Avon and Wiltshire Mental Health Partnership NHS Trust

Inspection report

Bath NHS House
Newbridge Hill
Bath
Somerset
BA1 3QE
Tel: 01249468000
www.awp.nhs.uk

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

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

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

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

Summary of findings

Background to the trust

Avon and Wiltshire Mental Health Partnership NHS Trust serves four clinical commissioning groups and six local authorities, NHS England also commission specialist services. It has an annual income of £220 million and employs 3,600 substantive staff. It operates from over 90 sites including eight main inpatient sites and services are delivered by 150 teams. It has a total of 16 locations registered with CQC.

The trust sits within two sustainability and transformation plans (STP). These are:

1. **Bristol, South Gloucestershire and North Somerset,**
2. **Bath and North-East Somerset, Wiltshire and Swindon.**

Summary of findings

The trust provides the following services –

- Community-based mental health services for adults of working age
- Crisis teams and health based places of safety.
- Acute wards for adults of working age and psychiatric intensive care units.
- Wards for people with learning disabilities or autism
- Community mental health services for people with learning disabilities or autism
- Specialist community mental health services for children and young people
- Child and adolescent mental health wards.
- Wards for older people with mental health problems
- Community based services for older people
- Long stay/rehabilitation mental health wards for working age adults.
- Forensic inpatient/secure wards
- Community based services for older people
- Substance misuse services

We previously carried out a comprehensive inspection of Avon and Wiltshire Mental Health Partnership NHS Trust in June 2017 as part of comprehensive mental health inspection programme, and rated the trust as requires improvement overall, although we rated it good for caring, responsive and well-led.

At this inspection the overall rating stayed the same. We rated it requires improvement for safe, effective and well-led and good for caring and responsive.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Requires improvement

What this trust does

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

Key questions and ratings

We inspect and regulate healthcare service providers in England.

Summary of findings

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

At this inspection we inspected five mental health core services:

- Acute wards for adults of working age and psychiatric intensive care units (PICU's)
- Child and adolescent mental health wards
- Mental health crisis services and health based places of safety
- Specialist community based mental health services for children and young people
- Wards for people with a learning disability or autism

Our last inspection of the core services was in June 2017. Overall, we rated the trust as requires improvement but rated two core services requires improvement and one core service inadequate.

At this inspection we have looked at whether improvements had been made in these core services. In addition, we used our intelligence to identify which core services to inspect on this inspection.

Our comprehensive inspections of NHS Trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For this reason, all trust inspections now include inspection of the well-led key question at the trust level. Therefore, we conducted an inspection of the Avon and Wiltshire Mental Health Partnership NHS Trust's leadership team. Our findings are in the section headed 'Is this organisation well-led?'

On the inspection we:

- Spoke to 56 patients/service users
- Spoke to 17 carers/family members
- Reviewed 150 records
- Spoke to 156 staff members, including consultants, nurses, health care assistants, occupational therapists, junior doctors and admin staff
- Reviewed 122 medical charts
- Spoke to 29 managers and deputy managers
- Attended 24 ward/area and clinic room tours
- Attended 9 staff meetings, MDTs and handovers
- Reviewed 44 meeting minutes and staff supervision records.

What we found

Summary of findings

Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement because:

- We rated safe, responsive and well led as requires improvement and rated effective and caring as good. Our rating for the trust considered the previous ratings of services not inspected this time.
- We rated well led for the trust overall as requires improvement. The rating for well led is based on what we found during our well-led inspection but also takes into account the aggregated ratings from each of the core services. Ratings for other key questions are derived from aggregating the ratings from each of the core services.
- Whilst the chief executive provided positive and passionate leadership working with two strategic transformation plans (STPs) took up a considerable amount of time. The trust had not progressed a number of required improvements as quickly as it should have done. We were concerned that the trust did not have the leadership capacity it needed to deliver its vision and strategy, as well as focus on day to day delivery.
- Although the trust had a vision for what it wanted to achieve staff were not fully aware of the trust plans to turn this into action. The relatively new trust strategy had not really been embedded across the trust and staff were unclear as to the direction of travel and how they played a part in achieving the strategy. The measures or milestones to demonstrate progress with the strategy were not clear and were not well understood. However, the trust had structures, systems and processes in place to support the delivery of its strategy including committees, sub-committees and team meetings
- The trust did not use a systematic approach to continually improve the quality of its services or safeguard standards of care. There was a lack of quality governance systems in place. However, there were some good local initiatives to improve services being progressed in different services across the trust. It was unclear how some of the assurance frameworks used by the trust related to one another. For example, there was no clear alignment between the board assurance framework and corporate risk register although the trust was subsequently reviewing this. However, the trust had structures, systems and processes in place to support the delivery of its strategy including committees, sub-committees and team meetings. In 2018, the trust underwent an external review of its committees and their terms of reference. The review identified the need for more robust quality governance reporting systems.
- Prior to undertaking an inspection CQC asks trusts to submit a range of up to date information about it how managers and delivers its services. The trust was unable to provide us with the full range of information requested. The trust appeared to hold information at service level but we were told it was difficult to pull this together to give a trust wide picture. This led us to question whether the trust board had all the information it needed to assure itself of the quality of care delivered across the trust.
- Across the acute wards and psychiatric intensive care units the trust had not made the improvements that we told it must be made at the two previous inspections in 2016 and 2017. At this inspection we found that there were still improvements required to ensure that environmental risks related to ligatures and seclusion practices were effectively managed.
- Within the child and adolescent inpatient unit, we found that some of the environmental risk issues that we identified at the last inspection remained. During a period of building works, the ward was unable to admit young people with a high level of risk because it could not care for them safely. Although the trust planned to relocate the ward to complete the next phase of building works it was unclear when this would take place.
- Community child and adolescent mental health teams were understaffed and there was a high turnover of staff. We found staff had increased levels of stress caused by a combination of complex caseloads and the pressures of long waiting lists.

Summary of findings

- We rated the Daisy unit, an inpatient service for people with a learning disability, as inadequate overall. We found that there were a high number of physical interventions used to manage the behaviour of patients but that the unit did not have a plan to reduce the use of these practices. The model of care was not clear. The unit did not have a focus on enabling people to leave hospital and integrate back into the community in line with national guidance and best practice.
- Staff, including managers, did not know about the Freedom to Speak Up Guardian and some staff were not aware of the whistleblowing procedure.
- Many staff we spoke with were concerned about a current review of the administration staff roles and were concerned this would lead to a reduced number of administration staff.
- The roles and purpose of infection prevention and control (IPC) within the trust needed further development. IPC was not a high priority throughout the trust. However, the new Director of Nursing and Quality had taken on the director of infection prevention and control role and was planning to ensure this was given a higher priority to ensure patients were not put at risk of infection whilst receiving care at the trust.

However:

- The trust board and senior leadership team had a wide range of skills and experiences and were passionate about wanting to deliver safe, high quality services for the patients that used the trust services. The non-executive directors brought a range of expertise from their professional backgrounds, such as organisational change and financial performance. The board was building a new leadership team; there had recently been a number of new directors appointed. Following the appointment of the director of finance there was now assurance that, while there was still more to do, there was movement towards a more robust and transparent financial position. The new director of human resources had made good progress to address recruitment issues and the newly appointed Director of Nursing and Quality had a good grasp of what needed to be done to address the quality governance issues.
- The culture of the organisation had improved since our last inspection. The majority of staff said they felt respected, supported and valued by the trust. Staff felt that the senior leadership team had supported a number of significant improvements in services and as such staff now had more confidence in senior leaders.
- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity, and supported their individual needs. We observed staff responding well to individual patient need. Staff usually involved patients and those close to them in decisions about their care and treatment.
- The trust had a structured approach to engaging with people who used services, those close to them and organisation representing them. The wards, teams and divisions had access to feedback from patients, carers and staff and were using this to make improvements.
- Within the core services staff, analysed, managed and used information well to support all its activities, using secure systems with security safeguards**.** The wards and community teams had good systems and processes in place to assess and monitor quality and safety. Staff participation in audits was good and there were regular audits conducted including infection control and medication audits.
- Acute wards had moved towards a trust wide approach of bed management with the aim of ensuring a bed could be found as near as possible to where they lived for anyone who needed to be admitted. The trust had introduced a daily bed management call for all ward managers and matrons to manage the effective discharge of patients, and any potential barriers to discharge.
- Staff assessed the mental health and physical health of patients on admission. Staff supported patients with their physical health and encouraged them to live healthier lives.

Summary of findings

Are services safe?

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

- On the acute wards we found that, although all the wards had ligature risk assessments, there lacked robust plans for the management of the environmental risk. There was also a lack of clarity regarding plans to remove the identified risk.
- When we inspected in June 2017, staff secluded male patients in the seclusion facility on the female ward. On this inspection we found male patients still being secluded on the female PICU.
- Oakwood ward had a low fence and low roof which could be scaled. There were four absconsions by this route in the four weeks preceding the inspection. These areas were not part of regular observation beyond the hourly check. When asked about this, the matron responded by placing the garden on 15-minute checks. There was a failure to learn from incidents that had happened on Oakwood ward; risks presented by the low fence had not been addressed.
- The level of cleanliness on Beechlydene Ward was of a poor standard. Patients reported that rooms were not being cleaned adequately. Our inspection team checked a room after cleaning and found it to still be dirty. The modern matron acknowledged that the standard of cleanliness was below the required standard.
- We found that 41% of all restraints across the trust were in the prone position. The trust's policy stated that prone restraint should be an exception. However, staff told us that they were trained to hold somebody in a kneeling position before moving them to the ground. It was therefore not possible to move easily into a supine position. Some staff told us that they were trained to use prone as the initial floor position.
- There was an inconsistency in the application of the seclusion policy. Some wards were only reporting a seclusion if the seclusion room door was locked. They were not recording periods spent in de-escalation or segregation when the door was not locked but the person would be prevented from leaving should they attempt to do so.
- On Riverside child and adolescent mental health ward (CAMHS) there were a range of environmental risks. Young people told us that sometimes the bathrooms and communal areas were unclean and the service had not completed environmental risk assessments".
- The Daisy unit reported a high level of use of physical interventions but there was no plan in place to reduce the use of these practices. The ward had behaviour support plans in place but these plans focused on what to do once a patient became unsettled, rather than focusing on how to prevent this occurring.
- There was a high level of vacancies across the CAMHS community service, with 21% of posts unfilled. This was accompanied by high turnover of staff. Although managers could show us the progress made with recruitment, the level of unfilled posts put pressure on the existing staff group. Staff reported that this was having a negative effect on them, with high stress levels, increased caseloads to cover these posts, and a risk of burnout among staff.
- Staff had complex caseloads. Some staff reported up to 40 young people on their caseload, some of whom had complex needs. Staff informed us that these caseload numbers related to where they were the primary clinician, and that on top of this staff were also secondary clinicians, for young people not on their caseload, and had other roles to attend to. The combination of the complex caseload, secondary clinician work and various other roles meant that staff did not have enough time and felt under pressure. The clinicians work in supporting other young people, not on their caseload, was also increasing due to staff sickness and turnover.

However:

- The trust had made significant improvements to the environment in the health-based places of safety since our last inspection in June 2017. The rooms used for patient appointments in the intensive team bases were suitable for seeing patients in and staff had access to personal alarms.

Summary of findings

Are services effective?

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

- Staff across the trust were generally experienced and had the skills to meet patients' needs. Patients of the intensive teams had timely access to psychological therapies recommended by the National Institute for Health and Care Excellence. Staff were also knowledgeable about how to help meet patient's other needs and worked well with other local services to ensure patient's needs were met. For example, links with local crisis houses and the food bank.
- Staff carried out comprehensive assessments on admission, including safety risks, physical and mental health needs. The duty doctors completed physical health assessments on admission. These assessments were ongoing following admission, including conducting the national early warning score (NEWS) and included in care plans. We saw evidence of good physical healthcare of patients on all the wards. Patients were regularly assessed in weekly physical health checks.
- Overall, patients had good access to multidisciplinary teams (MDT) including psychology, occupational therapy and a range of therapies such as art therapy, mindfulness and grounding and coping strategy groups. The MDT had weekly meetings to review patients. Staff handovers occurred at least twice a day in line with shift patterns. There was evidence across the wards of robust discharge planning throughout a patient stay.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Managers made sure that staff could explain patients' rights to them. Staff followed the Mental Health Act Code of Practice, including access to advocates, reading patients their rights and paperwork associated with the Mental Health Act.

