 2016 the trust had reported six deaths.
- The trust provided data on incidents that had occurred in the places of safety between October 2016 and March 2017. There had been 34 incidents of self-harming at the Mason Unit, with 14 of these by ligature, two self-harm incidents in Swindon and no self-harm incidents in Devizes or Salisbury. There had been 11 patient assaults on staff in the Mason unit, one in Swindon and two in Salisbury during this six-month period. At the inspection in May 2016, the trust had not supplied incident data for the places of safety apart from Mason unit. The trust produced an incident review document for the places of

safety for incidents between October 2016 and March 2017. They identified that their system recorded the incident against the ward to which the place of safety was attached.

## Reporting incidents and learning from when things go wrong

- The duty of candour is a responsibility for healthcare staff to be open and honest if something goes wrong or has the potential to cause harm or distress. Staff that we spoke with understood this responsibility. Senior managers wrote to families sensitively and with empathy when explaining the root cause analysis investigation process if something went wrong.
- Managers were able to spot trends in incidents and act on them. For example the service manager in Wiltshire had made changes to the process for booking emergency agency staff and the access for those staff to electronic records. This was in response to incidents raised by staff about these issues
- Incidents were a routine agenda item on the minutes of team meetings that we saw. The Trust disseminated learning from serious incident information trust-wide for teams to discuss. The South Gloucestershire team had a file that contained all alerts relating to learning from incidents. Staff were required to sign to indicate they had read these and the team manager monitored this. Staff in many teams were able to give examples of learning from incidents that they had discussed in team meetings.
- However, we found that managers did not share learning from incidents with the staff teams in Wiltshire. Although staff would receive email bulletins from the trust, staff did not discuss incidents specific to the service in team meetings. In Devizes, there was a learning folder in the staff room, but staff did not recognise it and there was no record that staff had read it. Most staff in Wiltshire could not describe any learning from recent incidents. However, some senior practitioners did discuss alerts and incidents in their supervision records with staff.
- Staff reported good supervision, debriefs and support following serious incidents with the offer of further support if they needed it.



# Are services effective?

Requires improvement 

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

#### Mental health crisis services

- We reviewed 59 clinical records. Staff carried out assessments of patients' needs following referral and used this to inform the risk assessment and care plans.
- We found the majority of care plans in Bristol South and Swindon to be up to date, and the quality and detail of assessments overall to be of a good standard. In Salisbury, seven out of eight records had a care plan and they were of a good standard. However, in South Gloucestershire two of the four care plans we reviewed were not up to date. In Bristol Central, all patients had a care plan but the quality of the care plans in the records we reviewed was not consistent, some were very brief and lacked a holistic approach. In Devizes, we found a care plan in 15 out of 19 care records, four of them were very brief, consisting of one line and were very medication-orientated.
- It was not always possible to tell from care records if staff had given patients a copy of their care plan. The majority of service users and carers said that they had been given care plans. Not all service users had been given crisis plans. Some had experienced a delay with this, and in some cases it took a few weeks before a care plan was in place.
- However, all of the records in South Gloucestershire clearly showed that patients' care plans were personalised and they had received a copy of their care plan.
- All teams operated a shared-caseload model, although teams attempted to ensure that a smaller number of the team worked with individuals. Feedback from patients was that they felt that they saw too many different people. Some teams operated a keyworker model. The role of the keyworker included ensuring that paperwork was completed, and liaison with other services.
- The Bristol access and triage service provided a rapid, comprehensive and prioritised specialist mental health triage service. It was open to referrals from GPs, service users known to mental health services, and social care professionals. Its primary aim was to identify appropriate mental health interventions based upon

presenting need and signpost as required. This information was used in the on-going assessment and planning of individuals care. Bristol access and triage team had an effective system in place to receive and allocate referrals by locality. All of the records we looked at in the Bristol triage team had a detailed assessment and risk-based plan, with clear rationale and engagement with the patient and carer.

- All records were kept on the trust's electronic record keeping system. The transfer of information between teams or the GP was also electronic. Doctors in the teams would write a discharge notification to the GP regarding medicine that would go to them on the same day.

#### Health based places of safety

- At the last inspection in May 2016, we found that there were no operational expectations to initiate care plans for those admitted under section 135 or section 136 to the place of safety suites. At this inspection in June 2017, staff told us that the trust had recently rolled out admission paperwork used in the Mason unit to the Swindon and Wiltshire places of safety. This contained a care plan section with a standard pre-printed care plan regarding basic expectations such as assessing a patient's mental and physical health, with space for staff or patients to record their thoughts or comments or immediate care needs.
- The admission paperwork prompted staff to record information such as a physical health screen, a record of property or medicine that the patient may have and if the patient had any dependent children or pets.
- We reviewed 15 clinical records at the places of safety. In Mason unit, we found that recording was very thorough and completed very promptly. In Swindon, we saw some examples where staff had not fully completed admission paperwork. In Swindon, one of the care records we reviewed was following the introduction of the new paperwork and we saw this had a care plan. In Salisbury, we found the risk information was limited in some cases.

### Best practice in treatment and care

#### Mental health crisis services

- We saw examples in the Bristol central team and South Gloucestershire teams of staff considering the impact of

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patient's current crisis on the rest of the family. The teams considered the risk carefully and the impact it would have on the family's social situation and which agencies they should contact to provide wider support outside of what the team could offer.

