Avon and Wiltshire Mental Health Partnership NHS Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute Wards for Adults of Working Age	Hillview Lodge	RVN2A
Acute Wards for Adults of Working Age	Green Lane Hospital (imber Ward	RVN6A
Acute Wards for Adults of Working Age	Longfox Unit	RVN4B
Acute Wards for Adults of Working Age	Sandalwood Court	RVN8A
Acute Wards for Adults of Working Age	Callington Road Hospital (Silver Birch Ward)	RVN4A
Acute Wards for Adults of Working Age	Callington Road Hospital (Lime Ward)	RVN4A
Acute Wards for Adults of Working Age	Fountain Way (Beechlydene)	RVN9A
Acute Wards for Adults of Working Age	Southmead AWP	NRV3N
Acute Wards for Adults of Working Age	Callington Road Hospital (Elizabeth C. Ward)	RVN4A
Acute Wards for Adults of Working Age	Callington Road Hospital (Hazel Unit)	RVN4A
Acute Wards for Adults of Working Age	Fountain Way (Ashdown Ward)	RVN9A

Summary of findings

Acute Wards for Adults of Working Age	Callington Road (ECT)	RVN4A
Acute Wards for Adults of Working Age	Green Lane Hospital (ECT)	RVN6A
Long-stay / rehabilitation mental health wards for working age adults	Whittucks Road	RVN5J
Long-stay / rehabilitation mental health wards for working age adults	Callington Road	RVNEQ
Long-stay / rehabilitation mental health wards for working age adults	Sandalwood Court	RVN8D
Long-stay / rehabilitation mental health wards for working age adults	Elham Way	RVN4M
Forensic inpatient / secure wards	Blackberry Hill Hospital	RVN3Q
Older people - inpatient wards	Callington Road	RVN4A
Older people - inpatient wards	Fountain Way	RVN9A
Older people - inpatient wards	Longfox Unit	RVN4B
Older people - inpatient wards	St Martin's Hospital	RVN2B
Older people - inpatient wards	Victoria Centre	RVNCE
Older people - community based	Blackberry Hill Hospital	RVN3Q
Older people - community based	Victoria Centre	RVNCE
Older people - community based	Trust Headquarters	RVN1H
Older people - community based	Southmead AWP	RVN3N
Community health services for people with learning difficulties or autism	Trust Headquarters	RVN1H
Mental health crisis services and health based places of safety	Hillview Lodge	RVN2A
Mental health crisis services and health based places of safety	Sandalwood Court	RVN8A
Mental health crisis services and health based places of safety	Blackberry Hill Hospital	RVN3Q
Mental health crisis services and health based places of safety	Longfox Unit	RVN4B

Summary of findings

Mental health crisis services and health based places of safety	Trust Headquarters	RVN1H
Specialist Services	Southmead Hospital	RVN3N
Substance Misuse	Blackberry Hill Hospital	RVN3Q
Substance Misuse	Trust Headquarters	RVN1H

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

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated one of the core services inspected as 'inadequate' and one as 'requires improvement'. We rated five of the core services 'good' overall. We rated the specialist services as 'good' overall

We rated the trust as requires improvement overall because;

- We have served two warning notices in the past six months which imposed a legal duty on the trust to make significant improvements. We served one warning notice in December 2015 because we had significant concerns about the Bristol crisis, assessment and recovery services delivered to adults of working age and one during this inspection (May 2016) because of serious concerns about the quality of care in the health based places of safety across the trust. On both occasions we found that the trust did not have effective governance arrangements in place to enable it to assess, monitor and improve the quality of services (including the quality of the experience of service users in receiving those services). The trust had little knowledge of either of the issues until we raised these at the respective inspections and as such, we were not assured that governance arrangements and board oversight were robust enough to identify, address and learn from key risks in a timely manner.

We had serious concerns about the trusts ability to deliver safe, effective and responsive health based place of safety services. Patients were regularly taken to police cells (used as health based places of safety) because of the lack of availability of beds in the trust's health based places of safety (police cells should only be used in exceptional circumstances). In addition, if the Mason unit at Bristol was full patients would be taken to the emergency departments at the local general hospitals. Emergency department staff raised concerns as this was felt to potentially put patients and staff at risk. Patients waited too long for a Mental Health Act assessment in the health based places of safety. Patients regularly waited over twelve hours for assessment and then waited many more hours for admission to a suitable ward if they needed inpatient care. In addition we had concerns about the safety of the environments of some of places of safety. at The new health based place of safety at Devizes had only been opened the week prior to our inspection despite us telling the trust that the old health based place of safety was not suitable for use during our inspection in 2014. It was not fit for purpose and did not have an appropriate emergency response system.There were on-going environmental issues with legionella at the Mason unit in Bristol as well as multiple known ligature points (environmental features that could support a noose or other method of strangulation).