However

- Although staff provided care and a range of treatments that met the young people's needs on the Riverside ward (CAMHS), these were not reflected in the written care plans. Care plans were generic and used standard statements that did not show personalised care. Young people had a nursing treatment care plan but there was no evidence of input from the wider multi-disciplinary team for example the occupational therapist, social worker and psychologist.
- The leadership team on the Daisy unit could not explain how a patient progressed to discharge from the unit. The model of care was not clear. The trust believed that unit was implementing a positive behavioural support model but staff were not trained appropriately to use this model and managers confirmed it was not being used. The unit did not have a focus on enabling people to leave hospital and integrate back into the community in line with national guidance and best practice. The unit did not use an outcome measure to record the patients progress.
- The Daisy unit did not employ or have access to a full multidisciplinary team. There was no occupational therapist, dietician or speech and language therapist. Without these key skills the patients lacked the opportunity to develop the necessary skills to prepare for discharge. The staff team had not received the appropriate training to ensure they had the specific skills needed to meet the needs of the patients.

Are services caring?

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

- Staff treated patients with empathy, compassion and kindness. They respected patients' privacy and dignity, and supported their individual needs.
- Feedback from most patients was positive. Patients said that staff responded compassionately to their needs and were skilled in dealing with vulnerable individuals with complex physical and mental health needs.
- Staff were hard working, caring and committed to delivering a good quality service. They spoke with passion about their work and were proud of what they did.

Summary of findings

- Staff attitudes and behaviour when interacting with patients showed they were discreet, respectful and responsive.
- Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of consequences.
- Staff understood the needs of patients; including their personal, cultural, social and religious needs. Staff maintained the confidentiality of information about patients and supported them to make choices about sharing information.
- There was a positive culture of acceptance within the trust towards patients and staff that belonged to the lesbian, gay, bisexual and transsexual community.

Are services responsive?

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

- Young people on Riverside ward (CAMHS) did not always have a discharge plan in place. Of the six records reviewed, only one young person had a discharge plan.
- Due to the current layout of Riverside ward young people with higher levels risk, for example, those with self-harming behaviour or suicidal thoughts were unable to be admitted and were referred elsewhere. However, following our inspection we were informed that the service will close for a refurbishment that will address the issues with the ward environment. At the time of the inspection two young people required the use of a wheelchair. We were told by the young people that the garden could not be accessed with a wheelchair and the ramp on the minibus had been broken for some time. Young people told us this meant they had been unable to go on some trips.
- Access to outside space was limited on Beechlydene as the garden was unsafe; this resulted in patients using small high walled court yards. Applewood had a garden but the single sex outside areas did not have any benches for patients to sit on as these had been removed because of the risk of patients using them to abscond, as a result these were not used. The outside areas on the Callington Road site had no lighting.
- Staff on the Daisy unit did not routinely give care plans in an easy read format and there were no easy read menus to help patients choose their meals.
- Staff on the Daisy unit had not developed discharge plans for any of the patients, including a patient that a senior manager said was ready for discharge.
- There were long waiting lists across the CAMHS community service that led to delays in young people accessing the service. The average waiting time for non-urgent referrals was 25 weeks with the longest wait of 42 weeks. The longest waiting list had 111 children and young people waiting for assessment, with 23 young people waiting over 18 weeks. The NHS Constitution expectation is of a maximum of 18 weeks from referral to treatment.

However

- A bed management team managed access to beds and the effective discharge of patients to ensure beds were available when needed. The trust had introduced a daily bed management call for all ward managers and matrons to manage the effective discharge of patients, and identify any potential barriers to discharge. Some wards had specific members of staff recruited to aid with the discharge process.
- Staff supported patients to access the wider community. This was done through escorted and unescorted leave. Local voluntary agencies attended the wards to engage in educational and training opportunities for the patients.
- In line with the accessible information standard, the trust had a variety of measures in place to ensure they could meet the needs of their patients. For example, access to signers, a specialised phone for patients that were deaf and staff could also access easy read information and information in languages other than English.

Summary of findings

- There was good work being done around looked after children, and unaccompanied minors and asylum seekers accessing mental health services. Children at risk of sexual exploitation also had good access. This was done through the Thinking Allowed and Be Safe initiatives.

Are services well-led?

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

This was our first review of well led under our next phase methodology. We rated well led as requires improvement because;

- Whilst the chief executive provided positive and passionate leadership although working with two strategic transformation plans (STPs) took up a considerable amount of time. The trust had not progressed some required improvements as quickly as it should have done. We were concerned that the trust did not have the leadership capacity it needed to deliver its vision and strategy, as well as focus on day to day delivery. There was no deputy to the chief executive in post at the time of the inspection.
- Although the trust had a vision for what it wanted to achieve staff were not fully aware of the trust plans to turn this into action. The relatively new trust strategy had not really been embedded across the trust and staff were unclear as to the direction of travel and how they played a part in achieving the strategy. The measures or milestones to demonstrate progress with the strategy were not clear and were not well understood. However, the trust had structures, systems and processes in place to support the delivery of its strategy including committees, sub-committees and team meetings.
- The trust did not use a systematic approach to continually improve the quality of its services or safeguard standards of care. There was a lack of quality governance systems in place. However, there were some good initiatives to improve services being progressed in different services across the trust. It was unclear how some of the assurance frameworks used by the trust related to one another. For example, there was no clear alignment between board assurance frame work and corporate risk register although the trust was subsequently reviewing these. The Board Assurance Framework was submitted to the Board every six months. In 2018, the trust underwent an external Well Led assessment. The review identified the need for more robust quality governance reporting systems.
- Prior to undertaking an inspection CQC asks trusts to submit a range of up to date information about it how managers and delivers its services. The trust was unable to provide us with the full range of information requested. The trust appeared to hold information at service level but we were told it was difficult to pull this together to give a trust wide picture. This led us to question whether the trust board had all the information it needed to assure itself of the quality of that are delivered across the trust.
- Senior managers we spoke with confirmed the feedback from the clinical commissioning groups, and our own observations, that the timeliness and content of the investigation and learning from serious incidents, route cause analysis (RCA) investigations and reports, needed improvement.
- Across the acute wards and psychiatric intensive care units the trust had not made the improvements that we told it must be made at the two previous inspections in 2016 and 2017. At this inspection we found that there were still improvements required to ensure that environmental risks related to ligatures and seclusion practices were effectively managed.

Summary of findings

- Within the child and adolescent inpatient unit, we found that some of the environmental risk issues that we identified at the last inspection remained. The layout of the building posed significant risk to the safety of young people and staff found it difficult to manage these risks effectively. Although the trust planned to relocate the ward for major refurbishment it was unclear when this would take place.
- Community child and adolescent mental health teams were understaffed and there was a high turnover of staff. We found staff had increased levels of stress caused by a combination of complex caseloads and the pressures of the long waiting lists. Vacancies increased pressure on the remaining staff and further increased workload and the length of waiting lists. For example, autism spectrum assessments could take up to a year.
- We rated the Daisy unit as inadequate overall. We found that there were a high number of physical interventions used to manage the behaviour of patients but that the unit did not have a plan to reduce the use of physical interventions. The model of care was not clear. The trust believed that unit was implementing a positive behavioural support model but staff were not trained appropriately to use this model and mangers confirmed it was not being used. The unit did not have a focus on enabling people to leave hospital and integrate back into the community in line with national guidance and best practice.
- Staff, including managers, did not know about the Freedom to Speak Up Guardian and some staff were not aware of the whistle blowing procedure. They met with the chief executive every six weeks and had direct access anytime to the chief executive and the senior independent non-executive director. However, we were concerned the role did not have enough dedicated sessions allocated to it, as the incumbent had to balance the demands along with a four-day week role elsewhere.
- Many staff we spoke with were concerned about a current review of the administration staff roles and were concerned this would lead to a reduced number of administration staff.
- Medicines optimisation for the trust required improvement. Whilst the chief pharmacist had a good understanding of how delivery of pharmacy services supported the delivery of the trust strategy, they were not able to tell us how they were assured that the issues were escalated to a higher level.
- The roles and purpose of infection prevention and control (IPC) within the trust needed further development. IPC was not a high priority throughout the trust. However, the new Director of Nursing and Quality had taken on the director of infection prevention and control role and was planning to ensure this was given a higher priority to ensure patients were not put at risk of infection whilst receiving care at the trust.

However:

- The trust board and senior leadership team had a wide range of skills and experiences and were passionate about wanting to deliver safe, high quality services for the patients that used the trust services. The non-executive directors brought a range of expertise from their professional backgrounds, such as organisational change and financial performance. The board was building a new leadership team; there had recently been a number of new directors appointed. Following the appointment of the director of finance there was now assurance that, while there was still more to do, there was movement towards a more robust and transparent financial position. The new director of human resources had made good progress on address recruitment issues and the newly appointed Director of Nursing and Quality had a good grasp of what needed to be done address the quality governance issues,
- The trust had structures, systems and processes in place to support the delivery of its strategy including committees, sub-committees and team meetings.
- The culture of the organisation had improved since our last inspection. The majority of staff said they felt respected, supported and valued by the trust. Staff felt that the senior leadership team had supported a number of significant improvements in services and as such staff now had more confidence in senior leaders.

Summary of findings

- The trust had a structured approach to engaging with people who used services, those close to them and organisation representing them. The wards, teams and divisions had access to feedback from patients, carers and staff and were using this to make improvements.
- Within the core services staff, analysed, managed and used information well to support all its activities, using secure systems with security safeguards**.** The wards and community teams had good systems and processes in place to assess and monitor quality and safety. Staff participation in audits was good and there were regular audits conducted including infection control and medication audits.
- The trust had introduced a daily bed management call for all ward managers and matrons to manage the effective discharge of patients, and any potential barriers to discharge. Acute wards had moved towards a trust wide approach of bed management with the aim of preventing patients being moved to another part of the country.
- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity, and supported their individual needs. We observed staff responding well to individual patient need. Staff usually involved patients and those close to them in decisions about their care and treatment.
- Staff assessed the mental health and physical health of patients on admission. Staff supported patients with their physical health and encouraged them to live healthier lives.
- Ward managers felt they had autonomy to make decisions to ensure the safe running of the service.
- Ten of the 14 core services achieved the trust's clinical supervision target. The core services failing to achieve the trust's target were 'Mental health crisis services and health based places of safety' with 83%, 'Other' with 83%, 'Child and adolescent mental health wards' with 81% and 'Specialist community mental health services for children and young people' with 81%.

Ratings tables

The ratings tables in our full report show the ratings overall and for each key question, for each service and for the whole organisation. We inspected and rated five core services on this inspection, as well as the well-led aspect of the trust. Our decisions on overall ratings also took into account all the necessary information of the organisation as a whole, for example, the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in the specialist community based mental health services for children and young people.

For more information, see the Outstanding Practice section of this report.

Areas for improvement

we found areas for improvement, including 20 breaches of legal requirements that the trust must correct. We found 29 things that the trust should improve to either comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement in the future or to improve the quality of the service.

Action we have taken

We issued five requirement notices to the trust. Our action related to 20 breaches of regulations in four core services.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory Action.

Summary of findings

What happens next

We will monitor and continue to engage with the trust to ensure that it takes the necessary actions to improve its services. We will continue to monitor the safety and quality of the services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

We found the following examples of outstanding practice:

Specialist community based mental health services for children and young people

The programs Thinking Allowed and Be Safe were examples of outstanding practice. These initiatives were dedicated to giving access to mental health therapies for looked after children, unaccompanied minors and asylum seekers, as well as children vulnerable to sexual exploitation. Bristol has a high number of unaccompanied minors and asylum seekers, many of whom are trafficked into the UK. Emphasis is placed on collaborative and multi-agency working, with child and adolescent mental health services working alongside social care services and primary medical services.

Areas for improvement

Action the trust MUST take is necessary to comply with legal obligations. Action the trust SHOULD take is either to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services in line with legal requirements. This action related to five core services.