- Doctors prescribed medicines in line with National Institute for Health and Care Excellence (NICE) guidance. We saw evidence of this in letters to GPs and individual electronic care records. Consultant psychiatrists and non-medical prescribers were able to explain the use of NICE guidance. Staff also held discussions as part of the good practice network meeting. Staff at the Swindon intensive team were able to tell us about their use of NICE guidelines for treating emotionally unstable personality disorder (EUPD), and how they used this in home treatment of people with a diagnosis of EUPD.
- The average length of time that someone would receive home treatment was four to six weeks. The Bristol South team did not keep people for longer than three weeks. All teams offered at least two visits a day, and three visits per day in some circumstances.
- With the exception of the Swindon and North Wiltshire intensive team, staff in all teams could access support and guidance from clinical psychologists and could offer short-term psychological therapies.
- The teams offered a range of interventions that could include support with housing, benefits and employment. However, we found that care records showed limited evidence of this in Devizes. The Bristol central and east team worked with a range of very complex issues and was responsible for all patients in the Bristol area who were of no fixed abode.
- Bristol had a male-only crisis house, and a female crisis house, run by a local charity, although staff told us they were difficult to access straightaway.
- In line with the crisis care concordat, complex care and multi-agency meetings took place. These involved police, ambulance, mental health liaison, street triage, service user groups, the local clinical commissioning groups and local authorities. They tried to establish consistent responses and adherence to treatment plans for people who frequently presented with complex needs and high levels of distress.
- Intensive teams liaised with GPs for physical health checks in all teams. The teams undertook baseline physical observation checks for patients on anti-

psychotic and lithium medicines. Staff recorded assessments of physical health on all patient notes that we looked at in South Gloucestershire. In the remaining teams, staff did not consistently record this information.

- Teams used Health of the Nation Outcome Scales (HONOS) and clustering tools. They did not use other outcome measures to assess the effectiveness of the service.
- Clinical staff in the intensive teams took part in clinical audit required by the trust. All teams undertook regular care record audits. Team managers received a list of five cases for audit each month from the trust. Some teams were also using peer auditing of case records as a way of encouraging staff to learn good practice from each other.
- An important role of the intensive teams was to gate-keep admissions to the trust's acute mental health wards. The national priority target set by NHS improvement is for NHS trusts to achieve this for 95% of admissions. Between January 2017 and March 2017 the trust had achieved this for 98% of admissions. The trust had also exceeded the 95% target for the 12 months prior to January 2017.

## Health based places of safety

- The trust had been engaged in multi-agency work which aimed to address some of the issues having an impact on delays for people using the places of safety and the level of people being detained. The trust had been piloting a number of police control room or street triage projects across different geographical areas. Mental health professionals provided on the spot advice to police officers who were dealing with people with possible mental health problems. This advice included an opinion on a person's condition, or appropriate information sharing about a person's health history. The trust's staff based at the control room triage were also able to speak with the person that the person that police were dealing with over the telephone. The aim of this triage was, where possible, to help police officers make appropriate decisions, and for people to receive appropriate care more quickly. The trust hoped this would lead to better outcomes and a reduction in the use of section 136. Feedback from staff, police and other stakeholders was very positive. The police had recorded approximately a 50% reduction in the use of section 136 in Wiltshire and Swindon in between March 2017 and June 2017 compared to the same period in 2016.

# Are services effective?

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- At the last inspection in May 2016, we found significant problems with the availability and robustness of the data collected to monitor the operation of places of safety in Wiltshire and Swindon. At this inspection in June 2017, we found that the trust was collecting some data regarding the operation of the places of safety. The trust informed us that the use of section 136 was monitored internally through the trust mental health legislation (MHL) group which reported to the clinical quality governance group and externally through multi-agency meetings. The minutes of the MHL meeting in March 2017 indicate that the group were reviewing the MHA information that would be helpful for them to consider, as the data in the MHA usage report was described as basic. The section 136 data that we saw consisted predominantly of data represented in graphs and spreadsheets.
- At the last inspection in May 2016, we were concerned the trust could not effectively monitor their operation of places of safety or provide assurance about the care they provided to people subject to section 136. At this inspection in June 2017, we found that the trust had been engaged in a range of activity to address these concerns. These included a new section 136 recording template on the trust's electronic recording system and a new escalation system. The escalation system provided managers with regular email alerts at periodic intervals when a patient was waiting more than four hours for a Mental Health Act (MHA) assessment. The trust had introduced a report section on their intranet where they collated and analysed section 136 data. The availability of beds in the trust's places of safety was also available as live data on the intranet.
- The trust had undertaken a thematic review of incident data for the places of safety from October 2016 to March 2017. Of the 248 incidents, 102 related to bed availability when seeking to admit someone at the places of safety, or when transferring people following an assessment. The majority of other incidents fell under the category of self-harm or violence. A report by the trust's director of nursing commented on the thematic review and indicated that the trust planned to set up a central bed management team with the aim of providing a more coordinated approach. The trust told us that they had discussed the findings of the thematic review at the trust's place of safety group meeting. At the meeting, it was agreed that managers should review specific incidents to identify any potential improvements with

level of observations, risk assessments and searching that could be made. However, not all ward managers that we spoke with who had responsibility for the places of safety had been involved in this recent work. The trust intended to repeat the thematic review in November 2017 for incidents logged between April 2017 and November 2017.