- All crisis and health based place of safety staff we spoke with told us of the lack of bed availability across the trust which caused significant delays in getting patients into a bed following admission and had a serious impact on the capacity of staff (for example, taking clinician's a whole shift to find a bed) and on the care of patients.
- The trust board was going through a period of significant change. The chief executive had only been in post three months during our inspection. The trust was recruiting to a number of director posts, including the medical director and finance director and was waiting for a new director of operations to commence in post. In addition, the chair was coming to the end of his term of office. Once the chair left post an interim chair would cover until a perminant appointment could be made. A number of non-executive director posts were also in the process of being appointed to. Alongside this, there had been a whole scale review of senior roles and strengthening of nursing leadership with the director of nursing and quality taking the lead for quality governance. This had caused significant instability, a lack of clear leadership and accountability for some initiatives and delivery of functions and some lack of engagement between senior leaders and staff. Staff reported that senior management based at trust headquarters were not as visible as they would like them to be.
- The triumvirates (locality and speciality management arrangements), whilst generally working well locally, often worked independently of each other and staff felt that they sometimes worked in silos, resulting in a lack of sharing and learning across the trust.
- We found that seclusion practices at Callington Road Hospital were not safe and that Silver Birch ward did

not have adequate resources or facilities to care for people requiring seclusion. On some wards when seclusion was required patients were escorted, under restraint, out of the ward and across the hospital grounds to an available seclusion room. We felt that this placed patients in significant danger and did not preserve their dignity. The trust had advised that Silver Birch used secure transport to transfer patients to wards with seclusion facilities. However, the secure transport often took in excess of five hours to respond causing further delays in ensuring patients received the appropriate care at the right time.

- Older people's wards across the trust, with the exception of ward four at Bath, did not provide appropriate environments to care for people with dementia. Laurel, Amblescroft North and Dune wards had made minimal adjustments to ensure they were 'dementia friendly'. Laurel and Amblescroft were bleak and sparse with little in the way of decoration and no dementia friendly signage. Staff had made some changes on Dune, with some tactile artwork, appropriate signage and brightly coloured furniture. In some older peoples wards staff did not always report all incidents that occurred as there was a culture of acceptance about aggression exhibited by elderly patients with mental health problems, including dementia.

In the rehabilitations wards the trust was not meeting guidance on same sex accomadation. For example, Whittucks Road only had bathrooms

in female areas, which meant staff had to supervise if male patients requested a bath.

- In the acute wards and psychiatric intensive care units bed availability caused significant issues. Patients were regularly cared for in an 'out of area' bed, sometimes a long way from home. When patients went on leave there was often not a bed in the same ward that they left to come back to.

- The trust faced major challenges with maintaining safe staffing levels. In some services, particularly in crisis services the trust had difficulty providing data outlining the staffing establishments and when it did provide this it provided different information prior to inspection, during inspection and directly from the teams. This made it difficult to understand the staffing arrangements of the teams but all the data reflected that there were significant numbers of vacancies in some teams. The trust had undertaken a review of staffing levels on inpatient wards and for most staffing levels increased. This had resulted in a number of vacancies but the trust was proactively recruiting to fill these. In community and crisis teams, the trust had commissioned a review of working practices and caseloads and as a result staffing numbers had been reduced in some teams, for example the Wiltshire crisis team. Staff were not happy about this and reported that they felt there were not always enough staff to safely meet the needs of the service. There were high vacancy, turnover and sickness rates in a number of services including, forensic, acute inpatient and psychiatric intensive care, older people's wards and substance misuse services. All areas used bank and agency staff but all areas tried to use the same staff to ensure continuity of care. Ward managers and team leaders were able to adjust staffing levels when bank staff were required. If bank staff were not available, ward managers and team leaders had to seek authority to use agency from service managers.

- In community based mental health services for older people targets for waiting times for memory service assessment were not always being met and in services for people with learning disabilities there was no information kept about waiting times.

However:

- Generally, the trust were aware of areas that required improvement. When we raised issues that the senior team wasn't as sighted on as they thought they were the response was immediate, really positive and they put in mechanisms to ensure they would be sighted in the future. Throughout the inspection the trust were very receptive to any comments that we made and took immediate action when we raised a concern. For example, the trust undertook an immediate review of seclusion practice at Callington Road Hospital, it put in a senior nurse to support staff and immediately changed transport arrangements so patients could be transported to seclusion facilities in around 10 minutes. It made changes to the health based place of safety environment at Devizes and ensured appropriate emergency equipment and an emergency response system was available.

Summary of findings

- We found that the trust had made some significant improvements to the safety and quality of services, staffing levels and governance arrangements across the Bristol community teams. During this inspection we were able to lift the warning notice that we had served during an unannounced, focussed inspection in December 2015. However, we identified that some further improvements were still required in the Bristol north team and asked the trust to provide written assurance by 13 June 2016 of action it would take to ensure the required improvements were made.
- Without exception patients and carers spoke positively about the care they received and patients said they felt safe. Staff were caring, enthusiastic and committed to delivering high quality care and treating patients and carers with dignity and respect. We observed therapeutic, compassionate and relaxed relationships between staff and patients. Across the majority of services patients had good access to emotional support and there was clear evidence that staff considered patient's diverse and cultural needs.
- There were some impressive services with staff going the extra mile to deliver innovative service in challenging circumstances. For example, substance misuse services where there was a real evidence base to the service delivery with, creative, strong pathways, comprehensive assessments, positive working relationships with commissioners, good partnership working across services. In addition, forensic services had transformed service delivery since our last inspection with a good environment, good risk assessments, some excellent practice around the minimal use of restraint and seclusion. The triumvirate were working well together and had developed a positive culture which staff bought into.
- It is our view that the provider had made significant progress in developing services and bringing about improvements since our last comprehensive inspection in 2014. The new chief executive and director of nursing and quality had brought a real focus on quality and a proactive style of leadership. The 'can do' attitude of the senior leaders was having a positive effect on changing culure and there was a real commitment to actively engage with staff, patients, the public and partner organisation. Given time, we believe, that with a continued focus on quality and the establishment of a stable trust board to lead and drive through changes the provider will realise its vision. However, some significant work is still required to improve quality and consistency of services and effectiveness of working practices across the trust.
- We will be working with the trust to agree an action plan to assist them in making the improvements the standards of care and treatment.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