Specialist community based mental health services for children and young people

- The provider must take all possible steps to reduce the waiting lists across the service to ensure children and young people have timely access to mental health support. (Regulation 12)
- The provider must ensure that risk assessments and care plans are completed in a timely manner, and where no risk is present this needs to be stated with rationale. If the young person was seen by crisis teams first then a copy of the risk assessment completed by the crisis team must be included in their care record. (Regulation 12)

Child and adolescent mental health wards

- The trust must ensure that environmental risk assessments are completed and identified actions are followed. (Regulation 12)
- The trust must update the service's ligature assessment with detailed actions of how ligature risks will be mitigated; including minimising the number of ligature points. (Regulation 12)
- The trust must ensure that the service takes appropriate actions to allow airflow into the dining room during times of high temperatures. (Regulation 12)
- The trust must ensure that the service reviews the blanket restriction on the use of the garden area. (Regulation 12)
- The trust must ensure that young people are involved in their care-planning and that their views are incorporated into plans. (Regulation 9)

Summary of findings

- The trust must ensure that care plans are person-centred and that young person's feedback is listened to and valued. (Regulation 9)

Acute wards for adults of working age and psychiatric intensive care units (PICU's)

- The trust must ensure that all wards have robust plans in place to ensure risks presented by ligatures are managed robustly, including removing ligature points as appropriate. (Regulation 12)
- The trust must reduce the number of prone restraints and ensure staff are trained appropriately and consistently in undertaking restraint. (Regulation 12)
- The trust must address the issues caused by the seclusion of male patients on the Elizabeth Casson ward (female PICU). (Regulation 12)
- The trust must ensure that it addresses the risks posed by the low fence and low roof on Oakwood ward. (Regulation 12)

Wards for people with a learning disability or autism

- The trust must ensure the model of care is clear and based on nationally recognised best practice and that care and activities are focused on enabling patients to leave hospital and live in the community. Regulation 12
- The trust must ensure that information is given to patients in way that enables them to understand their care and treatment options and communicate their wants to the service and ensure the is recorded. Regulation 9
- The provider must ensure they appropriate assess and record patients' capacity to consent to treatment. Regulation 11
- The trust must ensure that patient records are stored in a way that ensure authorised people know where to find and can access the most up to date information without undue delay. Regulation 12
- The trust must ensure care plans instruct staff how to deliver care to the individual patient in a way that is suitable for them. Regulation12
- The trust must ensure that the Daisy Unit is part of the reducing physical intervention practice programme and that the managers and staff are aware of this programme. Regulation17.
- The trust must ensure the managers of the Daisy unit are aware of and use the trust governance process to improve the service, record risk on the local risk register and evidence learning from incidents. Regulation17
- The trust must ensure it meets the training needs of staff. Regualtion18
- The trust must ensure there are enough staff with the appropriate qualifications, skills and experience to meet all the needs of patients. Regulation18(

Action the trust SHOULD take to improve:

- We told the trust it should take action either to comply with a minor breach that did not justify regulatory action, to avoid breaching a legal requirement in the future or to improve services.

Specialist community based mental health services for children and young people

- The provider should ensure that sufficient numbers of suitably qualified and competent staff are employed in each team in order to meet the needs of young people accessing the service.
- The provider should ensure that team meetings are consistently recorded in the meeting minutes.

Summary of findings

- The provider should continue to support individual teams to further embed the necessary governance and support systems.
- The provider should ensure that all staff, managers included, know about the Speak Up Guardian and whistle blowing procedures.
- The provider should ensure that all young people are offered a copy of their care plan in a format that is beneficial to them. They should be able to sign a copy or sign off that they did not require a copy and this must be documented in their care records.

Mental health crisis services and health based places of safety

- The trust should ensure that they can provide timely and accurate information on request.
- The trust should ensure that staff are using an appropriate policy for health checks and that this policy is followed.
- The trust should take steps to address staffing issues in the North Bristol Intensive team so that they can meet their minimum staffing requirements.
- The trust should ensure that all intensive teams are using a standardised and appropriate way of managing medicines and logging when they are administered and received.

Child and adolescent mental health wards

- The trust should ensure that the service individually risk assesses young people in relation to the ward environment.
- The trust should ensure regular checks of the ward environment are conducted.
- The trust should consider use of convex mirrors to improve staff ability to observe all parts of the ward.
- The trust should ensure that each young person has a discharge plan in place that is regularly updated.
- The trust should ensure that care plans are holistic and contain input from the multi-disciplinary team.
- The trust should consider the provision for a female-only lounge in the upcoming refurbishment of the ward environment.
- The trust should ensure that all staff complete mandatory training in psychical emergency response training (PERT).
- The trust should ensure that staff receive the necessary specialist training so that all young people's needs can be met.

Acute wards for adults of working age and psychiatric intensive care units (PICU's)

Action the provider SHOULD take to improve

- The trust should improve the cleanliness on Beechlydene ward
- The trust should ensure that the correct fridge temperatures are maintained
- The trust should address the issue related to the garden areas at Beechlydene and Applewood wards and ensure appropriate lighting in the outside areas at Callington Road. lack of light in the gardens on the Callington road site
- The trust should ensure that all staff adhere to the trust's policy on seclusion and are aware of when an episode of seclusion begins
- The trust should ensure that there are always enough staff on Beechlydene and Poppy wards to facilitate patients accessing their section 17 leave.

Wards for people with a learning disability or autism

Summary of findings

- The trust should ensure patients have an alternative to daily patient meetings.
- The trust should ensure they record patients' informal concerns and complaints and act to resolve them.
- The trust should ensure they record all ligature point risks individually on the ligature point assessment.
- The trust should ensure staff do not use stock phrases to describe patients' behaviour.
- The trust should ensure there are enough appropriately qualified professionals to meet the needs of patients.

Is this organisation well-led?

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

This was our first review of well led under our next phase methodology. We rated well led as requires improvement because;

See guidance note 6 then add your text after the standard text paragraph below (and delete this help text).

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Whilst the chief executive provided strong and passionate leadership although working with two strategic transformation plans (STPs) took up a considerable amount of time. The trust had not progressed some required improvements as quickly as it should have done. Wbanke were concerned that the trust did not have the leadership capacity it needed to deliver its vision and strategy, as well as focus on day to day delivery. There was no deputy to the chief executive in post at the time of the inspection.
- Although the trust had a vision for what it wanted to achieve staff were not fully aware of the trust plans to turn this into action. The relatively new trust strategy had not really been embedded across the trust and staff were unclear as to the direction of travel and how they played a part in achieving the strategy. The measures or milestones to demonstrate progress with the strategy were not clear and were not well understood. However, the trust had structures, systems and processes in place to support the delivery of its strategy including committees, sub-committees and team meetings
- The trust did not use a systematic approach to continually improve the quality of its services or safeguard standards of care. There was a lack of quality governance systems in place. However, there were some good initiatives to improve services being progressed in different services across the trust. It was unclear how some of the assurance framworks used by the trust related to one another. For example, there was no clear alignment between board assurance frame work and corporate risk register. The board was not given sight of the corporate risk register. The Board Assurance Framework was submitted to the Board every six months. In 2018, the trust underwent an external review of its committees and their terms of reference. The review identified the need for more robust quality governance reporting systems.
- Senior managers we spoke with confirmed the feedback from the clinical commissioning groups, and our own observations, that the timeliness and content of the route cause analysis (RCA) was in need of improvement.

Summary of findings

- Across the acute wards and psychiatric intensive care units the trust had not made the improvements that we told it must be made at the two previous inspections in 2016 and 2017. At this inspection we found that there were still improvements required to ensure that environmental risks related to ligatures and seclusion practices were effectively managed.
- Within the child and adolescent inpatient unit, we found that environmental risk issues that we identified at the last inspection remained. The layout of the building posed significant risk to the safety of young people and staff found it difficult to manage these risks effectively. In addition, the ward was unable to admit young people with a high level of risk because it could not care for them safely. As such young people were being referred to other services, which could be a long way from their home. Although the trust planned to close the ward for major refurbishment it was unclear when this would take place.
- Community child and adolescent mental health teams were understaffed and there was a high turnover of staff. We found staff had increased levels of stress caused by a combination of complex caseloads and the pressures of the long waiting lists. Vacancies increased pressure on the remaining staff and further increased workload and the length of waiting lists. For example, autism spectrum assessments could take up to a year.
- We rated the Daisy unit as inadequate overall. We found that there were a high number of physical interventions used to manage the behaviour of patients but that the unit did not have a plan to reduce the use of physical interventions. The model of care was not clear. The trust believed that unit was implementing a positive behavioural support model but staff were not trained appropriately to use this model and mangers confirmed it was not being used. The unit did not have a focus on enabling people to leave hospital and integrate back into the community in line with national guidance and best practice.
- Staff, including managers, did not know about the Speak Up Guardian and some staff were not aware of the whistle blowing procedure. Many staff we spoke with were concerned about a current review of the administration staff roles and were concerned this would lead to a reduced number of administration staff. They met with the chief executive every six weeks and had direct access anytime to the chief executive and the senior independent non-executive director. However, we were concerned the role did not have enough dedicated sessions allocated to it, as the incumbent had to balance the demands along with a four-day week role elsewhere.
- Medicines optimisation for the trust required improvement. Whilst the chief pharmacist had a good understanding of how delivery of pharmacy services supported the delivery of the trust strategy, they were not able to tell us how they were assured that the issues were escalated to a higher level.
- The roles and purpose of infection prevention and control (IPC) within the trust needed further development. IPC was not a high priority throughout the trust. However, the new Director of Nursing and Quality had taken on the director of infection prevention and control role and was planning to ensure this was given a higher priority to ensure patients were not put at risk of infection whilst receiving care at the trust. and
- Prior to undertaking an inspection CQC asks trusts to submit a range of up to date information about it how managers and delivers its services. The trust was unable to provide us with the full range of information requested. The trust appeared to hold information at service level but we were told it was difficult to pull this together to give a trust wide picture. This led us to question whether the trust board had all the information it needed to assure itself of the quality of that are delivered across the trust
- However:
- The trust board and senior leadership team had a wide range of skills and experiences and were passionate about wanting to deliver safe, high quality services for the patients that used the trust services. The non-executive directors brought a range of expertise from their professional backgrounds, such as organisational change and financial performance. The board was building a new leadership team; there had recently been a number of new directors

appointed. Following the appointment of the director of finance there was now assurance that, while there was still more to do, there was movement towards a more robust and transparent financial position. The new director of human resources had made good progress on address recruitment issues and the newly appointed Director of Nursing and Quality had a good grasp of what needed to be done address the quality governance issues,

- The trust had structures, systems and processes in place to support the delivery of its strategy including committees, sub-committees and team meetings.
- The culture of the organisation had improved since our last inspection. The majority of staff said they felt respected, supported and valued by the trust. Staff felt that the senior leadership team had supported a number of significant improvements in services and as such staff now had more confidence in senior leaders.
- The trust had a structured approach to engaging with people who used services, those close to them and organisation representing them. The wards, teams and divisions had access to feedback from patients, carers and staff and were using this to make improvements.
- Within the core services staff, analysed, managed and used information well to support all its activities, using secure systems with security safeguards**.** The wards and community teams had good systems and processes in place to assess and monitor quality and safety. Staff participation in audits was good and there were regular audits conducted including infection control and medication audits.
- The trust had introduced a daily bed management call for all ward managers and matrons to manage the effective discharge of patients, and any potential barriers to discharge. Acute wards had moved towards a trust wide approach of bed management with the aim of preventing patients being moved to another part of the country.
- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity, and supported their individual needs. We observed staff responding well to individual patient need. Staff usually involved patients and those close to them in decisions about their care and treatment.
- Staff assessed the mental health and physical health of patients on admission. Staff supported patients with their physical health and encouraged them to live healthier lives.
- Ward managers felt they had autonomy to make decisions to ensure the safe running of the service.
- Ten of the 14 teams achieved the trust's clinical supervision target. The core services failing to achieve the trust's target were 'Mental health crisis services and health based places of safety' with 83%, 'Other' with 83%, 'Child and adolescent mental health wards' with 81% and 'Specialist community mental health services for children and young people' with 81%.

Use of resources

- The trust had seen significant changes at executive level over the last two years. The director of finance joined the trust in September 2016.
- The trust did not achieve its 2017/18 Financial Plan and had recently submitted its long-term financial model (LTFM) recovery plan to NHSI.
- The trust accepted a revised 2018/19 control total of £3.9m deficit, and at Month 5 was forecasting achievement of its financial plan. However, the trust needs to deliver £12.1m of efficiency savings (5.1% of expenditure) to achieve the control total of £3.9m deficit, before the application of provider sustainability funding (PSF). The trust had plans in place for the whole programme. The greatest programme risk area was the reduction of out of area placements to nil

by the end of September (£1.4m associated saving). All other instances of in-year slippage was being offset by various mitigations, including the holding of vacancies and non-recurrent measures. For reference, in 2017/18, the trust delivered £9.1m (3.8% of expenditure) against a notional target plan of 8.7%, that would have been required to deliver its Control Total.