- The trust's information team had carried out a review of the new recording practices to gain feedback on whether they were collecting the most useful data. The team stated this was also as part of preparation for the imminent change in the maximum detention time for section 136 to 24 hours proposed under the Policing and Crime Act 2017.

## Skilled staff to deliver care

### Mental health crisis services

- All the crisis teams had a skill mix of nursing staff, occupational therapists, social workers and psychiatrists. The managers had attempted to ensure a good skill mix of mental health practitioners. Some teams had more nurses in their mix than others as the roles were open to practitioners from any mental health discipline. All teams had access to pharmacist support. Some teams had non-medical prescribers. However, there was no access to psychology in Wiltshire and staff identified this as a gap. In other teams, the psychologist played a key role in reflective practice. The trust had recently agreed that 0.3 of a psychology post from the inpatient ward could be given to the crisis teams in Wiltshire once this post had been recruited to.
- New staff reported that their colleagues supported their integration into the teams and helped them understand the systems with good local inductions.
- Staff clinical supervision rates across the core service between April 2016 and March 2017 were on average 74% to 90% per month. The trust's target was to ensure 85% of non-medical clinical staff received supervision. The Mason unit consistently exceeded this target. However, the Swindon intensive team achieved an average 69% clinical supervision rate over the 12-month period. Staff also used handovers as a source of informal supervision and the teams who had a psychologist could access reflective supervision. Staff in the Salisbury team reported they had experienced some issues with the quality of their supervision, but this was being addressed.



# Are services effective?

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- The trust aimed to ensure that 95% of non-medical staff who were due an appraisal received one. In March 2017, 86% of staff requiring an appraisal had received one across the trust's crisis teams and place of safety staff. South Gloucestershire, Wiltshire South, BANES intensive and Mason unit teams all reported a 100% appraisal rate in March 2017. The trust figures indicated that the Bristol South team had an average appraisal rate of 66% over the year to March 2017, when we visited in June 2017 this team informed us that 100% of staff were up to date with their appraisal.
- The Bristol access and triage team offered supervision and support to its entire staff, including those on bank or agency contracts.

## Health based places of safety

- The places of safety were staffed by a dedicated team of experienced and suitably qualified practitioners at the Mason unit. At the other places of safety, the staff and managers of the acute wards ran the units. In Salisbury, the manager explained that the trust planned to close the place of safety. They therefore used bank staff to make up the staff team with the two additional posts allowed for the place of safety.
- The manager at the Mason unit told us that the team had benefitted from some specialist training relating to section 136.
- Managers were able to tell us of instances where they had needed to address staff performance and the support they had received from the trust's human resource department for this.

## Multi-disciplinary and inter-agency team work

### Mental health crisis services

- Staff worked well together and there was good evidence of multi-disciplinary and inter-agency working in all the crisis teams. Crisis team staff said that they felt that their colleagues listened to and valued their views, and people of different grades weren't treated differently. This was evident in the team meetings that we observed.
- The intensive teams had daily handover meetings. In Bristol, the crisis teams had a brief meeting at 9am, followed by a further handover meeting at 2pm. The intensive teams used handover meetings to discuss and

update risks and formulate plans, and they included discussion of new referrals. However, we saw the brief morning meeting in Bristol Central and noted that the risk rating or diagnosis of the patient was not included.

- Teams used white boards or electronic handover templates to display information about their caseloads. These were formatted differently in each team. At the last inspection in May 2016 we asked the trust to share good practice between the teams. The trust has informed us that they are writing a paper on handovers.
- Staff reported positive working relationships between various professionals and stakeholders such as the police and mental health liaison teams. There were locally agreed pathways with the intensive teams that they would accept referrals made by the mental health liaison team who worked within the acute hospitals. There was a range of multi-agency meetings in each area to help address complex case discussions and identify quality or safety issues with service delivery.
- Liaison services in the local hospitals were positive about the joint working with the crisis teams with good improvement in the relationships over the past two years.
- 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.
- In Salisbury, the Approved Mental Health Professionals (AMHPs) attended the morning handover with the crisis team daily to understand any potential areas of concern and discuss possible solutions for the patients. This was with the aim of avoiding admissions for patients.
- All teams had regular team meetings that covered issues such as complaints, incidents, training, recording standards and staffing. We saw minutes of these for several of the teams.
- We attended handover meetings at all the intensive teams that we inspected. Handover meetings varied between teams but all had at least once detailed handover a day. We noted that at the meeting in Salisbury there were different conversations happening at the same time in the meeting and the chairperson of

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the meeting wasn't clearly defined. The Bristol access and triage team had a daily meeting to discuss referrals and any issues that required escalating from the dashboard.

- At the last inspection in May 2016, we found that the Devizes team had a waiting list of 30 patients for transfer back to the recovery teams. However, at this inspection we found that the Devizes team was having weekly liaison meetings with the recovery team and this problem had been resolved.