We rated 'safe' as requires improvement because

- We had concerns about the safety and suitability of some of the environments of the health based places of safety across the trust including multiple ligature point and inappropriate furniture. The suite at Devizes had been opened the week prior to our arrival despite us telling the trust that the suite was not suitable for use during our inspection in 2014. The suite did not have an appropriate emergency response system in place. There were issues with the presence of the legionella bacteria in the water system at the Mason unit in Bristol and so patients susceptible to infections could not be admitted.
- In Bristol, when the health based places of safety were full patients would be taken to the emergency departments in the local general. Emergency department staff raised concerns as this was felt to potentially put patients and staff and patients at risk.
- We identified ligature risks across acute wards and psychiatric intensive care units and wards for older people with mental health problems. In some wards in these services ligature risk were not always managed appropriately.
- Seclusion practices at Callington Road hospital were not safe and Silver Birch ward did not have adequate resources or facilities to care for people requiring seclusion. On some wards, when seclusion was required, patients were escorted under restraint out of the ward and across the grounds of the hospital to an available seclusion room.
- Older people's wards across the trust, with the exception of ward four at Bath were did not provide appropriate environments for caring for patients with dementia
- There were major challenges with staffing levels. In some services, particularly crisis services the trust had difficulty identifying what staffing levels were as data varied significantly depending on its source. The Bristol central and east crisis team identified significant pressure due to staff shortages.
- .The long-stay and rehabilitation mental health wards did not comply with same sex guidance. On two wards, bathrooms were located in the female area, meaning that male patients required staff supervision when taking a bath. Similarly, separating doors on Whittucks Road and Alder Ward did not adhere to same sex guidelines.

Requires improvement

Summary of findings

- The trust was not able to identify incidents that occurred in the health based places of safety in Wiltshire as these were recorded as part of the ward incident data. The trust could not provide data for incidents that had occurred within these places of safety. There had been no reviews undertaken into the use of restrictive interventions across any of the places of safety.
- In some older people wards (which ones) staff did not always report all incident that occurred as there was a culture of acceptance about aggression exhibited by elderly patients with mental health problems, including dementia
- Some blanket restrictions were in place at Whittucks Road (rehabilitation) including patients not being able to watch television after midnight, patients not being able to leave the premises after 10pm and locking the kitchen, meaning patients always had to ask for a drink
- Not all acute wards or psychiatric intensive care wards adhered to the trust policy, national institute for health and care guidelines or the Mental Health Act code of practice when using rapid tranquilisation orally.

However:

- The trust had made significant improvements to staffing levels and practice across the Bristol community mental health teams. At this inspection we were able to lift the warning that we served in December 2015.
- Environmental security at the forensic and secure services had improved significantly since our inspection in June 2014.
- The majority of areas in the trust were safe and clean.
- With the exception of the health based places of safety, some acute and some older peoples ward ligature risk were managed well and completed regular completed risk audits
- The majority of wards that were mixed sex had separate facilities for men and women and staff were managing the mixed sex environment well.
- With the exception of the Devizes health based place of safety, all wards and clinical areas had emergency medical equipment
- The majority of the wards had good medication management processes in place.

Summary of findings

- In the majority of services across the trust arrangements for reporting,investigating, monitoring and manging incidents was in place. There was evidence of learning from incidents, including changes in learning practices.
- The majority of staff had completed their mandatory training. Staff received training in restraint and recognised that using any kind of physical intervention, even passive holds was classed as restraint. The trust was taking a proactive approach to recruting and retaining staff.
- There was generally a low use of blanket restrictions across the trust
- The majority of staff knew about the principles of the duty of candour and an audit of the implementation had been conducted in 2015

Are services effective?

Good

We rated 'effective' as good because

- Generally, patients could access services quickly and care records were of good quality. The majority that we looked at were holistic, recovery orientated and personalised and reviewed regularly
- In the crisis teams were clear clinical pathways to support effective assessment, management and treatment of clinical needs and effective, collaborative working with other services and external agencies.
- At Ladden Brook and Cary wards at Fromeside Hospital staff had developed excellent positive behavioural support plans in partnership with patients
- All babies on the New Horizons mother and baby perinatal mental health unit had their own care plans
- Staff in in-patient units monitored the physical health of patients well. Physical healthcare was discussed alongside mental health issues in ward rounds and documented appropriately
- The majority of teams were made up of a wide range of professionals

Summary of findings

- Staff understood and had received training in the Mental Health and Mental Capacity Acts and generally these were applied. Patients had access to independent advocates and staff were familiar with obtaining consent appropriately and recognised when a patients autonomy needed to be respected
- Staff received regular supervision, appraisal and training. Staff in the teams reported working well with other teams within the trust, and with external services.

However:

- Staff did not complete care plans for patients admitted to the health based places of safety under section 135 or 136 of the Mental Health Act. Little information was recorded in electronic records of the detention in the suites at Salisbury and Devizes
- There were significant delays in the assessment of patients admitted to the health based places of safety and significant delays in accessing a bed if a patient needed to be admitted. A significant majority of individuals were detained far exceeding the timelines recommended within the Mental Health Act Code of Practice guidance. There were multiple, and often simultaneous, reasons for lack of access to the places of safety, delays in beginning and completing assessments and finding suitable placements for people following an assessment.
- There was no overarching policy for delivering physical health care in community services and none of the crisis teams were assessing, monitoring and planning for the physical health care needs of patients on their caseloads
- Over half of the caseloads of staff in the north and south Wiltshire intensive (crisis) teams were patients waiting for discharge to the community mental health teams but the teams didn't have enough capacity to take patients which meant that the intensive teams caseloads were difficult to manage
- In wards for older people there was little access to psychology at Swindon and occupational therapy across the service. In community learning disability services neither of the two teams had access to the full range of professional disciplines
- Staff in older peoples community mental health teams felt career progression was limited and were concerned that skills were being lost due to joint working and sharing of roles between nursing staff and social workers.