- The trust faced issues with regards to achieving its agency ceiling limit of £6.4m, which it was forecasting to exceed by circa £4m. The trust had established a new agency reduction project which was focussing on the use of technology and contract change for both staff and agencies.
- The trust was subject to shadow enforcement undertakings (agreed May 2017) with respect to board governance, strategy and financial recovery; since these were put in place a number of improvements to the financial governance have been seen.
- There was assurance that, while there was still more to be done, there was movement towards a more robust and transparent financial environment. The foundations for improvement have been put in place by the finance team, providing the basis from which to drive further improvement to financial governance and the financial position of the trust
- Further work was required to ensure that the programme management office (PMO) was supported to maturity and enabled to focus on delivering key workstreams to achieve the cost improvement programme. We heard concerns that some processes were overly complex. The trust could benefit from support in this area and seeing other high performing PMO functions in practice.
- A key issue for the trust remains control over the use of agency staff which has both a quality and financial impact. While we heard of contextual issues facing the trust, we also heard that there is further work to be done to ensure all appropriate controls are in place and applied consistently. We heard that there was no assurance that all possible action to reduce agency use, that is within the gift of the Trust, is consistently and robustly applied.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Sept 2018	Good ↑ Sept 2018	Good →← Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement →← Sept 2018	Requires improvement →← Sept 2018

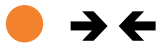
The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for mental health services

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

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

Child and adolescent mental health wards

Requires improvement 

Key facts and figures

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) provides inpatient child and adolescent mental health services (CAMHS) on the Riverside ward. The service provides assessment, care and treatment for males and females aged between 13 and 18 years old who cannot be safely or appropriately managed in the community. The ward has nine inpatient beds and four-day places. Young people can be admitted informally, by parental consent (if under 16 years of age), or if detained under the Mental Health Act (1983). On the day of our inspection, one young person was detained in accordance with the requirements of section three of the Mental Health Act.

The Riverside ward is located on the Blackberry Hill hospital site. NHS England commissions the trust to provide specialist CAMHS inpatient services in the south west region. Children and young people are typically admitted from Bristol, South Gloucestershire and North Somerset. The service also accepts young people out of area when required. CAMHS inpatient units are specialised services that provide assessment and treatment for children and young people with complex emotional, behavioural or mental health difficulties that require inpatient treatment.

The service was last inspected in June 2017 and was rated as requires improvement overall.

During this inspection we were told that the ward was due to be relocated for a large refurbishment so that the ward environment would become fit for purpose.

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

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?

During the inspection visit, the inspection team:

- visited the service and looked at the quality of the ward environment and observed how staff were caring for young people
- spoke with seven young people who were using the service
- spoke with four family members of the young people
- spoke with two managers
- spoke with 13 other staff members; including the social worker, clinical psychologist, occupational therapist, nurses and consultant psychiatrist.
- attended and observed a multi- disciplinary team meeting

Child and adolescent mental health wards

- looked at six care and treatment records of young people
- carried out a check of the clinical room and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Staff were unable to observe all parts of the ward due to the current layout. Staff did not routinely undertake observations of all of the ward, nor did they record when observations were carried out. Plans to mitigate ligature risks on the ward were reliant on staff being in communal areas at all times. The bannister and stair lift leading to the communal area posed a significant ligature risk and staff did not carry out observations sufficiently to ensure the safety of young people.
- The service had not completed environmental risk assessments. During the summer, staff placed a chain across the doors leading to the garden. This did not allow enough airflow into the dining room to cool it down. Staff had not completed individual risk assessments for use of the garden area therefore there was a blanket restriction on young people having access to the garden. Risks identified in the risk assessment were not always addressed within a care plan. Not all young people had a crisis plan.
- Although staff provided care and a range of treatments that met the young people needs, these were not reflected in the written care plans. Care plans were generic and used standard statements that did not show personalised care. Young people told us they were not involved in their care planning and that their feedback was not incorporated or listened to. Care plans were not holistic. Young people had a nursing treatment care plan however there was no evidence of input from the wider multi-disciplinary team for example occupational therapist, social worker and psychologist. Some care plans had not been updated in a timely manner in line with trust policy.
- Staff did not receive specialist training to ensure they could meet the needs of all young people. For example, working with someone diagnosed with eating disorder or an autistic spectrum disorder.
- Young people did not always have a discharge plan in place. In the year prior to the inspection, seven young people's discharge had been delayed. The manager had not completed an analysis to determine causes of the delayed discharges.

However:

- The trust had taken action the action we had required it to make at the last inspection and had ensured the fence that led from the garden directly onto the car park was now secure.
- Staff were trained in safeguarding, knew how to make a safeguarding alert and knew how to identify young people at risk of significant harm.
- Young people had a wide range of treatment and therapies available to them. This included a structured therapeutic programme consisting of psychological therapies, family therapy and numerous activities on and off the ward.
- Staff interacted and engaged well with the young people. Most young people were very complimentary of the staff and the level of care available to them. For example, during the recent building work the staff organised additional activities off the ward so they could escape the disruption.

Child and adolescent mental health wards

- The service ensured that young people continued with their education when admitted and provided young people with the educational materials required for continuing with their education.
- There was a consistent management team in place. This had improved since the last inspection. The service had implemented a management structure that included a ward manager and a service manager.

Is the service safe?

Requires improvement 

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

- Staff were unable to observe all parts of the ward due to the current layout. Staff did not routinely undertake observations of all of the ward, nor did they record when observations were carried out.
- Plans to mitigate ligature risks on the ward were reliant on staff being in communal areas at all times. The bannister and stair lift leading to the communal area posed a significant ligature risk and the mitigation in place was not sufficient to ensure the safety of young people.
- Young people told us they were were unhappy with the level of ward cleanliness as sometimes bathrooms and communal areas were unclean**.**
- The service had not completed environmental risk assessments. During the summer, staff placed a chain across the doors leading to the garden. This did not allow enough airflow into the dining room to cool it down. Staff had not completed individual risk assessments for use of the garden area therefore there was a blanket restriction on young people having access to the garden.
- The rights of the young people were not always respected. For example, young people who were admitted informally could not access the garden area due to a blanket restriction. The service was unable to provide a female-only day area for example a female-only lounge.
- Risks identified in the risk assessment were not always addressed within a care plan. Not all young people had a crisis plan.
- Only 74% of staff had completed mandatory physical emergency response training.

However:

- The trust had ensured the safety of the premises by securing the fence that led from the garden directly onto the car park. This was an improvement from the last inspection.
- The trust had carried out some works on the building to improve the safety of the ward environment for example the majority of the suspended ceiling had been replaced.
- The clinic room was fully equipped and staff followed good practice in medicines management.
- Staff responded to changing risks of young people for example a change in mental state.
- Staff were trained in safeguarding, knew how to make a safeguarding alert and knew how to identify young people at risk of significant harm.
- At the time of inspection, the nursing and therapy teams were fully staffed.

Child and adolescent mental health wards

Is the service effective?

Requires improvement 

Our rating of effective went down. We rated it as requires improvement because:

- Care plans were not holistic. Young people had a nursing treatment care plan but there was no evidence of input from the wider multi-disciplinary team such as occupational therapists, social workers and psychologists.
- Although staff provided care and a range of treatments that met the young people's needs, these were not reflected in the written care plans. Care plans were generic and used standard statements that did not show personalised care.
- Some care plans had not been updated in a timely manner in line with trust policy.
- Staff had not received specialist training to meet some of the young people's specific needs. For example, working with someone diagnosed with eating disorder or an autistic spectrum disorder.

However:

- Staff assessed the mental and physical healthcare needs of young people on admission. They monitored young people's physical health throughout admission. Staff documented their findings in the care record.
- Young people had a wide range of treatment and therapies available to them. This included a structured therapeutic programme consisting of psychological therapies, family therapy and numerous activities on and off the ward.
- There was a full range of multi-disciplinary staff on the ward. This included psychiatrists, psychologists, nurses, occupational therapist, education staff, family therapist, a social worker and, a dance and movement psychotherapist.

Is the service caring?

Requires improvement 

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

- Staff did not provide young people with written information about the ward at the time of admission. Young people received verbal information and found this overwhelming. At the time of the inspection, staff were developing a welcome pack for young people and a draft version was reviewed during the inspection.
- Young people told us they did not play a key role in developing their care plans. Young people told us that they were not involved in developing their care plans and that their feedback was not incorporated or listened to. Care plans had a section for staff to record the young person's views but young people felt these were ignored. Staff tended to record in this section whether the young person agreed or disagreed with the content of the plan.
- Young people were not provided with a copy of their care plans.
- Of the carers we spoke with, three out of four said that communication with staff was inconsistent. For example, phone messages for young people would not get passed on or if a young person's named nurse was on leave, carers would receive infrequent updates from the team.

However:

Child and adolescent mental health wards

- Staff interacted and engaged well with the young people. Most young people were very complimentary of the staff and the level of care available to them. For example, during the recent building work the staff organised additional activities off the ward so they could escape the disruption.
- Staff involved young people with decisions about the service. For example, young people were involved in the recruitment of staff.
- Young people had good access to advocacy, and knew about this service. The advocate would visit the ward once a week.

Is the service responsive?

Requires improvement 

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

- Young people did not always have a discharge plan in place. Of the six records reviewed, only one young person had a discharge plan.
- Between 8 May 2017 and 1 March 2018, seven young people's discharge from the service were delayed. Two young people's discharge was delayed by 20 days. The five other young people's discharge were delayed by 38, 41, 81, 88 and 177 days. Whilst the service had identified that delays were due to a lack of social placements in the area, young people who were returning to the family home did not have a discharge plan. For those young people who were unable to return to their family home there was no discharge plan in place detailing other options.
- At the time of the inspection two young people required the use of a wheelchair. We were told by the young people that the garden could not be accessed with a wheelchair and the ramp on the minibus had been broken for some time. Young people told us this meant they had been unable to go on some trips.

However:

- There was a full range of facilities for the young people, including an art room, occupational therapy kitchen, outdoor areas and games rooms. Young people were given opportunities for regular exercise and activities.
- Young people's bedrooms were personalised and had ensuite facilities. Young people could decorate their bedrooms.
- The service ensured young people continued with their education when admitted and provided young people with the educational materials required for continuing with their education.

Is the service well-led?

Requires improvement 

Our rating of well-led stayed the same. We rated it as requires improvement because:

The management team had not ensured that young people had individualised environmental risk assessments in place and therefore a blanket restriction was in place meaning that no one could access the garden, even though a number of young people were not detained under the Mental Health Act.

In the summer, the management team did not respond appropriately to the hot weather. They placed a chain around the back door with did not allow adequate air flow and created a ligature point, which young people highlighted to the inspection team.

Child and adolescent mental health wards

The management team had not ensured that staff had completed specialist training to support all young people's needs for example eating disorder training.

The management team had not conducted a thematic review on the causes of young people's discharge from the service being delayed. Whilst there is a lack of social placements in the area, further causes could contribute to the delayed discharges in the service.

Staff did not always feel they had the opportunity to contribute to discussions about the strategy for their service. Staff reported that when changes have happened they have not been discussed with the staff.

Many staff were concerned about a current review of the administration staff roles and were concerned this would lead to a reduced number of administration staff

However:

There was now a consistent management team in place. This had improved since the last inspection.

Managers were visible in the service and approachable to young people and staff. For example, the manager ensured all staff, including themselves, attended a coffee and cake event whenever a young person was discharged or a member of staff left.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Action the provider MUST take to improve

- The trust must ensure that environmental risk assessments are completed and identified actions are followed. (Regulation 12)
- The trust must update the service's ligature assessment with detailed actions of how ligature risks will be mitigated; including minimising the number of ligature points. (Regulation 12)
- The trust must ensure that the service takes appropriate actions to allow airflow into the dining room during times of high temperatures. (Regulation 12)
- The trust must ensure that the service reviews the blanket restriction on the use of the garden area. (Regulation 12)
- The trust must ensure that young people are involved in their care-planning to ensure care plans are person-centred and that young people's views are incorporated into plans. (Regulation 9)
- The trust must ensure that each young person has a discharge care plan in place that is regularly updated. (Regulation 9)

Action the provider SHOULD take to improve

- The trust should ensure that the service individually risk assesses young people in relation to the ward environment.
- The trust should ensure regular checks of the ward environment are conducted to ensure regular assessment of the identified ward environment risks.
- The trust should consider use of convex mirrors to improve staff ability to observe all parts of the ward.
- The trust should ensure that care plans are holistic and contain input from the multi-disciplinary team.
- The trust should consider the provision for a female-only lounge in the upcoming refurbishment of the ward environment.

Child and adolescent mental health wards

- The trust should ensure that all staff complete mandatory training in physical emergency response training.
- The trust should ensure that staff receive the necessary specialist training so that all young people's needs can be met.
- The trust should ensure that communication is improved with young people's carers to ensure they are kept updated with young people's care and treatment where appropriate.
- The trust should ensure that staff are consulted when changes to the service are implemented.
- The trust should ensure that the garden is wheelchair accessible and that the ramp on the minibus is repaired.

Mental health crisis services and health-based places of safety

Good ↑↑

Key facts and figures

Avon and Wiltshire Mental Health Partnership Trust call its mental health crisis service teams intensive teams.