## Health based places of safety

- Local authorities are responsible for ensuring that there are enough approved mental health practitioners (AMHPs) to meet local need. Prior to our inspection, we held engagement events that invited key crisis stakeholders to discuss local service provision across organisations. Feedback from attendees suggested that there were serious concerns about the availability of AMHPs and S12 doctors to undertake assessments. AMHPs from the local authority told us that there were delays in doctors attending the places of safety. They informed us that they were having issues getting doctors to attend outside of working hours; therefore, the person in the place of safety could wait between 12 and 24 hours to see a doctor. This wait could be longer if it was a weekend or bank holiday. Staff at the places of safety and multi-agency meeting minutes confirmed that this was a significant issue. Data containing information about how long people waited for assessment confirmed that there were significant delays before a person was assessed in the place of safety or were transferred to a hospital bed if required. These issues had also been evident at our last inspection in May 2016.
- Swindon was still integrated with the local authority and reported less significant delays in both undertaking the Mental Health Act assessment and finding an appropriate bed. The place of safety was on the same site as the AMHP service, the intensive team and the in-patient unit. All reported working well together to reduce the length of time people were in the place of safety suite. Staff in Swindon expressed concern that patients from Swindon would face lengthier periods for assessment and would be less likely to be assessed by a doctor with prior acquaintance under proposals to relocate the place of safety from Swindon to Devizes.

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

- Training in the Mental Health Act (MHA) was a mandatory e-learning session for registered staff within the trust. At Mason unit, the manager advised us that she was happy for non-registered staff to complete this too. The manager told us that the Mason unit staff had also had some face-to-face training sessions on issues relating to section 136.
- The MHA training compliance rate was 87% overall for the crisis teams and health based place of safety at 31 March 2017. At the Mason unit, 100% of staff had completed this mandatory training. However, five of the crisis teams had not met the trust's 85% target at 31 March 2017, with the Bristol Crisis Central and East and the Bristol triage service having the lowest percentages of staff completing the training.
- None of the intensive or crisis teams that we inspected had patients on their caseloads who were under a community treatment order. All of the intensive teams attended MHA assessments where possible to help look at alternatives to hospital admission.
- Between 28 March 2017 and 27 June 2017 60% of people detained under section 136 were conveyed to the trust's places of safety in police transport. The MHA code of practice says at paragraph 16.41 that 'people taken to a health-based place of safety should be transported there by an ambulance or other health transport arranged by the police who should, also escort them in order to facilitate hand-over to healthcare staff'.
- At our last inspection in May 2016, we found that the police regularly took people to police custody because the trust's places of safety were full. From 1st June 2016, Avon and Somerset police adopted the position that they would no longer take people detained under section 136 to the police cells when there was no capacity in the health based place of safety unless there were exceptional risk reasons that made this appropriate. The review undertaken by the Mason unit indicated that two people were taken to the cells between June and November 2016 for exceptional reasons. The trust's data did not monitor this on a standard basis. Wiltshire constabulary informed us that since March 2017 they had not taken anyone to the police cells under section 136 in Wiltshire. Avon and

# Are services effective?

Requires improvement 

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Somerset constabulary informed us that since 1 June 2016 there had been five people taken to the police cells under section 136, and all had been because of the person's level of violence or aggression.

- The multi-agency protocol regarding management of section 136 provided to us by the trust states 'it is not the intention of this protocol, to promote the use of Emergency Departments as a Place of Safety. This is recognised as inappropriate'. However a review undertaken by the Mason unit recorded that an average of five people per month between June 2016 and November 2016 were taken to the emergency department under section 136 as the Mason unit was full (not for physical health reasons). The months of June and July 2016 showed the highest levels. This coincided with the police deciding to no longer use the police cells if the health based place of safety was full. The trust's data did not monitor this on a standard basis.
- AMHPs told us of occasions when people had been brought to the emergency department by police, and it was not entirely clear if the person was under section 136. The minutes of a local multi-agency meeting indicated that the Mason unit had raised examples with the police of people being detained in their front garden as the police had not found the crisis team to be responsive. Each police force in the trust's area had mental health leads who were able to follow up issues such as these.
- Following our last inspection in May 2016 we asked the trust to ensure that people were not detained over the legal maximum period of 72 hours. When we returned for this 2017 visit the trust informed us that there had been two occasions in the year prior to the inspection where people had been detained over 72 hours. The most recent of these had been in January 2017 and we saw this was recorded as an incident. There were no

overarching guidelines to advise staff on what the process should have been when people remained on the unit for longer than 72 hours and under what legal framework they should have been managed.

## Good practice in applying the MCA

- Training in the Mental Capacity Act (MCA) was a mandatory e-learning session for registered staff within the trust. The intensive teams and Mason Unit reported 100% compliance at 31 March 2017. The trust had a Mental Capacity Act policy.
- Mental Capacity Act training was not mandatory for band 2-4 staff in the crisis teams or health based place of safety. These staff worked with patients without the presence of registered staff. A lack of training in the Mental Capacity Act did not assist these staff to develop skills in identifying capacity issues that may be relevant to their role such as carrying out blood tests.
- When we reviewed records in the intensive teams, we saw that staff were not always clear about consent to treatment. Staff recorded consent to treatment on all the patient notes we looked at in Bristol South and South Gloucestershire. However in the remaining teams, this information was not consistently present on case records. In Devizes this was not recorded in any of the records we reviewed. In this team there was also only reference to capacity in six of 12 notes that we reviewed. In the Swindon team we saw instances in records when capacity issues were noted by staff but not formally assessed.
- We saw that training around the Mental Capacity Act had been a learning point following a serious incident, and face-to-face training had been a suggested outcome. The team meeting minutes for this team indicated that the team members were to repeat the trust's MCA e-learning and the manager was arranging a face to face training session.