Are services caring?

We rated 'caring' as good because

Good

Summary of findings

- Patients were treated with kindness and respect, and we saw positive and warm engagement between staff and patients. We observed therapeutic, compassionate and relaxed relationships between staff and patients.
- Community meetings were held regularly and some wards held drop-in sessions for family members.
- Patients informed us they felt safe and without exception patients and carers spoke positively about the care they received.
- Patients were involved in planning their care, managing their physical health care needs, and in the discharge planning process where possible.
- Wards displayed posters for advocacy services to protect their patients' rights.
- In community-based mental health services for people with learning disabilities and autism, there was a forum which allowed people to be involved in service development and recruitment.
- Consent to share information with carers was clearly documented and patients were given opportunities to change their minds about their consent should they wish
- Some teams had carers champions and specific carers pack were available

Are services responsive to people's needs?

Good

We rated 'responsive' as good because

- The trust was piloting a number of street triage projects with the aim of helping police officers make appropriate decisions about whether a person was potentially suffering from a mental illness so leading to a better outcome for patients and a reduction on the use of section 136 (detention in a health based place of safety)
- In community-based mental health services, there were clear criteria for referrals within the teams. There was the option for services to visit patients within their homes, and for out-of-hours appointments.
- In most services, there were a range of psychological, educational and recreational activities to meet patients' needs. There was access to a range of spiritual support if needed.

Summary of findings

- The majority of the areas were care was delivered were appropriate, well maintained and had appropriate furnishings. There was access to outside space and private areas to receive visitors.
- There was a good range of leaflets and information available in all services, patients had access to advocacy services and d Patient Advice and Liaison Service (PALS).
- Patient knew how to complain if they wished to and there was evidence of learning from complaints at a local and trust wide level. Staff responded positively to general feedback from patients and made changes accordingly in a timely manner.
- In community-based mental health services, there were clear criteria for referrals within the teams. There is the option for services to visit patients within their homes, and for out-of-hours appointments.

However:

- Often, the police could not take a person who was detained under section 136 of the Mental Health Act to a health based place of safety because the health based places of safety were already in use. Patients were regularly taken to police cells (used as health based places of safety) because of the lack of availability of beds in the trust's health based places of safety. The Mental Health Act Code of Practice states that police cells should only be used in exceptional circumstances. We had serious concerns with the timeliness of Mental Health Act assessments for people detained in the places of safety. Children and young people spent long periods of time in the Mason unit health based place of safety due to complex aftercare arrangements. Adult could not be admitted to the Mason unit when a child or young person was being cared for reducing capacity even further. There was a lack of system in place to monitor the health based places of safety across the trust in order to identify gaps in service provision.
- All the crisis teams and places of safety staff we met told us that lack of bed availability caused significant issues and that the delays had a serious impact on staff capacity (taking a clinician a whole shift to locate a bed) and on care for some patients.
- In the acute wards and psychiatric intensive care units bed availability caused significant issues. Patients were regularly cared for in beds outside the trust (sometimes a long way from home).

Summary of findings

- Wards for patients experiencing dementia in Salisbury, Bristol and Weston-Super-Mare had few adjustments made to make them dementia friendly.
- In community-based mental health services for older people, targets on waiting times for assessment were not always being met. And in services for people with learning disabilities and autism, there was no information kept in relation to waiting times.

Are services well-led?

Requires improvement

We rated 'well-led' as requires improvement because:

- We have served two warning notices in the past six months which imposed a legal duty on the trust to make significant improvements. On both occasions we found that the trust did not have effective governance arrangements in place to enable it to assess, monitor and improve the quality of services (including the quality of the experience of service users in receiving those services). The trust had little knowledge of either of the issues until we raised these at the respective inspections and as such, we were not assured that governance arrangements and board oversight were robust enough to identify, address and learn from key risks in a timely manner.
- For the health based places of safety across the trust governance arrangements were not effective in identifying and prioritising the provision of safe environments', safety of patients, capacity of the service, gaps in service or the quality of services, including the quality of the experience of patients detained in the health based places of safety. An operational policy and audits for the places of safety were not in place in line the Mental Health Act Code of Practice.
- Staff told us that there were too many initiatives being implemented too quickly at one time. Staff found it difficult to engage and keep up with some of these. We found that there were lots going on, much of which was required. However, the reasons for the initiatives and were not always communicated as effectively as they might have been.
- Significant changes had been made to the board recently with many new appointments, including that of the chief executive. In addition, the chair was coming to the end of his term of office. Once the chair left post an interim chair would cover until a perminant appointment could be made.This had caused significant instability, a lack of clear leadership for some

initiatives and some lack of engagement between senior leaders and front line staff. Staff reported that senior management based at the trust headquarters were not as visible as they would like them to be.

- The triumvirates (locality and speciality management arrangements) often appeared to work independently of each other and staff often felt as though the trust worked in silos.
- The trust had not undertaken disclosure and barring checks on non clinical directors and senior leaders.