The intensive teams provide emergency and urgent assessment and home treatment for adults who present with a mental health need that require a specialist mental health service. Their primary function is to undertake an assessment of needs, whilst providing a range of short-term treatment as an alternative to hospital admission. The team are also gatekeepers so can admit patients to an inpatient unit if this is required. This service has nine teams that cover Bath, Bristol, North Somerset, South Gloucestershire, Swindon, and Wiltshire.

The intensive teams were based at the following sites:

Bath and North East Somerset Intensive Team were based at Hillview Lodge in Bath.

Bristol Central Intensive Team based at the Speedwell Centre in Bristol.

Bristol North Intensive Team based at the Greenway Centre in Bristol.

Bristol South Intensive Team based at Petherton Resource Centre, Bristol.

North Somerset Intensive Team were based at the Longfox unit in Weston-super-mare.

South Gloucestershire Intensive Team based at the Kingswood Civic Centre in Kingswood, Bristol.

Swindon Intensive Team based at Sandlewood Court in Swindon.

Wiltshire Intensive North based at Green Lane Hospital in Devizes.

Wiltshire Intensive South based at Fountain Way Hospital in Salisbury.

The trust has two health-based places of safety, The Mason Unit at Southmead Hospital in Bristol, and Bluebell Unit at Green Lane Hospital in Devizes. A health based place of safety is a place where someone who may be suffering from a mental health problem can be taken by police officers, using the Mental Health Act, to be assessed by a team of mental health professionals. Previously, the trust had operated an additional place of safety in Salisbury at their Fountain Way site, but they had closed this unit and re-organised how they delivered health based places of safety.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. Before the inspection visit we reviewed information that we held about these services and information requested from the trust. We inspected all five key questions for this core service.

The inspection team visited the intensive teams and the health based places of safety between 4 and 6 September 2018.

During the visit the inspection team:

- Inspected the two health-based places of safety, and the Bath and North East Somerset, Bristol Central, Bristol North, Bristol South, South Gloucestershire, and Swindon Intensive teams.
- Spoke with the managers in charge of the teams and the places of safety.
- Spoke with 46 other members of staff including nursing staff, psychiatrists, psychologists and a pharmacist.
- Spoke with 14 patients.

Mental health crisis services and health-based places of safety

- Observed six episodes of care (either home visits or calls to patients).
- Reviewed 34 medicines charts and 45 care records.
- Reviewed 13 staff supervision records and appraisals
- Reviewed a range of policies and procedures used by staff.

Summary of this service

Our rating of this service improved. We rated it as good because:

- The service had taken steps to address environmental and safety concerns raised at our last inspection in June 2017. We saw that there were now safe lone working policies and staff could access personal alarms when seeing patients on site. Patient environments were assessed for risks and staff undertook checks and assessments to ensure that patients were kept safe.
- On this inspection we found that that staff assessed patients' mental health and risk well, updating these assessments appropriately and regularly in patient records. Staff discussed patient risk frequently in handovers, complex case review meetings and had access to supervision to help them provide high quality care.
- Patients had access to experienced staff from a variety of mental health professional backgrounds. From observing care, speaking with patients and reviewing records, we saw that staff worked collaboratively with patients to develop care plans and meet the patient's needs. Staff were able to offer a range of nationally recommended interventions (such as psychological therapies recommended by the National Institute for Health and Care Excellence) and had good links with local services to help meet patient's needs.
- Staff routinely met their targets for assessing patients in a timely way. In the health-based places of safety this ranged from 95-97% of patients being seen in 24 hours. In the intensive teams, staff saw patients within 4 hours, or within 72 hours depending on the risks of the patient. While they were with the teams, patients had access to appropriate care environments that protected their dignity and privacy appropriately. After they had left the care of the teams, staff collected patient feedback and used this to learn and improve their services.
- Patient representatives were included in recruitment panels for new starters and managers held meetings with patient representatives to gather feedback for service developments. Staff would also meet with carers and help them receive carers assessments to meet their needs.
- Staff teams had strong bonds and reported respecting and valuing their local leadership. They felt their managers were approachable and supportive. Staff felt able to raise concerns without reprisals.

However:

- The North Bristol Intensive team reported that there were a number of shift were staffing levels had fallen below the minimum agreed staffing levels and had not been able to access bank or agency staff to cover these. This problem was made worse when they covered the out of hours cover for the Bristol intensive teams and meant they had to postpone visits.
- Medicines were not managed consistently across the intensive teams. Where we found issues with how medicines were managed, staff addressed these promptly.
- Trust policies on completing physical health checks for patients had not yet been implemented by the intensive support teams.

Mental health crisis services and health-based places of safety

- The North Bristol Intensive team did not have good access to therapy rooms on site. Staff prioritised meeting patients the patients home. Some patients would have preferred meeting staff away from their homes due for privacy reasons.

Is the service safe?

Good ↑↑

Our rating of safe improved. We rated it as good because:

- The service had made improvements to the environment in the health-based places of safety since our last inspection in June 2017. This included fixing problems with damp and improving lines of sight. The rooms used for patient appointments in the intensive team bases were suitable for seeing patients in and staff had access to personal alarms.
- Most of the teams reported having manageable caseloads and enough staff at the time of inspection. This included them having rapid access to a psychiatrist if they needed one.
- Staff had received mandatory training in core aspects of their work. Where staff were due to attend training, they were booked onto upcoming courses and managers had good oversight of mandatory training compliance.
- We reviewed 45 care records and saw that staff regularly updated risks and completed appropriate risk assessments. Staff had in-depth conversations about patients risk weekly, as well as in the handovers each day.
- At our last inspection we saw sharp item disposal boxes were stored incorrectly, they had been stored correctly at this inspection.

However:

- The North Bristol Intensive Team reported difficulties in meeting their minimum staffing numbers, this problem was worsened when they covered the out of hours service covering Bristol. This had meant that staff had to postpone visits to patients. Most of the intensive teams we spoke with were concerned about the plans to expand the out of hours service as the service had not been able to recruit to the posts needed for the changes to start in November 2018 (two months after our inspection visit).
- There were inconsistencies in the way medicines were managed between the intensive teams. Where we noticed errors or omissions in the records, the teams took steps to correct this.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- Staff comprehensively assessed the mental health of each patient. We reviewed 45 records and saw timely updates to patients care records, and saw that staff worked with patients to develop crisis plans.
- Staff were experienced and had the skills to meet patients' needs. Patients of the intensive teams had timely access to psychological therapies recommended by the National Institute for Health and Care Excellence. Staff were also knowledgeable about how to help meet patients' other needs and worked well with other local services to ensure patients' needs were met. For example, links with local crisis houses, and the food bank.

- Staff received meaningful and appropriate supervision and appraisals to help them develop in their roles and provide high quality care.

However:

- Staff had not fully implemented the trust's policy on ongoing physical health checks. Staff were not completing health checks on people who did not have pre-identified health needs.
- Some staff said that additional training was dependant on the professional group the staff belonged to, with nursing staff having less access than psychiatrists to additional specialist training.

Is the service caring?

Good 

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

- Staff treated patients with dignity and worked with them collaboratively to meet the patient's needs. In the patient visits and calls, and in the way staff spoke about patients, we saw that they were respectful and compassionate to patients.
- There was a culture of acceptance and inclusion within the service towards patients and staff that belonged to the lesbian, gay, bisexual and transsexual community.
- Staff engaged patients (and their carers when appropriate) in not only their individual care, but also in the wider development of the service. They did this by including service user representatives on recruitment panels, holding groups where they could talk to managers in the service, and by collecting feedback from patients and their carers.

Is the service responsive?

Good 

Our rating of responsive improved. We rated it as good because:

- Intensive team staff did not hold a waiting list, and reported consistently meeting the four hour assessment targets. At the health-based place of safety, most assessments were carried out within the 24 hour target time. Where this wasn't the case, there was a clear policy for staff to follow.
- The facilities in the health-based places of safety had improved since our last inspection in June 2017, with refurbishment and additional features in place to ensure the unit could be safely observed. Most of the intensive teams had access to suitable therapy rooms at their base and all would visit patients in their homes.
- All of the care environments had adaptions in place to allow disabled patients access to rooms and toilet facilities. The health-based places of safety had adapted washing facilities as well.
- In line with the accessible information standard, the service had a variety of measures in place to ensure they could meet the needs of their patients. For example, access to signers, a specialised phone for patients that were deaf and staff could also access easy read information and information in languages other than English.
- Staff collected and discussed patient feedback and we saw evidence of them addressing concerns that had been raised.

However:

- The North Bristol Intensive team did not have good access to therapy rooms at their base.

Is the service well-led?

Good 

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

- The teams benefited from strong team managers that had the experience and tools to lead their teams well. Staff felt confident and supported by their local leadership, and reported that the community services manager was visible and approachable.
- There was a strong bond in the intensive teams we inspected, and all staff subscribed to the trust's values and applied them in their day to day work. Staff reported feeling free to raise concerns without reprisal.
- Managers had access to local governance systems to help them track their performance on a range of indicators, such as referral times, staff sickness and staff mandatory training.
- Since our last inspection in June 2017, the trust had put in a procedure for escalating and managing out of area child and adolescent patients in the health-based places of safety. However, no contractual agreement with local trusts had been established to ensure that these patients could be assessed appropriately.

However:

- Despite managers having access to timely and correct information about their services, the service was unable to provide us with completely clear and accurate information before the inspection visits.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Action the provider SHOULD take to improve:

- The trust should ensure that they can provide timely and accurate information to the Care Quality Commission on request.
- The trust should ensure that staff are completing physical health checks in line with an appropriate policy.
- The trust should take steps to address staffing issues in the North Bristol Intensive team so that they can meet their minimum staffing requirements.
- The trust should ensure that all intensive teams are using a standardised and appropriate way of managing medicines and logging when they are administered and received.

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

Requires improvement 

Key facts and figures

The trust's acute admission wards for adults of working age are located on seven hospital sites across Bristol, Weston- Super-Mare, Bath, Swindon, Devizes and Salisbury. The sites in Bristol and Salisbury both have psychiatric intensive care units (PICU) to provide higher levels of care to patients, if required.

Services are delivered from the following locations:

Beechlydene & Ashdown - Fountain Way, Wilton Road, Salisbury, Wiltshire, SP2 7FD

Sycamore ward, Hillview Lodge, Combe Park, Bath, Avon, BA1 3NG is a 15-bedded acute admissions ward for both men and women. The patient bedrooms do not have ensuite facilities.

Juniper ward, Longfox Unit, Grange Road, Uphill, Weston-Super-Mare, BS23 4TQ is an 18-bedded acute admissions ward for both men and women. There are no ensuite facilities in patient bedrooms.

Lime ward, Callington Road Hospital, Marmalade Lane, Brislington, Bristol, BS4 5BJ

is a 23-bedded acute admissions ward for both men and women with ensuite facilities.

Poppy ward, Green Lane Hospital, Marshall Road, Devizes, Wiltshire, SN10 5DS is a 20-bedded acute admissions ward for both men and women. There are no ensuite facilities for patients here.

Silver Birch, Callington Road Hospital, Marmalade Lane, Brislington, Bristol, BS4 5BJ is 19-bedded acute admissions ward for both men and women. All bedrooms have ensuite facilities. There are two separate gender corridors. Each corridor contains a bedroom that is equipped to accommodate a patient with physical health needs. Oakwood ward, Southmead, Southmead Road, Westbury-on-Trym, Bristol, Avon, BS10 5NB is a 23-bedded acute admissions ward for male and female patients. All bedrooms have ensuite facilities. There are two separate corridors for male and female patients and three single rooms available for either men or women. Each corridor contains a bedroom that is equipped to accommodate a patient with physical health needs.

Applewood ward, Sandalwood Court, 53 Downs Way, Swindon, Wiltshire, SN3 6BW is an 18-bedded acute admissions ward for male and female patients. There are separate male and female corridors. Each corridor has seven bedrooms and a further two bedrooms which can be used for any gender dependent on need. There are no ensuite facilities at Applewood.

Elizabeth Casson, Callington Road Hospital, Marmalade Lane, Brislington, Bristol, BS4 5BJ is an eight-bedded psychiatric intensive care (PICU) ward for women in the acute stages of psychosis. There are ensuite facilities available.

Hazel Unit, Callington Road Hospital, Marmalade Lane, Brislington, Bristol, BS4 5BJ

is a 12-bedded psychiatric intensive care ward for men in the acute stage of psychosis. There are ensuite facilities here.

Ashdown Fountain Way, Wilton Road, Salisbury, Wiltshire, SP2 7FD is a six-bedded psychiatric intensive care unit for men in the acute stages of psychosis. Ashdown ward has ensuite facilities.