# Are services caring?

Good 

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

## Our findings

### Kindness, dignity, respect and support

- Staff showed empathy and good listening skills whenever we observed them interacting with patients.
- Staff showed commitment to the people they cared for, wanting to ensure they got the right care. For example, staff worked long past their shifts had finished to ensure a patient who was visiting the area and had a crisis returned to their own city 100 miles away for inpatient care rather than be admitted to one of the local units. This took a great deal of negotiation but it ensured that the patient was admitted to a service that knew them, close to their home and family.
- Following the death of a service user, staff sent a letter of condolence to the family with details of how to arrange a funeral as following phone calls with the nearest relative they had raised concerns that they did not know what to do.
- Staff maintained confidentiality at all times during our inspection. All staff we spoke with understood the need to maintain confidentiality and to keep information secure

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

- We saw evidence in patients' involvement in care plans in care records. Patients confirmed they had been involved in care planning. However, in some cases patients told us that they did not feel involved in care planning or there had been a delay in being given a care plan.
- Patients were involved in the interviewing of all staff. Advocacy was available in all areas. There were groups or forums to encourage service user and carer involvement in some areas.
- In Wiltshire, patients were involved in the design of information leaflets about the service and care pathways for patients. The South Gloucestershire team had developed a comprehensive information pack for service users and carers.
- Staff contacted all patients after they had been discharged to do a 'friends and family' questionnaire. In some teams, this was done by a peer worker; that was, someone who had experience of using mental health services. We observed that when peer workers obtained feedback it tended to be very comprehensive.

# Are services responsive to people's needs?

Inadequate 

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

## Our findings

### Access and discharge

#### Mental health crisis services

- All the intensive teams had capacity and systems to see people within urgent and routine target times. The intensive teams had criteria regarding which people they offered support. Senior band 6 staff completed new assessments due to their level of experience. The nature of the service meant that treatment would start immediately, if people were accepted onto the caseload. In Wiltshire, the service offered support to older people supporting the older people's mental health service when necessary.
- The Bristol access and triage service were responsible for performing telephone triage to prioritise mental health referrals within Bristol. After telephone triage, they could transfer the referral directly to the crisis service for an emergency (within 4 hours) assessment, or to the assessment and recovery service within the community mental health teams for urgent and routine assessments. GPs retained primary clinical responsibility, unless an individual required treatment within the trust, or was already known to services.
- At the last inspection in May 2016, the Devizes crisis team had a waiting list. At this inspection in June 2017, there was no waiting list for the service. Managers within Wiltshire had started meeting colleagues from the primary care liaison service, the recovery team, the Improving Access to Psychological therapies (IAPT) service and the acute inpatient wards weekly to discuss patients. The meeting focussed on those waiting for a service, and those who needed to transition between different services. This meant there were no longer patients in the crisis team waiting for Care Programme Approach CPA care coordinators in the recovery team.
- The trust monitored the response rate for an assessment. Their target was for 95% to be within four hours. In May 2017 all teams met or exceeded this apart from the Wiltshire South team who met this four hour target in 90% of cases.
- The trust did not monitor its response times to the crisis lines out of hours. Some staff reported possible delays in answering at night due to assessing other patients or being in the 136 suites. Service users in some teams reported that they found it difficult to wait for call backs. This was also an issue at our inspection in May 2016.
- Arrangements for night-time calls varied between the localities. Calls to the Swindon, South Gloucestershire and north and south Wiltshire intensive teams were taken by a call centre from 5pm until 8am weekdays and at weekends. The call centre was a messaging service and took basic information from the caller, but it was not staffed by trained mental health clinicians.
- All teams except South Gloucestershire had one band 6 member of staff available throughout the night to take calls from people in crisis and undertake urgent assessments. South Gloucestershire's on-call worker was a lone worker, and would arrange to do night time assessments with the on-call doctor. Staff in the intensive teams were unable to tell us how long it took, on average, for someone who had called the call centre to be contacted by the intensive team. Sometimes, if they were undertaking an assessment they were not available to call back until they had completed it. From October 2017, the South Gloucestershire team planned to provide a member of staff who was awake at night.
- Staff in the crisis teams would 'cold call' patients that were not engaging. Across all services staff considered best ways and times to engage those patients who were reluctant to be seen. However, we did find a case example in Devizes where the risk had been categorised as high and the team had left messages for the patient for four days, there had also been a delay in liaising with a key community professional. This case was brought to the team manager's attention. We found another example in Salisbury where a patient referred following detention under section 136 due to an act of self-harm, was not seen by the team for eight days. During this time the crisis team left messages but did not 'cold call' at the patient's address. One patient in Devizes complained that she had been expecting a visit and no one from the team had attended which had increased her anxiety.
- The Devizes team extended their contact with patients with weekly telephone contact at the point of discharge. This was not standard practice across the trust. This practice may have presented some challenges for staff in monitoring risk through telephone contact only.