However:

- The trust had a clear vision and set of values which staff were aware of and recognised how they reflected their teams' values.
- The trust had governance processes in place to manage quality and safety within the services, although these were not totally effective at the time of the inspection. It had mapped its strategic priorities to CQC five key questions and based all its quality improvements on standards set around the five key questions. The trust had made significant improvements to governance systems in place to manage the quality and effectiveness of its community mental health services in Bristol. In December 2014 we served a warning notice and told the trust it must improve these. We were able to lift the warning notice following this inspection. Information on how the trust was performing was presented on a clear dashboard and reported at trust, local delivery (triumvirate) and team/ward level. The IQ system that held this information could be accessed by staff across the trust
- The majority of staff across the trust had completed the required mandatory training, had access to regular supervision and annual appraisals. Staff understood the trusts' safeguarding, complaints and whistle blowing procedures and felt confident in using them.
- Staff morale was generally good and it was reported that the trust was a good employer. Staff felt listened to and valued and were very complimentary about the support received from their immediate line manager.
- There was a trust wide service user group and a trust wide carers group. These groups were developing a new service user and carer strategy in partnership with staff.
- The trust had invested in developing involvement coordinators at a local level who engaged carers in a range of activities like recruiting staff and evaluating services.

Summary of findings

- The trust was committed to quality improvement. It participated in a number of national quality assurance schemes and audits. It also had developed a nationally, well respected research and development department and was involved in over 200 national studies. It had an ethos of 'everyone involved' through which it aimed to involve as many patients as possible in research.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Maria Kane, Chief Executive, Barnet, Enfield and Haringey Mental Health NHS Trust

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

The team of 67 included CQC inspectors and a variety of specialist advisors:

CQC staff –

- three inspection managers
- 18 inspectors
- four Mental Health Act reviewers
- an inspection planner
- two assistant inspectors
- two analysts
- an inspection planner

Specialist Advisors –

- 14 nurses (with a variety of specialities including mental health nursing, substance misuse and eating disorders)
- two specialist advisors with leadership and governance experience in senior positions
- two nurse team leaders
- five social workers
- five consultant psychiatrists
- three occupational therapists
- two psychologists
- three Mental Health Act reviewers (acting as specialist advisors)

Why we carried out this inspection

We inspected Avon and Wiltshire Mental Health Partnership NHS Trust as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

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

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

We carried out an announced inspection visit over a two week period from 16 May to 27 May 2016. Before visiting, we reviewed a range of information we hold about Avon and Wiltshire Mental Health Partnership NHS Trust. We also:

- Requested data and policies from the trust and reviewed the information
- Conducted 11 focus groups with staff, held across nine sites of the trust.
- Asked a range of different organisations for information/feedback on the trust, including NHS Improvement, NHS England, clinical commissioning groups, Healthwatch, Health Education England, the Royal College of Psychiatrists and local patient representative groups

During the inspection we visited 37 wards, four health based places of safety, 28 community teams and spoke with:

- 127 patients
- 22 carers
- members of the executive team and trust board, including the chief executive and the chair
- twenty two senior managers
- 93 service and ward managers

Summary of findings

- 357 other staff, including registered nurses, health care support workers, doctors, psychologists, occupational therapists and practitioners.

We received 44 comments from patients, relatives and staff collected from comment cards placed in comment boxes form various trust sites.

In addition, we

- Reviewed 406 patient records
- Reviewed 129 medication records

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

Information about the provider

Avon and Wiltshire Mental Health NHS Partnership Trust was formed in April 1999 following a review of mental health services in the Avon Health Authority area carried out by the Sainsbury Centre for Mental Health. The formation of the trust brought together mental health services in Bath and North East Somerset (B&NES), Bristol, North Somerset, South Gloucestershire, Swindon and Wiltshire into one organisation. The trust also provides specialist services for a wider catchment extending throughout the south west.

The trust provides the following core services which we inspected:

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Forensic inpatient /secure wards
- Wards for older people with mental health problems
- Community-based mental health services for adults of working age
- Mental health crisis services and health based places of safety
- Community-based mental health services for older people
- Community mental health services for people with a learning disability or autism

and the following specialist services which we also inspected:

- Substance misuse services
- Perinatal (mother and baby) mental health services
- Eating disorder services

The trust also provides inpatient and community mental health services for children and young people. However, these services were only transferred from North Bristol NHS Trust on the 1st April 2016. We did not inspect these services during this inspection but will return to the trust to inspect these services within six months of this inspection.

The trust serves six clinical commissioning groups and six local authorities, has an annual income of £196 million and employs 3,270 substantive staff. It operates from over 90 sites including eight main inpatient sites and services are delivered by 150 teams.

During 2015/2016 the trust's community services saw 75,863 individuals, received over 67,500 new referrals, processed 1,939 admissions into its' inpatient units and had more than 461,000 contacts with service users (phone/face-to-face).

Avon and Wiltshire Mental Health Partnership NHS Trust has a total of 16 locations registered with CQC. We previously inspected the trust from 10-13 June 2014; this was one of CQC early comprehensive inspections and we did not provide a rating. However, we found that the trust needed to take significant steps to improve the services and served four warning notices and several compliance actions (now requirement notices). .

We returned to the trust on 11 December 2014 and 17–18 December 2014 and carried out focusedinspectionsat Hillview Lodge, Fromeside, Juniper Ward, Elizabeth Casson, Range Ward at Callington Road, crisis team Swindon, community team South Gloucester and North Somerset. We found that the trust had taken all reasonably practicable steps to comply with the warning notices within the timeframe provided. We therefore lifted these warning notices but the compliance actions remained in place.