Beechlydene, Fountain Way, Wilton Road, Salisbury, Wiltshire, SP2 7FD is a 22-bedded unit for both men and women. All rooms have ensuite facilities and there are clear male and female areas of the ward.

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

We carried an announced inspection across all 11 wards

During the inspection visit, the inspection team:

- interviewed 38 nurses and healthcare assistants,
- spoke with 32 patients and 7 relatives
- interviewed 11 managers and deputy managers
- spoke with 11 consultants or junior doctors,6 members of the wider MDT
- we reviewed 11 clinics rooms and toured the ward environments
- reviewed 78 medication charts,
- 66 sets of notes
- Attended 4 MDTs and handovers

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- The trust had not acted to address some of the required improvements that we had told it that it must make in this services at two previous inspections to ensure that environmental risks to patients and seclusion practices were effectively managed.
- During our inspections in May 2016 and June 2017 we told the trust it must ensure it maintained safe environments. On this inspection we found that staff on the wards across the trust were not managing ligature risks effectively. There were areas of wards that staff had identified as posing a high ligature risk but observation of these areas relied on casual observation as opposed regular observation that was recorded. The risk mitigation plan stated that doors to these areas should be locked, although on inspection we found that staff had left these doors open exposing patients to risk. Staff had not updated the environmental risk assessments to include new risks from potential ligature points.
- During our inspections in May 2016 and June 2017, we found that male patients were being secluded on a female psychiatric intensive care unit (PICU). This caused distress for the female patients as male patients had to be brought through the ward plus it did not preserve the dignity of the male patients. We told the trust it must revisit this arrangement to ensure it met the safety, privacy and dignity needs of patients. On this inspection we found that male patients from Silver birch ward were still being secluded on the female PICU (Elizabeth Casson ward).
- Staff were not recognising or recording seclusion in line with trust policy or the Mental Health Act (1983) Code of Practice. Staff on some wards only reported that seclusion was taking place if they had locked the seclusion room door. They were not recording episodes where they confined patients to an unlocked room from which they would have prevented the patient leaving had they attempted to do so.
- There was a high level of prone restraint used across all the acute wards. Prone restraint had been used in 41% of all episodes of physical intervention.
- The level of cleanliness on Beechlydene ward was of a poor standard. Patients reported that rooms were not being cleaned adequately. We found that rooms that we were told had been cleaned were still dirty.

However:

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

- Staff were caring and compassionate. Staff communicated well with patients and introduced new initiatives such as the safe wards.
- The physical health of patients was well cared for on all the wards. Patients were regularly assessed in weekly physical health checks.
- There was good multi-disciplinary work among nurses and other professionals on all the wards. All staff, including healthcare support workers, peer support workers, advocates and social workers felt involved in patient care and were invited to the patient review meetings.
- Care records on all the wards were comprehensive, holistic and personalised. Patients told us that that they were involved in their care and that staff listened to their wishes.
- Staff were very passionate about ensuring that carers felt involved in their loved ones' care and had introduced support groups and sessions for carers.
- Staff felt that they had good opportunities for personal and professional development and that the trust encouraged career progression.
- Most staff spoke highly of their managers and management teams, and felt supported and listened to. Supervision and appraisal was being carried out in most cases.

Is the service safe?

Requires improvement 

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

- Wards were not safe as staff could not clearly see all areas of the wards and did not effectively manage all the risks posed by this. Staff did not know about all ligature anchor points and had not taken actions to mitigate risks to patients who might try to harm themselves. During our inspection in May 2016, we told the trust it must act to mitigate the risks, including undertaking work to reduce the number of ligature points on wards. When we inspected in June 2017, the trust had made some improvements but there was still some work to do and staff were still not fully. identifying or mitigating all potential risks. On this inspection we found that, although all the wards had ligature risk assessments, they lacked robust plans for the management of the environmental risk. There was also a lack of clarity regarding plans to remove the identified risk. The number of ligature incidents reported varied across the service. We noted that on Oakwood ward there had been several incidents were patients had attempted to self-ligature. Staff told us this was a regular occurrence.
- During our inspections in May 2016 and June 2017, we found that male patients were being secluded on a female psychiatric intensive care unit (PICU). This caused distress for the female patients as male patients had to be brought through the ward plus it did not preserve the dignity of the male patients. We told the trust it must revisit this arrangement to ensure it met the safety, privacy and dignity needs of patients. On this inspection we found that male patients from Lime ward were still being secluded on the female PICU (Elizabeth Casson ward).
- Oakwood ward had a low fence and low roof which could be scaled. On four occasions, in the four weeks before the inspection, a patient had absconded from the ward by this route. This area was not part of regular observation beyond the hourly check. We raised this with the matron who acted at once to ensure 15-minute checks were carried out.

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

- During our inspection in in June 2017, we found that emergency equipment and emergency drugs were not being checked in line with trust policy. During this inspection we found that checks were being undertaken. The staff on Silver Birch told us they had been told to use the out of date intubation tubes (if needed) until the new emergency bags arrived. On Sycamore ward, one of the two sets of defibrillation pads were out of date. Staff informed us that the trust was not providing new equipment as a complete review of all equipment due to take place.
- The level of cleanliness on Beechlydene ward was of a poor standard. Patients reported that rooms were not being cleaned adequately. We found that rooms that we were told had been cleaned were still dirty. The modern matron acknowledged that the standard of cleanliness was below the required standard.
- There was a high level of prone restraint used across all the acute wards. Prone restraint had been used in 41% of all episodes of physical intervention in the last 12 months. The trust's policy stated that prone restraint should only be used in exceptional circumstances. Staff said that they were trained to hold the person in a kneeling position before holding them on the ground. It was therefore not possible to move easily into a supine position. Some staff told us that they were trained to use prone as the initial floor position.
- There was an inconsistency in the application of the seclusion policy. Some wards were only reporting a seclusion if the seclusion room door was locked. They were not recording periods spent in de-escalation or segregation when the door was not locked but the person would be prevented from leaving should they attempt to do so.
- Staff did not follow followed best practice when storing, dispensing, and recording medication. We found that on Applewood ward the clinic fridge temperatures were exceeding 25 degrees Celsius which could affect the efficacy of medication stored within.
- When we visited in June 2017 we found that although the trust was making efforts to address staffing issues across the service, some wards had many band 5 vacancies. On this inspection we found that the across the service the registered nursing vacancy rate was 33%; the main challenges were in the Wiltshire services. This had resulted in the high use of agency use across the service.
- Although staff had a good knowledge of safeguarding processes and reported safeguarding incidents to the local authority, there was inconsistency in the reporting of safeguarding incidents through the trust incident reporting system. Incidents which occurred on the ward were both reported to the local authority and reported through the trust incident reporting system. However, on some wards if an incident occurred prior to admission (and staff were told about it on admission) they only reported this the local authority and not through the trust system. The trust policy did not make it clear what was required.
- We found that not all wards received feedback from incidents that were reported and therefore there was little learning from incidents. Some wards had clear lines of communication via the cascading of the safety briefings and standing agenda items, whereas other teams did not feel that they were made aware of incidents from across the other acute wards or from the trust.

However:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. When we visited in June 2017 we found that not all staff we spoke with were familiar with the term neuroleptic malignant syndrome (NMS) and would not know how to identify symptoms or what action to take. On this inspection we found that staff could identify the symptoms and treatments of NMS.
- Staff completed risk assessments for patients on admission or within 72 hours of admission and used these to understand and manage risks individually.

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

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. When we visited in June 2017 we found that patient observation records on Elizabeth Casson (PICU) unit were not being completed in line with the trust's policy, placing patients at increased risk of harm. On this inspection we found that observations were being recorded in line with trust policy.
- Staff regularly reviewed the effects of medications on each patient's physical health.
- When we visited in June 2017 we found that personal alarm systems were not adequate on Ashdown and Beechlydene unit. Staff were supplementing the system by investing in personal attack devices. On this inspection we found that a new system had been installed.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Staff completed safeguarding training and had a good knowledge of safeguarding processes.
- Some wards used route cause analysis (RCA) to ensure there was learning from incidents and to ensure learning was used to improve practice and services.

Is the service effective?

Good ➔➔

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

- Staff carried out comprehensive assessments on admission, including safety risks, physical and mental health needs. The duty doctors completed physical health assessments on admission. These assessments were ongoing following admission, including conducting the national early warning score (NEWS) and recording in care plans. Hazel ward had developed a one-page prompt sheet to be given to patients so than they could have their views recorded, as this was more accessible that using the whole care plan. On Hazel ward nurses developed personalised positive behavioural support plans.
- Staff provided a range of treatment and care for patients based on national guidance and best practice.
- All wards provided good physical healthcare for patients. Patients received weekly physical health checks and staff encouraged them to live healthier lives through initiatives such as smoke free wards.
- Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision, opportunities to update and to further develop their skills.
- Supervision and appraisal rates for the nursing staff across the services were good as were those for associated professionals
- Patients had good access to multidisciplinary teams (MDT) including psychiatrists, psychologists and occupational therapists. They also had access to a wide range of therapies such as art therapy, mindfulness and grounding and coping strategy groups. The MDT had weekly meetings to review patients. Staff handovers occurred three times a day in line with shift patterns. All wards had access to dieticians and nutritionists as well as physiotherapists, tissue viability nurses and other specialists.
- Patients had robust discharge plans and staff started working, with the involvement of patients, on these soon after admission and throughout the admission.

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

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Staff followed the Mental Health Act Codes of Practice, including ensuring access to advocates, reading patients their rights and paperwork associated with the Mental Health Act.
- Staff supported patients to make decisions about their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly as needed. All staff understood the key elements of the Mental Capacity Act.

However:

- Team meetings across the wards were inconsistent. All wards had team meetings but not all had a standing agenda. Some included feedback from across the trust and others did not.

Is the service caring?

Good 

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

- Staff treated patients with compassion, kindness and respected. In most of cases patients' privacy and dignity was considered whilst supported their individual needs. Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of consequences.
- Feedback from most patients was positive; they said that staff responded compassionately to their needs and were skilled in dealing with vulnerable individuals with complex physical and mental health needs.
- Staff were hard working, caring and committed to delivering a good quality service. They spoke with passion about their work and were proud of what they did.
- Staff understood the needs of patients; including their personal, cultural, social and religious needs. Staff maintained the confidentiality of information about patients and supported them to make choices about sharing information.
- Staff listened to patients and gave them emotional support. Staff overcame communications obstacles compassionately.
- Staff involved patients and those close to them in decisions about their care, treatment and changes to the service. Patients were included in decision-making; staff listened to their wishes. We observed staff discussing care options and treatments, and providing choice to patients. Relatives said they felt involved and had the opportunity to speak with medical and nursing staff when required. Ward managers were available on the wards so that relatives and patients could speak with them as necessary.
- Patients had access to advocacy services.
- Patient feedback was collected and used to make improvements. We saw evidence of community meetings being held across the acute wards.
- Patients were trained and encouraged to join the recruitment process to appoint substantive staff.

However:

- Ward staff did not complete carers assessment. This was passed to the community mental health teams to complete, potentially leading to delays in these being carried out.

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

Is the service responsive?

Good ➔➔

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

- Patients could access the service closest to their home when they needed it. Arrangements to admit, treat and discharge patients were in line with good practice.
- A bed management team managed access to beds and the effective discharge of patients to ensure beds were available when needed. The trust had introduced a daily bed management call for all ward managers and matrons to manage the effective discharge of patients, and identify any potential barriers to discharge. Some wards had specific members of staff recruited to aid with the discharge process.
- Discharges that were delayed were due to funding issues for onward placements or a lack of appropriate accommodation in the community. Staff supported patients during these delays and kept them informed. Staff also supported patients when it came to discharge or transfers.
- Patients had their own rooms where they could keep personal belongings safely**.** There was good access to rooms and facilities to support care and treatment.
- All wards had access to quiet areas and family rooms that allowed patients to maintain relationships with their loved ones. Patients also had access to mobile phone in accordance with their individual risk assessments and there were private spaces for patients to make phone calls.
- Staff supported patients to access the wider community including activities such as work, education and family relationships, through escorted and unescorted leave. Local voluntary agencies attended the wards to engage in educational and training opportunities for the patients.
- The service was accessible to all who needed it and took account of patients' individual needs. Staff helped patients with communication, advocacy and cultural support.
- Most wards had good access to daily activities for the patients. Patients told us that often there were regular scheduled activities on the wards.

However:

- Staff from across the service had differing experiences of receiving feedback from complaints. Some told us that feedback was consistently given from across the service, whereas others told us that they only receive feedback regarding complaints on their ward.
- Access to outside space was limited on Beechlydene as the garden was unsafe; this resulted in patients using small high walled court yards. Applewood had a garden but the single sex outside areas did not have any benches for patients to sit on as these had been removed because of the risk of patients using them to abscond, as a result these where not used. The outside areas on the Callington Road site had no lighting.
- Beechlydene and Poppy wards did not always have sufficient staff to provide leave or unlock the doors to let informal patients out of the ward.