# Are services responsive to people's needs?

Inadequate 

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

- Many of the teams had high caseloads that included the numbers of inpatients at the team's allotted ward in the trust. As the teams might not be working with many of these patients to facilitate discharge it increased the team's caseload.
- In Salisbury, we found that although staff completed discharge summaries in a timely manner, their quality was inconsistent. One that we saw simply stated that the patient would step down from the intensive team support to their care coordinator, but did not include any information on diagnosis, medicine or risks in the letter.
- The trust had been involved in one external review regarding this core service when a relative raised concerns that due to the delay in finding a bed for a man he was kept in the emergency department for 37 hours. The relative considered that the man's mental state deteriorated due to the wait and this led to a chain of events which led to him being put in medically induced sedation.
- At the last inspection in May 2016 we had serious concerns with the timeliness of Mental Health Act assessments for people detained in the places of safety. The MHA Code of Practice states that assessment by the doctor and AMHP should begin as soon as possible after the person arrives at the place of safety, and unless there are clinical grounds for delay, it recommends that joint assessments should begin within three hours.
- At the last inspection in May 2016 we found that a significant majority of individuals were detained within a trust designated place of safety for periods far exceeding the timescales recommended within the MHA Code of Practice guidance. When we returned in June 2017 we found that between December 2016 and May 2017, 7% of people were assessed between 0-4 hours after arrival at the place of safety, 23% 4-9 hours after arrival, 9% 9-12 hours after arrival, 51% 12 and 24 hours after arrival, 7% 24-36 hours after arrival and 3% 36-48 hours after arrival. This meant that overall 61% of people waited more than 12 hours to be seen for assessment. This was an increase on the level of people waiting 12 hours or more than at our inspection in May 2016.
- At the last inspection in May 2016, we found that some patients remained in the place of safety for hours, or days, after their Mental Health Act assessment due to the lack of availability of beds to admit people to. At this June 2017 visit, we found that between December 2016 and May 2017 the majority of people who had been assessed and needed admission, (58%) had a delay in discharge from the place of safety recorded due to identifying a bed. We saw eight cases recorded where the person had waited between 32 and 50 hours after their assessment before their detention at the place of safety ended, with the delay recorded as due to identifying a bed.
- AMHPs also told us that there were still significant issues identifying beds, that they often had to wait until after a trust wide bed discussion at midday before available beds could be identified, and that bed managers would often prioritise a patient in the community in need of admission. When we reviewed the Bristol bed management spreadsheet on this inspection, we saw that there were 15 requests for beds and two of these were patients in the community whose medical recommendations had lapsed due to the wait. In Bristol

## Health based places of safety

- The crisis care concordat states that significant delays in assessment at a place of safety can impact negatively on the health and wellbeing of people and possibly increase the likelihood of an inpatient admission. The units we inspected generally tried not to use medicine before an assessment so that the assessing doctor and social worker were more clearly able to assess someone's presentation. This could mean that the patient's level of agitation and distress were greater than if they had been given medication. Staff told us that people could become increasingly frustrated with the length of time they waited to be seen, and for a decision to be made about whether they could go home. The majority of people also experienced a delay following assessment if they needed admission to a hospital bed. On the morning of our visit to the Mason unit, a patient had become very agitated in seclusion. The manager explained that waiting for an assessment had been a factor. The manager at the Mason unit expressed the view that if delays in assessment and people leaving the unit were reduced, it would be likely to reduce the levels of seclusion for patients, which she considered were quite high in the unit.

# Are services responsive to people's needs?

Inadequate 

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

staff told us that the demand for beds was very high and they weren't able to admit people who had been recalled from a community treatment order. In Bristol, there was a dedicated bed management team, staffed by non-clinical staff and in the other areas a member of staff in the intensive teams took the lead. The trust informed us that capacity and bed availability was a high operational priority for them, and had been the focus of work on the acute care pathway and there were plans to set up a central bed management team to ensure a more coordinated, responsive approach. The trust had introduced a place of safety care pathway flowchart and escalation procedure since our last inspection.

- We also had concerns about the problems with capacity at the places of safety at the May 2016 inspection and the lack of trust awareness of the numbers of people who were being detained in police custody or the emergency department as a consequence. This has been covered in the MHA section of this report. There had been a reduction in people going to police custody, but the trust did not routinely monitor this issue.
- Staff and stakeholders told us that patients detained in the east of the trust who would normally be admitted to the Mason unit, were frequently diverted a considerable geographical distance (one to two hours' drive) to a place of safety in Wiltshire. This was usually due to a lack of capacity in the Mason unit. The majority of these patients returned to Mason unit after a few hours to have their MHA assessment. This often meant these patients waited longer before having an assessment. The police told us that this was also having an impact on police time. The police told us that sometimes a person detained on s136 would become more agitated at having to travel, and there had been cases of these people going to a police cell. The trust told us that they did not routinely monitor this. However, there had been a six-month review from June to November 2016 undertaken by the ward manager on Mason unit to ascertain the scale of the problem.
- The data from the six-month review showed that on average eight people per month were diverted to another place of safety in Wiltshire as the Mason unit was full. Sixty five percent of people diverted to another place of safety were transferred to Mason unit for their assessment. The delay before a person's return to

Mason unit for assessment was 15 hours on average. In addition five people per month were taken to the emergency department as the Mason unit was full (not for physical health reasons) and there had been four occasions overall where the detained person had waited with police until a bed became available.