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

Summary of findings

found that the Bristol community assessment and recovery services were not safe and served a warning notice. We returned to the trust on 17 February 2016 to check that specific actions requiring completion by 1 February 2016 had been taken. We found that the trust had taken the action required but the warning notice remained in place.

During this inspection (May 2016) we found that the trust had made some significant improvements across the Bristol community teams so lifted the warning notice. However, we identified that further improvements were still required in the Bristol north team and asked the trust to provide written assurance by 13 June 2016 of action it would take to ensure the required improvements are made. An action plan was received on time.

What people who use the provider's services say

- Patients Said the staff were patient, kind and respectful and mindful of patients' wishes when giving care. Across most services, patients told us they felt involved in the care they received and that staff supported and listened to them. Patients at Fromeside compared this service favourably as compared with other secure units they had been in.
- Without exception patients and carers spoke positively about the care they received and patients said they felt safe.

Good practice

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

- Green Lane Hospital ECT provided treatment at local general hospital sites for patients who required ECT treatment but had underlying physical health problems.

Forensic inpatient/secure wards

- There was good practice in involving service users in the reduction of blanket restrictions.
- Patients on clozapine, an anti-psychotic medication, had their blood test results recorded on their medicine charts which ensured clinicians had the most recent blood levels available.
- Collaborative risk plans were of excellent quality. Ladden Brook had piloted these plans which were developed with patients. They were holistic and comprehensive.

Community based mental health services for older people

- The Bath and North East Somerset (BANES) therapies team employed an ex service user to implement a project called `fresh art at work`. This art project was provided at community locations and on in-patient wards.
- Psychological therapy services in BANES undertook an extensive audit of quality improvement in the service. This took into account the trust's values and CQCs five key questions. There were a number of improvements that had been made as a consequence of this evaluation

Mental health crisis services and health-based places of safety

- The south Gloucestershire team had employed a peer support worker to assist a range of activities.
- The BANES intensive team were using a senior nurse to undertake police liaison work in order to fill an identified gap in service provision due to there not being any funding for street triage.
- The Swindon intensive team identified lead roles for all team members, including those without professional qualifications, to encourage staff development and team accountability. .

Summary of findings

- We saw a very good example of creative and person centred care planning by the Swindon intensive team for a service user with personality disorder. This had resulted in a significant decrease in risk taking behaviours and reduction in hospital admission.
- Complex care meetings had been established in all localities for people who used a range of services. These involved police, ambulance, mental health liaison, street triage, and the service user to try to establish consistent responses and adherence of treatment plans for people who frequently presented with complex needs and high levels of distress.

Community Mental Health Services for people with learning disabilities or autism

- The forensic community team has identified needs and developed interventions based on good practice and adapted them to be accessible for people with a learning disability.

Specialist Services

- STEPS and New Horizons had received Quality Network Accreditation.

Substance Misuse Services

- The Bristol recovery orientated alcohol and drugs service (ROADS) integrated service third sector partner agency, as part of the integrated model, supplied Naloxone to all at risk service users, to help in reducing drug related deaths in the city of Bristol.

Areas for improvement

Action the provider MUST take to improve

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

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

Wards for older people with mental health problems

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

Mental health crisis services and health-based places of safety

Summary of findings

- The trust must review and address the reasons for lack of access to the places of safety, significant delays in beginning and completing Mental Health Act assessments and finding suitable placements for people following an assessment.
- The trust must ensure that people are not detained in police custody other than in exceptional circumstances.
- The trust must ensure that people are not detained longer than the legal maximum time of 72 hours
- The trust must review and ensure that premises and equipment within the health based places of safety are suitable and safe for use, and that effective risk assessments are in place to mitigate identified and known risks
- The trust must ensure that incidents are recorded and governance systems are effective, to allow for review and audit of restrictive interventions used in health based places of safety
- The trust must ensure that governance systems accurately record and report all of the required monitoring data for the health based places of safety and audits are undertaken to identify issues.
- The trust must ensure that the Wiltshire and Swindon health based places of safety operational policy is updated to reflect the changes made to the MHA Code of Practice

Community mental health services for people with learning disabilities or autism

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

Action the provider SHOULD take to improve

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

- The provider should consider alternative child visiting arrangements on Imber ward to avoid children having to enter the ward area to access the visiting room.

Long-stay rehabilitation wards

- The trust should ensure privacy screens are installed on all wards.
- The trust should ensure all staff are aware of where the ligature cutters are kept.
- The trust should ensure risk assessments are linked with the appropriate care plan.
- The trust should ensure patient and carer involvement is present across all wards.
- The trust should ensure there is a clear rationale for any blanket restrictions
- The trust should ensure the night staff at Whittucks Road is adequately staffed to support the intensive on-call service
- The trust should ensure all wards comply fully with the same sex guidance.
- The trust should ensure assessment of patients' capacity and consent to treatment is decision-specific.
- The trust should ensure all staff know who the senior managers of the organisation are.

Forensic inpatient/secure wards

- The trust should develop a system to monitor the implementation of the new search policy to ensure it is being implemented consistently.
- The trust should address staffing shortfalls on Siston ward.
- The trust should provide additional support for staff members experiencing racism or any other form of abuse which focuses on their belonging to a minority group.

Wards for older people with mental health problems

- The trust should ensure that patients on Ward 4 have access to a telephone to make private calls if they do not have access to their own.
- The trust should ensure that the multidisciplinary team meetings in Weston-Super-Mare have a full range of professions and are held in an appropriate room.
- The trust should ensure that they have patients or their representative's consent before locking patient's private property in cabinets in their rooms.