Is the service well-led?

Requires improvement ↓

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

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

- The trust had not taken action to address some of the required improvements that we had told it that it must make in this services at two previous inspections (in 2016 and 2017) to ensure that environmental risks to patients and seclusion practices were effectively managed. Managers in the service were not ensuring that environmental risk assessments were carried out and that there was robust ligature risk management. Male patients were still being secluded on the female PICU (Elizabeth Casson ward) compromising the safety, privacy and dignity of patients.
- The staff and managers were not able to describe the trust's vision and strategy, so did not understand what was planned for the future and how the strategy would be achieved.
- The matrons did not have adequate oversight of the maintenance and cleaning of the wards on some sites.
- Beechlydene and Poppy wards did not always have sufficient staff to provide leave or unlock the doors to let informal patients out of the ward. Patients told us that the staff were not able to be responsive.
- Managers were not ensuring that the trust policy of prone restraint was adhered to by staff and that issues impacting on this such as the intramuscular medicines administration policy were addressed.
- There was no plan in place to manage the risk posed by the low fence or low roof on Oakwood ward despite patients having absconded over the fence or climbed onto the roof on multiple occasions.

However:

- Managers had access to dashboards that allowed them to monitor key performance indicators. Staff participation in audits was good and there were regular audits conducted including infection control and medication audits. All the wards had a risk register and staff could escalate concerns when appropriate.
- Staff members felt that ward managers and matrons provided good support on the wards. Ward managers were aware of the staffing challenges that they faced, and some used creative means to address this. Ward managers felt they had autonomy to make decisions to ensure the running of the service and were confident that approval would be given for the use of agency staff to maintain safe staffing numbers.
- There was a positive culture on all the wards, and staff were proud of the work and care they gave. Staff said they felt valued and respected. Staff said there were good opportunities for personal and professional development and that the trust encouraged career progression.
- Staff, patients and families had access to adequate information via the trust's intranet and website pages. Families and carers had access to a Friends and Families test where they could give feedback about the service.
- Staff from Elizabeth Casson ward had visited a PICU run by another service to look at how they managed restrictive practice and consider how they might improve their own practice. The intensive care wards were involved in improvement work related to the National Association of Psychiatric Intensive Care Units (NAPICU).

Areas for improvement

Action the provider MUST take to improve:

- The trust must ensure that all wards have robust plans in place to ensure risks presented by ligatures are managed robustly, including removing ligature points as appropriate. (Regulation 12)
- The trust must reduce the number of prone restraints and ensure staff are trained appropriately and consistently in undertaking restraint. (Regulation 12)

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

- The trust must address the issues caused by the seclusion of male patients on the Elizabeth Casson ward (female PICU). (Regulation 12)
- The trust must ensure that it addresses the risks posed by the low fence and low roof on Oakwood ward. (Regulation 12)

Action the provider SHOULD take to improve

- The trust should improve the cleanliness on Beechlydene ward. The trust should ensure that the correct fridge temperatures are maintained
- The trust should address the issue related to the garden areas at Beechlydene and Applewood wards and ensure appropriate lighting in the outside areas at Callington Road. lack of light in the gardens on the Callington road site
- The trust should ensure that all staff adhere to the trust's policy on seclusion and are aware of when an episode of seclusion begins
- The trust should ensure that there are always enough staff on Beechlydene and Poppy wards to facilitate patients accessing their section 17 leave.

Wards for people with a learning disability or autism

Inadequate ↓↓

Key facts and figures

The Daisy is a purpose-built hospital for people with learning disabilities. It opened in January 2017.

The Daisy provides five individual living areas known as pods, built around a large communal area. The design of each pod allows it to be a self-contained living environment for the patient.

The pods have their own front doors, doorbells and gardens in addition to a lounge, dining area/kitchenette, bedroom and ensuite bathroom. All the pods have two bedrooms, each with an ensuite bathroom.

The Daisy aims to offer a placement that could help the patient to learn the skills needed within the community whilst having the safety offered by a hospital. This means that patients detained under the Mental Health Act, due to their behavioural difficulties, can develop the independent living skills needed for discharge, and have the independence offered by a supported living placement.

All patients at the Daisy have individual care packages. To ensure that staff give individualised care, each patient has an allocated staff team for each shift. The Daisy agreed the number of allocated staff working with each patient prior to admission. In addition to the patients' core staff teams, there are floating staff who can give additional support.

The Daisy unit provides longer-term placement, with funding agreed for each patient for at least six months.

The inspection was announced to ensure the staff we needed to speak to were available and that the patients knew we were visiting.

At our previous inspection in June 2017 we rated the service good overall. We rated the service good for Safe, Caring, Responsive and Well-led domains and requires improvement in the Effective domain.

We issued the service two requirement notices, one for not ensuring care plans focused on recovery, were in an assessible format and that patients received a copy. The second requirement notice was for not ensuring all patients had a capacity assessment and that the capacity assessments were decision specific.

We carried out an announced inspection across the only ward for people with a learning disability or autism.

During the inspection visit, the inspection team:

- interviewed five nurses and healthcare assistants
- interviewed the ward manager, deputy manager and clinical services manager
- spoke with one patient
- interviewed the consultant psychiatrist and clinical psychologist
- we reviewed the clinic room and toured the ward environment
- reviewed all four medication charts
- all four sets of notes
- attended one multidisciplinary meeting and handover.

Wards for people with a learning disability or autism

Summary of this service

Our rating of this service went down. We rated it as inadequate because:

- There were a high number of physical interventions used to manage the behaviour of patients at the Daisy Unit and the staff did not have a plan in place to reduce the use of physical interventions. Because of poor recording the unit could not provide the inspection team with accurate information about whether there had been an increase in physical interventions during the period that it had been open (less than two years).
- The model of care was not clear. The trust believed that unit was implementing a positive behavioural support model. However, staff were not trained appropriately to use this model and mangers confirmed it was not being used. Staff were unable to explain how they used National Institute for Health and Care Excellence best practice guidance in delivering care to ensure a focus on enabling people to leave hospital and integrate back into the community.
- There was little evidence of discharge planning undertaken and staff had not considered how patient activities would prepare them for potential discharge.
- The unit did not use a recognised tool to measure patients' progress. The patients did not have access to a range of professional to fully meet their needs. For example, there were no dedicated occupational therapists or speech and language therapists at the unit. A number of staff had not received specific training required to help them meet the needs of the patients.
- Care plans did not explain what care should be provided to individual patients. Patients were not consistently involved in developing their care plan and staff did not record when a patient did not want to be involved. Staff did not regularly give care plans to patients or provide these or other information in an easy read format.
- Staff at the unit used four separate patient records. Due to the number of records, staff found it difficult to find information quickly and could not be certain that they always had the most up to date information.
- The assessment of and recording of patients' capacity was inconsistent. Most capacity assessments contained a very limited amount of information and what was there did not make it clear how patients' right were being protected. Patients did not get easy read menus and had to choose meals a week in advance.
- The regular community meeting had been cancelled because staff believed that these caused patients to become agitated. These had not been replaced with an alternative means by which patients could contribute their thoughts or views on how the unit was run or what activities should take place each day.
- The ward manager was not able to explain the unit's governance processes. The local risk register did not list all of the risks at the unit and risks had not be escalated as needed. Audits had not been used to support improvements. Whilst staff did review every incident that occurred there was little evidence analysis of trends and learning from incidents. The unit nor the trust had any way of monitoring the quality of the service provided at the Daisy unit.

However:

- The trust had designed the building to meet patients' needs. Nurse and healthcare assistant staffing levels had been planned to allow them to respond to challenging behaviour and allow patients to access the community daily.
- Staff treated patients with respect and built open relationships so that patients felt able to discuss their needs and raise concerns. The unit would invite families and advocates to be involved in meetings about the patients.
- All assessments undertaken at admissions were person-centred and took place at a time that suited patients. Staff met the physical health needs of patients.
- Staff felt the local management team was approachable and acted on their concerns.

Wards for people with a learning disability or autism

Is the service safe?

Requires improvement  

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

- There were a high number of physical interventions used to manage the behaviour of patients at the Daisy Unit but the staff did not have a plan to reduce the use of restrictive interventions. Staff did not participate in the trust's programme to reduce the use of restrictive interventions.
- The unit could not provide the inspection team with accurate information about whether there had been an increase in physical interventions during the period that it had been open (less than two years).
- The unit used four separate patient records. Staff found it difficult to find information when needed and there was no plan on how they were co-ordinated.
- Patient's behavioural support plans focused on what to do once a patient became unsettled, rather than focusing on how to prevent this occurring.

However:

- The unit was purpose built and offered ample space and good lines of sight to allow observation of the ward environment. Staffing was based on patient individual needs.
- Staff had taken the correct action when equipment was faulty.

Is the service effective?

Inadequate  

Our rating of effective went down. We rated it as inadequate because:

- The model of care was not clear. The trust believed that unit was implementing a positive behavioural support model. However, staff were not trained appropriately to use this model and mangers confirmed it was not being used. Staff were unable to explain how they used National Institute for Health and Care Excellence best practice guidance in delivering care to ensure a focus on enabling people to leave hospital and integrate back into the community.
- The unit did not use a recognised tool to measure patients' progress. The patients did not have access to a range of professionals to fully meet their needs. For example, there were no dedicated occupational therapists or speech and language therapists at the unit.
- Each patient had multiple care plans and it was difficult to see what care should be provide to individual patients. Patients were not consistently involved in developing their care plan and staff did not record when a patient did not want to be involved.
- The staff team had not received the appropriate training to ensure they had the specific skills needed to meet the needs of the patients.
- There was inconsistent recording of patients' mental capacity and capacity assessments were not appropriately detailed. When there were concerns around the capacity of patients' staff did not develop care plans to ensure the patients' rights were protected. Staff had not made sure they had told informal patients about their rights to leave. The ward did not display information telling informal patients they could leave the ward.

Wards for people with a learning disability or autism

However:

- Staff completed assessments of patients' mental and physical health needs and promoted healthy lifestyles.
- There was a local induction in place for all staff including agency staff.

Is the service caring?

Requires improvement  

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

- Staff did not routinely involve patients in planning their care. The staff team had not documented how patients had been involved or when they had refused to be involved.
- The regular community meetings had stopped due to staff identifying them as initiating challenging behaviour. These had not been replaced with an alternative to enable patients to contribute their thoughts or views on how the unit was run or what activities should take place each day.

However:

- Staff treated patients in a respectful manner. Staff encouraged patients to raise concerns and discuss their needs with them. Senior staff were approachable to patients and families when needed.
- Staff arranged personalised admissions that included patients visiting the unit and the staff team visiting the patient. The staff team involved families and advocates in meetings about the patients.

Is the service responsive?

Inadequate 

Our rating of responsive went down. We rated it as inadequate because:

- There was little evidence of discharge planning undertaken and staff had not considered how patient activities would prepare them for potential discharge. Patients who were ready for discharge did not have discharge plans.
- There were no easy read menus to help patients choose their meals, the manager told us this was because trust policies prevented them from taking photographs. Patients had to choose meals a week in advance.
- Care plans to promote health eating were not in an easy read format and did not provide staff with strategies to encourage healthy eating.
- Activities did not focus of patients gaining skills to help them plan for discharge.

However:

- Staff planned all admissions and they took place at an appropriate time.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate because:

Wards for people with a learning disability or autism

- Managers had not identified a model of care or a care pathway that was used to support patients throughout their stay at the Daisy unit (from admission to discharge). Care and activities was not based on National Institute for Health and Care Excellence best practice guidance and did not focus on enabling patients to leave hospital and integrate back into the community. There was little evidence of discharge planning undertaken and staff had not considered how patient activities would prepare them for potential discharge. This is not consistent with the approach required by the Transforming Care Programme – which expects that people with learning disabilities should not reside in a hospital ward indefinitely.
- The high use of restrictive interventions shows that staff found the behaviour of some of the patients challenging. Despite this, the unit was not participating in the trust's restrictive interventions reduction programme nor were staff skilled in the techniques required to anticipate and deescalate challenging behaviour.
- The ward manager could not explain the trust's governance structure and how it was used to improve the quality of the Daisy Unit.
- The auditing of care plans had not identified issues around patient involvement, easy read care planning and multiple care plans for single issues.
- Staff did review incidents but they did not identify patterns or trends or record any learning they identified.
- The local risk register did not robustly detail all the risk in the unit and risks had not been escalated as needed. Staff did not review or learn from incidents.
- The unit nor the trust had any way of monitoring the quality of the service provided at the Daisy unit.