- There were four place-of-safety beds in the Mason Unit and three in the Wiltshire and Swindon areas. The trust proposed to increase the place of safety provision in the Wiltshire and Swindon area to five beds, meaning that the Wiltshire/Swindon area would have more capacity than the Mason unit. We enquired with the manager of Mason unit if the trust was considering expanding capacity at Mason unit where the greatest demand appeared to be. The manager explained that if delays in assessment and discharge were addressed then the Mason unit would have sufficient beds for its area. She envisaged that funders wanted to see the impact of the new 24 hour time limit for detention when it came in, before looking at increasing capacity.
- The trust's data indicated that 1211 people had used the trust's places of safety in the 12 months up to 29 June 2017. Of these 776 people were from the Bristol, North Somerset, Bath and North East Somerset (BANES) or South Gloucestershire area. This area had the Mason unit as its place of safety resource. We saw that 197 people using the place of safety in this period were from the Wiltshire or Swindon area.
- We also noted that the place of safety in Devizes was closed for maintenance work in 2017. However, the trust had not logged this as an incident.

## **The facilities promote recovery, comfort, dignity and confidentiality**

### **Mental health crisis services**

- The intensive teams mostly saw people at home, or in a place of their choice. Assessment rooms staff used were clean and comfortable.

### **Health based places of safety**

- Mason unit was a four-bedded unit within the Southmead adult mental health in-patient facility. Mason unit was spacious with separate lounge areas, and bedrooms had ensuite bathroom facilities. The Mason unit had a large enclosed garden. The Mason unit design and layout meant that there was no potential

# Are services responsive to people's needs?

Inadequate



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

physical or visual cross over or interaction between adults and young people. The Mason Unit could facilitate visitors. There were activities available for young people. However, a window in the seclusion room at the Mason unit that overlooked the path running behind the building had been replaced with clear glass, this compromised patients' privacy and dignity.

- The Salisbury place of safety suite had a bedroom with an outside window and a television, but the other part of the suite had no window and it was quite dark. This area had a toilet and sink. People would need to access the garden facilities or bathing facilities on the ward. Therefore, they would only be able to do this if it was appropriate for them to leave the suite. Whilst there was no landline, staff had a designated mobile. The person detained could use this phone to talk to friends and family. The place of safety suite at Swindon was approximately six years old. The Swindon suite was a clean bright environment but did not have access to a garden area.
- The place of safety at Devizes was in a refurbished unused ward. It was spacious, with separate lounge and bedroom areas. However, there had been a lack of suitable furnishing and no equipment for activities or means of distraction at the last inspection in May 2016. At this inspection in June 2017, we found that there was suitable new furnishing in the place of safety in Devizes and a television, reading material and games as a means of distraction. There was no clock on display in the patient areas at Devizes. The matron located the clock in the staff office and explained that some items needed to go up on the walls following decoration.
- The trust informed us that they proposed to develop the Devizes site into a five-bedded place of safety for the west of the trust, and to close the places of safety in Salisbury and Swindon soon after our inspection.
- We saw leaflets, posters and information on display in the places of safety, giving patients information about relevant local services, staff and how to complain.

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

- The trust produced leaflets in different languages. These were available for staff to download from the intranet. Staff could access interpreters through the trust.
- There was disabled access to the places of safety and crisis team bases that saw patients on-site.

## Listening to and learning from concerns and complaints

- The trust's complaints records showed that there had been 52 complaints across the intensive teams between 1 April 2016 – 31 March 2017. Of these complaints, 13 were upheld, 14 partially upheld, nine had been withdrawn, seven were ongoing and none had been referred to the ombudsman. The main themes in the place of safety related to length of stay, the way staff communicated about length of stay and communication with carers. We saw examples of how staff had responded to complaints. For example, the Mason unit had changed their documentation to represent the 'triangle of care' (a therapeutic alliance between service user, staff and carer) following complaints made about staff communicating with carers.
- There was a complaints procedure, although in the first instance people were encouraged to speak with a member of staff involved in providing the care. Patients and carers told us that they felt able to raise concern or make a complaint. However several patients and carers we spoke to told us that staff had not given them information on how to make a complaint.
- Compliments and complaints were not considered in the Wiltshire Crisis services. They were not discussed in team meetings and we did not see evidence that the lessons learnt were considered.



# Are services well-led?

**Requires improvement** 

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

## Our findings

### Vision and values

- Most staff we spoke with were aware of the trust vision and values and who the most senior managers were in the trust. However, they did not necessarily feel connected with them. All staff were aware of the triumvirate management system that the trust had in place.

### Good governance

- The intensive teams and the Mason unit had access to effective trust governance systems that enabled them to manage their teams. Senior managers in the trust accessed the information generated through these systems. The governance systems at the other places of safety were managed by the wards they were attached to as they were not stand-alone units.
- The trust provided a random selection of five case notes per month to team managers for auditing. All team managers were aware of this and said they undertook the audit. However we still identified gaps in recording. Some teams had introduced additional peer review of case notes, so that team members could learn good practice from each other.
- Managers were supportive and encouraging of their teams' development. Apart from one team where there were issues that were being addressed, staff we spoke with felt respected and valued by their team managers.
- The planning of the new street triage service had not taken into account the impact on the crisis team in Devizes with four of the senior staff leaving at the same time following successful applications by the staff. Although the trust provided block booking of agency nurses, all the staff left in a two-week period rather than a staggered transition to manage the change. The team had managed to recruit two new staff.
- In Bristol Central crisis team the staffing had been increased shortly before our inspection due to the level of activity in the service increasing. The manager reported that they had the ability to adjust the staffing dependent on demand. Some crisis teams were well-staffed and bank shifts were used predominantly to cover sickness and leave, often permanent staff members from the team would work these extra shifts.