Summary of findings

- The trust should ensure that there are effective governance arrangements to monitor and review the criteria for reporting both safeguarding and incidents across the service to ensure consistency and patient's safety.

Community based mental health services for older people

- The trust should ensure that personal alarms used by staff are regularly tested and that this is documented.
- The trust should review each team `s capacity to undertake urgent and routine assessments within the agreed timeframes and ensure action is taken where teams are consistently not able to meet the assessment target.

Mental health crisis services and health-based places of safety

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

Specialist Services

- The trust should ensure that staff are provided with specialist training in working with people who have eating disorders and in working with mothers and babies.
- The trust should ensure that domestic staff are provided with specific training related to their role. For example, COSHH training, which is Control ofSubstances Hazardous to Health Regulations 2002 and help to keep people safe.

Community mental health for people with learning disabilities or autism

- The trust should ensure that intensive support team provide care plans and risk assessments that develop with people changing needs.
- The trust should ensure staff upload all documents to the electronic record system in a timely fashion.
- The trust should ensure they keep information about waiting times and referral to community team times.
- The trust should ensure they can identify the outcomes of people accessing their services.
- The trust should review delays in people receiving care plans.

Substance misuse services

- The trust should ensure updated risk reviews are clear and accessible on Acer Unit.
- The trust should ensure staff carry out discreet observations as much as possible to reduce impact on privacy.
- The trust should ensure all community specialist substance misuse services commence and prepare discharge plans upon admission.
- The trust should prioritise safety around the caseloads and transfer of clients using the rapid prescribing service at Bristol recovery orientated alcohol and drugs service (ROADS) Colston Fort and Stokes Croft.

Trust wide

- The trust should develop a trust wide system were it records and monitors all safeguarding referrals it makes to the local authorities (as it does in Bristol).

Avon and Wiltshire Mental Health Partnership NHS Trust

Detailed findings

Mental Health Act responsibilities

- Mental Health Act training was part of statutory and mandatory training for staff and data from the trust indicated 92% compliance with this.
- Appropriate arrangements were in place for the safe management and administration of the Mental Health Act. Administrative and legal support was provided by the trust's Mental Health Act Administrator and her team. The team were based at several geographical locations in order to provide a service across a wide area. There were systems in place regarding statutory notifications for death of detained patients or the absence without leave of patients in secure services.
- We met with one of the trust's lead associate Mental Health Act managers who was also a trust non-executive director. There was a comprehensive induction, training and re-approval process for associate Mental Health Act managers. The trust had been making efforts to liaise with black and minority ethnic organisations when recruiting new associate managers in order to work towards having a representatively diverse pool of associate managers. The associate managers found that their independent challenge was well received by clinical staff. The associate managers found the Mental Health Act administration of the trust was very well organised by the Mental Health Act administrator and her team. It was noted by the associate managers that patients were rarely represented at Managers reviews of detention by solicitors or advocates since legal aid to solicitors for this service had ceased.
- Mental Health Act statistics, procedures and policies are considered as an agenda item in a four monthly forum held by the trust. There had previously been a specific Mental Health Act committee but this function had now been incorporated into a wider governance forum. A lead associate Mental Health Act manager usually attends this forum.
- It was noted by Mental Health Act managers that the acuity of patients in the inpatient settings had increased, and that bed availability could impact on how soon a patient was discharged from an inpatient setting and the potential to recall a patient on a community treatment order who may be in need of this.
- The trust covers a large geographical area comprising six local authority areas. In some local authorities social work and AMHPs are employed in fully integrated mental health services provided by the trust, however in Bristol and Wiltshire, the two largest authorities, there had been a disaggregation of mental health services.
- We held three focus groups for Approved Mental Health Professionals (AMHPs) across the trust. These were attended by AMHPs working within the trust and in local authority roles. It was clear that there was significant pressure on providing a responsive service across the trust, with some variation in the degree of this. AMHPs described a challenging, and at times chaotic climate in which to carry out their functions. There was a significant shortage of inpatient beds within the trust which contributed to situations where it was common for this to contribute to considerable delays in undertaking Mental Health Act assessments in the community. It was a common occurrence for patients to require conveyance to a bed out of the trust's area and

we were told of cases of acutely unwell patients being conveyed very long distances. Transfers of care during an acute inpatient admission also appeared to be common, and concern was expressed on the impact of this on continuity of care and patient experience. We were told of instances of patients being conveyed prior to an AMHP application being made, patients travelling to an independent sector bed only to be declined on arrival or transferred a few hours later into a trust bed.