However:

- The management team were approachable and listened to staff concerns.

Areas for improvement

Action the provider Must take to improve:

- The trust must ensure the model of care is clear and based on nationally recognised best practice and that care and activities are focused on enabling patients to leave hospital and live in the community. Regulation 12(1)
- The trust must ensure that information is given to patients in way that enables them to understand their care and treatment options and communicate their wants to the service and ensure this is recorded. Regulation 9(1)(a)(b)(c)
- The provider must ensure they appropriate assess and record patients' capacity to consent to treatment. Regulation 11(1)
- The trust must ensure that patient records are stored in a way that ensure authorised people know where to find and can access the most up to date information without undue delay. Regulation 12 (1)(2)(b)
- The trust must ensure care plans instruct staff how to deliver care to the individual patient in a way that is suitable for them. Regulation12(2)(a)
- The trust must ensure that the Daisy Unit is part of the reducing physical intervention practice programme and that the managers and staff are aware of this programme. Regulation17(1)(2)(a)(b) and (f).
- The trust must ensure the managers of the Daisy unit are aware of and use the trust governance process to improve the service, record risk on the local risk register and evidence learning from incidents. Regulation17(1)(2)(a)(b) and (f).
- The trust must ensure it meets the training needs of staff. Regualtion18(2)(a)

Wards for people with a learning disability or autism

- The trust must ensure there are enough staff with the appropriate qualifications, skills and experience to meet all the needs of patients. Regulation18(1)

Action the provider SHOULD take to improve:

- The trust should ensure patients have an alternative to daily patient meetings.
- The trust should ensure they record patients' informal concerns and complaints and act to resolve them.
- The trust should ensure they record all ligature point risks individually on the ligature point assessment.
- The trust should ensure staff do not use stock phrases to describe patients' behaviour.

Specialist community mental health services for children and young people

Requires improvement 

Key facts and figures

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

Community child and adolescent mental health services (CAMHS) are provided by four locality teams across Bristol and South Gloucestershire. Referrals came through a central outreach, assessment and triage team, which serves as a single point of access to the service. The locality teams are based in Kingswood (South Gloucestershire), Barton Hill Settlement (east and central Bristol), Brentry (north Bristol) and Osprey Court and Knowle (south Bristol). These teams deliver tier 3 (assessment and consultation services delivered by multidisciplinary CAMHS teams) and tier 2 (early intervention) services. There was an increased budget agreed upon by the trust and NHS England. This budget, once delivered, will enable further recruitment to take place

At the last inspection we rated the specialist community mental health services for children and young people as requires improvement overall, with requires improvement in safe, effective, responsive and well led. Caring was rated as good.

During the inspection, the inspection team:

- Visited the community teams at South Gloucestershire, Bristol Central and East and Bristol South.
- Interviewed five managers and team leaders, quality facilitator, head of operations, child and adolescent mental health safeguard lead, six nurses, four primary mental health specialists, one student nurse, six administrative staff, seven clinical psychologists, one trainee doctor, two psychotherapists, one trainee psychotherapist, one family therapist and three consultant psychiatrists.
- Spoke to six parents/carers and two young people.
- Observed two team meetings.
- Reviewed 29 care records, 16 team meeting minutes, nine supervision records and six quality and performance meeting minutes.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Teams were understaffed. We found staff had increased levels of stress caused by a combination of complex caseloads and the pressures of the long waiting lists. Vacancies increased pressure on the remaining staff and further increased workload and the length of waiting lists. For example, autism spectrum assessments could take up to a year.
- Staff did not record risk assessments consistently across the teams. Numerous young people did not have risk assessments.
- Clinical records for children and young people did not always contain care plans.

Specialist community mental health services for children and young people

- Staff did not have access to facilities to allow them to do their jobs properly. There were not enough therapy rooms and there were not enough desks for staff to use, some staff in the South Gloucestershire service reported working on the floor due to a lack of desk space.
- Policies and procedures had yet to fully embed within the teams, for example staff did not know about the Speak Up Guardian and few knew about the whistle blowing process.

However:

- The culture in the teams had improved since the last inspection and there was now a clearer management structure. Staff were confident to approach managers without fear of discrimination and there was a positive and optimistic staff culture, despite all the pressures currently faced.
- The Thinking Allowed and Be Safe programs were well constructed and operated well. They allowed very vulnerable groups of young people to access mental health, primary medical and other services.
- Care plans and assessments that were in place, were of good quality and showed involvement and input from the young people and if appropriate, their families or carers.
- Staff had caring and compassionate attitudes towards young people, and treated with dignity and respect.

Is the service safe?

Requires improvement 

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

- There was a high level of vacancies across the service, with 21%(31) of posts unfilled. This was exacerbated by the turnover of staff. Although managers were making active attempts to recruit new staff, this level of unfilled posts put pressure on the existing staff group. Staff reported that this was having a negative effect on them; they were experiencing high stress levels; their caseloads had increased due to having to cover the caseloads of vacant posts and many staff felt 'burnt out'.
- Staff had complex caseloads. Some staff reported up to 40 young people on their caseload, some of whom had complex needs. Staff informed us that these caseload numbers related to where they were the primary clinician, and that on top of this staff were also secondary clinicians, for young people not on their caseload, and had other roles to attend to. The combination of the complex caseload, secondary clinician work and various other roles meant that staff did not have enough time and felt under pressure. The clinicians work in supporting other young people, not on their caseload, was also increasing due to contributory factors such as staff sickness and turnover.
- Assessment of risk was not always consistent across young people's records. The trust had audited a large number of care records for this core service and found that 8.8% (104) of all records had missing risk assessments. There was no reason given in the individual care records why this was the case.

However:

- The building and rooms that young people were seen in were well maintained, clean and had good furnishings.
- Staff had up to date disclosure and barring service (DBS) checks.
- Staff were trained in safeguarding and knew how to recognise and report any safeguarding concerns. Each team had a designated safeguarding lead, and the CAMHS service had a safeguard lead who visited each location weekly should any further advice be sought by staff.

Specialist community mental health services for children and young people

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- There were regular, effective multi-disciplinary team meetings to discuss new referrals and complex cases. There were also dedicated meetings for young people on the transition pathway from CAMHS to adult mental health services.
- Staff provided a range of therapies and care that were suitable for the patient group. These were recommended by, and delivered in line with, the national institute for health and care excellence (NICE) and included cognitive behavioural therapy, family therapy and eating disorder therapy. Audits were conducted to ensure that the guidance for these therapies was followed. The Bristol and south Gloucestershire services are part of the improved access to psychological therapies services.
- There was no trust specific policy for LGBT+ and young people going through gender reassignment. However, staff were aware and well equipped to approach any young person who identified as LGBT+ or going through gender reassignment. Staff felt confident to refer them to the Gender Identification Service and Off the Record, with which the teams had good working relationships.

However:

- The trust had undertaken a large-scale audit of care records and found that 30% contained no care plan. We were told that care plans may be missing because either the young person was seen by crisis team first or that they required more than the initial two sessions to complete the assessment. Seven of the 29 records that we reviewed did not contain a care plan. None of them recorded a reason why the care plan was missing. The risk of this is that if an agency worker or another member of staff had to take over care they would not have care plans to rely on.

Is the service caring?

Good →←

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

- Staff attitudes and behaviour when interacting with young people and their carers/families showed that they were empathetic, respectful, compassionate and responsive. Staff offered emotional support and advice when young people needed it, in an appropriate manner.
- Staff understood the needs of the young people, including personal, religious, cultural and social needs, and treated them on an individual basis.
- Young people we spoke to said staff treated them well and behaved appropriately towards them. Both families and carers were very complimentary of staff.
- Staff, young people and families/carers said they were confident and comfortable to report anything concerning. This could be done either directly to their clinicians, managers or through online systems such as the patient advice and liaison service.
- Young people were involved as much as possible in their care planning and risk assessment. Staff communicated with young people in a manner they could understand.

However:

Specialist community mental health services for children and young people

- Not every young person was offered a copy of their care plan, or was able to sign off that they had received or didn't want a copy. This was due to the setup of the electronic records that a printable version was not beneficial to the young person, as it printed of a verbatim format that was difficult to navigate in printed format.

Is the service responsive?

Requires improvement 

Our rating of responsive stayed the same. We rated it as requires improvement because:

- There were long waiting lists across the service that led to delays in young people accessing the service. We were told that the average waiting time for non-urgent referrals was six months with the longest wait of 42 weeks. The longest waiting list had 111 children and young people waiting for assessment, with 23 young people waiting over 18 weeks. Staff had put in place measures to monitor the waiting lists and to keep in touch with young people on the waiting list. If this indicated that the condition of a young person was deteriorating, staff would respond appropriately. Urgent cases, or young people that were on the waiting list whose condition had deteriorated, could be seen rapidly within seven days. Funding has been allocated to the community teams in 2019 to help alleviate the staffing pressure and therefore reduce the waiting list.
- The building environment was not ideal for staff. Specifically, staff who had to work from hot desks complained that there weren't enough desk spaces. Staff often had to work on the floor due to the lack of desk spaces.

However:

- Subsequently we were informed that the electronic record system that has been fully implemented across the services allows for robust management of the waiting list. This has resulted in the decrease of children and young people waiting over 18 weeks from 100 to 23.
- The teams were undertaking good work around looked after children, and unaccompanied minors and asylum seekers accessing mental health services. Children at risk of sexual exploitation also had good access. This was done through the Thinking Allowed and Be Safe initiatives.
- Young people and parents/carers were aware of the complaints and compliments procedure. There were many examples of compliments towards staff, and managers could show learning that had taken place following any complaints.
- The services had a transition plan for young people progressing on to adult mental health services. This transition plan incorporated the adult mental health services and social workers from an early stage.

Is the service well-led?

Good 

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

- The managers were new in post, within the last 12 months, and had been well prepared for managerial roles. Leadership development was available for both mangers and other staff, with professional leads within the service taking ownership for various functions.
- The leaders had a good awareness and oversight of the services they managed. Leaders were visible and staff reported that they could approach them for personal and professional concerns.

Specialist community mental health services for children and young people

- Staff were aware of the trust's vision and values, and stated that this had improved since the last inspection. There was a feeling that the service was now better incorporated into the wider organisation, with clear lines of management and hierarchy.
- Staff felt positive and optimistic about the service, and working for the trust. They reported that they felt valued and that teams worked well together. They felt that the managers in post had created stability and systems that functioned well.

However:

- The teams reported high levels of stress and burn out with staff leaving as a result. The primary reason given was that of high caseloads and the long waiting lists.
- Staff, including managers, did not know about the Speak Up Guardian and some staff were not aware of the whistle blowing procedure.
- Staff did feel that further embedding of policies and procedures was still required, for example consistent minute taking from team meetings across all teams to similar standards.
- The team meetings are not consistently recorded in the meeting minutes. There were also different standards in the quality of the minutes taken across the teams.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

The programs Thinking Allowed and Be Safe were examples of good practice. These initiatives were dedicated to giving access to mental health therapies for looked after children, unaccompanied minors and asylum seekers, as well as children vulnerable to sexual exploitation. Bristol has a high number of unaccompanied minors and asylum seekers, many of whom are trafficked into the UK. Emphasis is placed on collaborative and multi-agency working, with child and adolescent mental health services working alongside social care services and primary medical services.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Action the provider MUST take to improve

- The provider must take all possible steps to reduce the waiting lists across the service to ensure children and young people have timely access to mental health support. (Regulation 12)
- The provider must ensure that risk assessments and care plans are completed in a timely manner, and where no risk is present this needs to be stated with rationale. If the young person was seen by crisis teams first then a copy of the risk assessment completed by the crisis team must be included in their care record. (Regulation 12)

Action the provider SHOULD take to improve

- The provider should ensure that sufficient numbers of suitably qualified and competent staff are employed in each team in order to meet the needs of young people accessing the service.
- The provider should ensure that team meetings are consistently recorded in the meeting minutes.
- The provider should continue to support individual teams to further embed the necessary governance and support systems.

Specialist community mental health services for children and young people

- The provider should ensure that all staff, managers included, know about the Speak Up Guardian and whistle blowing procedures.
- The provider should ensure that all young people are offered a copy of their care plan in a format that is beneficial to them. They should be able to sign a copy or sign off that they did not require a copy and this must be documented in their care records.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

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

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 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

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 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 17 CQC (Registration) Regulations 2009 Notification of death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act 1983

Our inspection team

Karen Bennett-Wilson chaired this inspection and Anthony Fletcher, Inspection Manager led it. An executive reviewer, Vanessa Ford, supported our inspection of well-led for the trust overall.

The team included 15 inspectors, four executive reviewers, and 13 specialist advisers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.