In the Bristol triage team there were long term bank staff in several vacant posts. Where possible managers tried to use bank staff who were familiar with the crisis team or crisis team work.

- At our inspection in May 2016, data showed that there were serious issues with the capacity and service delivery within the Bristol place of safety and the governance structures were not in place within the trust to ensure effective escalation to the executive team. At this inspection we saw that complex issues and delays persisted. The trust had put governance systems in place to monitor issues more effectively however there was limited evidence that this was having an effect. The number of people detained for over 72 hours had reduced, however otherwise delays for assessment had increased since our inspection in 2016. Overall 61% of people waited more than 12 hours to be seen for assessment. This was an increase on the level of people waiting 12 hours or more than at our inspection in May 2016. We had to calculate some data that was useful when evaluating performance from the trust's raw data as we did not always see analysis of trends in data.
- The lack of availability of beds put significant pressure on the operation of the places of safety and had an impact on the acuity of risk that the crisis teams were dealing with. The trust planned to set up a trust-wide bed management team to provide a more co-ordinated approach.
- The trust had been engaging in trust-wide multi-agency work and had developed an action plan to address some of the reasons for the delays. The trust planned to employ more section 12 doctors. The trust was also engaged in more regionalised crisis care concordat meetings across its area.
- The trust had a mental health legislation group which reported to the clinical quality governance group and externally through multi-agency meetings. The minutes of the MHL meeting in March 2017 indicate that the group were reviewing the MHA information that would be helpful for them to consider, as the data in the MHA usage report was described as basic. The section 136 data that we saw consisted predominantly of data represented in graphs and spreadsheets.

### Leadership, morale and staff engagement

# Are services well-led?

Requires improvement 

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.

- A team of three senior clinicians, called the triumvirate led the services at locality level, staff reported varying levels of engagement from this management system. We saw good examples of local leadership from the team managers we met. Staff told us that they felt well supported by their team managers and were able to raise concerns and contribute to service development. The service managers and modern matrons we met across the trust showed a good understanding of the current challenges for both the individual teams and the wider trust.
- There was solid supportive leadership in Bristol central crisis team where the manager had brought about change and worked consistently with the consultants. Staff described credible clinical leadership that was supportive and enabling them to do their job. This was supported by the senior practitioner, both clinically and practically. For example they brought in bottled water for the team and encouraged all the staff to stay hydrated.
- The team in Salisbury had been through a turbulent time with morale and leadership. Senior managers had supported the service and individuals in the team and had worked sensitively to address the team dynamics. However, due to no funding for the senior practitioner role in Salisbury, the senior practitioner in Devizes was splitting their time between the teams to help address some of the issues, which led to a great deal of pressure. Salisbury was the only service not to have a senior practitioner. All the other crisis teams had one. The manager's role at the time of our inspection was also split between the crisis team and the primary care liaison service. This meant there was not full time management in post to address all the issues in the Salisbury team.
- In Devizes, the team was forming again after the loss four senior band 6 staff at the same time. The manager was confident in the new staff due to take up these roles. As the Devizes senior practitioner was also supporting the Salisbury team they had less capacity to model for the new workforce and monitor the standards of care planning and other quality issues in both services. Despite this staff morale in Devizes was good.
- The service manager for Wiltshire was aware of the pressures on the local managers and senior practitioner in Salisbury and Devizes and was working with them to address the issues. There had been a focus on building the teams and working on service delivery, activity, staff morale and team cohesion. The service manager acknowledged this needed to move onto a quality agenda. The service manager had a credible plan to achieve this now that the teams were more stable. Managers and staff felt supported by the service manager.
- Staff expressed confidence that they could raise issues and would be listened to by managers.
- Both nursing and medical students found staff to be supportive of their development and that the teams were good learning environments.

## Commitment to quality improvement and innovation

- There were no "CQUIN" (commissioning for quality and innovation) targets for the crisis/intensive teams.
- Crisis services conducted peer review on other teams in the trust creating (Crisis resolution team Optimisation and Relapse prevention) CORE fidelity reports. The South Gloucestershire team had achieved the highest score in 2017.
- The South Gloucestershire intensive team was part of a national pilot project trialling the use of the Open Dialogue model with patients and included a peer support worker in the team involved in the trial. Open Dialogue is a model of mental health care pioneered in Finland that involves a consistent family and social network approach, and all healthcare staff involved receive training in family therapy and related psychological skills. The team had trained several members of staff in this approach.
- Bristol and South Gloucestershire crisis teams were accredited by the Home Treatment Accreditation Scheme (HTAS).

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment <b>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.</b>  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 <b>Staff were not effectively monitoring fridge temperatures, emergency medical and fire equipment at the Devizes place of safety.</b>  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 <b>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.</b>

This section is primarily information for the provider

## Requirement notices

Sharps boxes were not always stored or sealed appropriately.

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

### 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 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

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 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.

This section is primarily information for the provider

## Requirement notices

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