- The trust was in the process of implementing a new multi-agency protocol regarding 'working together when Mental Health Act assessments are requested, including situations where resources are unavailable'. We were told that this had arisen following recommendations from a coroner's report. We were told of another recent case where root cause analysis following a death in the community had identified concerns with the delay in being able to carry out a Mental Health Act assessment due to bed and doctor availability.
- We noted a degree of disconnect between the very acute problems described in carrying out functions under the Mental Health Act regarding acute admissions in some parts of the trust, and the systems in place to monitor these issues and to identify where this was of most concern.
- The trust did not appear to have undertaken any analysis of the impact of disaggregation of services on the service received by service users and on the level of compulsory admissions to hospital. The trust had data on the use of the Mental Health Act per inpatient setting, but there was no overall analysis in trends in use of the Mental Health Act per geographical area for example. Feedback from focus groups suggested a significant variance in referrals for Mental Health Act assessments in different parts of the trust. The variance that was described appeared to be influenced to some degree by the functioning of local service provision in the community. The trust did however have a quarterly AMHP leads meeting where variations in practice and delays in admissions were discussed, and an audit had been undertaken regarding delayed Mental Health Act assessments.
- We were told that there were some local multi-agency forums regarding use of the Mental Health Act, but again the trust did not appear to have an overview and these issues were managed at a more local level. There were quarterly joint working groups with the two police forces in the trust regarding the use of section 136.
- At the start of our inspection a new post of associate director of statutory delivery, social care and allied health professionals was appointed to. This post would oversee both the clinical and Mental Health Act administration functions of the Mental Health Act. Previously the management of Mental Health Act functions had fallen under the remit of the head of patient safety systems, with policy responsibilities sitting with the head of safeguarding. We met with the new holder of this post and raised some of the issues identified such as the challenges to patient care of the bed shortage in the trust.
- We did not undertake Mental Health Act monitoring visits on this inspection but Mental Health Act Reviewers formed part of the overall inspection team and adherence to the Mental Health Act was considered in each of the services inspected. Across the trust it was noted that staff awareness and training in the Mental Health Act was good, staff felt supported by the Mental Health Act administration team and records were generally in good order. Good practice was noted in forensic services in working with service users to reduce blanket restrictions. The main issues noted related to serious concerns with the timeliness of Mental Health Act assessments in terms of increased length of time waiting in places of safety, deterioration in mental health in the community and patients being transferred multiple times between hospitals or to locations great distances from their homes. The trust did not have effective systems in place to monitor the health-based places of safety across the trust and to assess the impact of gaps in service provision.
- There were clearly significant challenges in relation to the capacity of places of safety in Wiltshire and Avon and Somerset police areas. There were multiple, and often simultaneous, reasons for lack of access to the places of safety, delays in beginning and completing assessments and finding suitable placements for people following an assessment. The CQC raised concerns previously. We served a warning notice against the trust that will require a multi-agency response.

Detailed findings

- We reviewed the trust's policies and procedures relating to the Mental Health Act in terms of compliance with Annex B of the Code of Practice to the Mental Health Act. The Code of Practice was significantly revised in April 2015 and Annex B outlines the policies, procedure and guidance that providers should have in place. The Mental Health Act administrator and associate director for statutory delivery provided us with an overview of their progress in revising policies, and acknowledged this was still a work in progress, and they intended to take a more systematic approach to checking all policies required by Annex B were updated or in place. Our review identified that some policies outlined in Annex B were out of date or did not appear to be in place. Some policies that had been revised were of questionable quality in that they did not contain all the key points regarding changes in the Code. We intend to revisit with the trust the progress they have made in relation to compliance with Code of Practice in this respect.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had a good understanding of the Mental Capacity Act and were able to explain the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions. People had access to independent mental capacity advocates if required.
- Between 1 October 2015 and 31 March 2016 the trust had made 50 Deprivation of Liberty Safeguards (DoLS) applications and indicated that only one application was granted. CQC did not receive any Deprivation of Liberty Safeguarding Applications (DoLS) from the trust between the same period (1 October 2015 and 31 March 2016).

Requires improvement

Are services safe?

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

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

Summary of findings

We rated 'safe' as requires improvement because

- We had concerns about the safety and suitability of some of the environments of the health based places of safety across the trust including multiple ligature point and inappropriate furniture. The suite at Devizes had been opened the week prior to our arrival despite us telling the trust that the suite was not suitable for use during our inspection in 2014. The suite did not have an appropriate emergency response system in place. There were issues with the presence of the legionella bacteria in the water system at the Mason unit in Bristol and so patients susceptible to infections could not be admitted.
- In Bristol, when the health based places of safety were full patients would be taken to the emergency departments in the local general. Emergency department staff raised concerns as this was felt to potentially put patients and staff and patients at risk.
- We identified ligature risks across acute wards and psychiatric intensive care units and wards for older people with mental health problems. In some wards in these services ligature risk were not always managed appropriately.
- Seclusion practices at Callington Road hospital were not safe and Silver Birch ward did not have adequate resources or facilities to care for people requiring seclusion. On some wards, when seclusion was required, patients were escorted under restraint out of the ward and across the grounds of the hospital to an available seclusion room.
- Older people's wards across the trust, with the exception of ward four at Bath were did not provide appropriate environments for caring for patients with dementia
- There were major challenges with staffing levels. In some services, particularly crisis services the trust had difficulty identifying what staffing levels were as data varied significantly depending on its source. The Bristol central and east crisis team identified significant pressure due to staff shortages.
- .The long-stay and rehabilitation mental health wards did not comply with same sex guidance. On two wards, bathrooms were located in the female area, meaning that male patients required staff supervision when taking a bath. Similarly, separating doors on Whittucks Road and Alder Ward did not adhere to same sex guidelines.
- The trust was not able to identify incidents that occurred in the health based places of safety in Wiltshire as these were recorded as part of the ward incident data. The trust could not provide data for incidents that had occurred within these places of safety. There had been no reviews undertaken into the use of restrictive interventions across any of the places of safety.
- In some older people wards (which ones) staff did not always report all incident that occurred as there was a culture of acceptance about aggression exhibited by elderly patients with mental health problems, including dementia
- Some blanket restrictions were in place at Whittucks Road (rehabilitation) including patients not being able to watch television after midnight, patients not being able to leave the premises after 10pm and locking the kitchen, meaning patients always had to ask for a drink
- Not all acute wards or psychiatric intensive care wards adhered to the trust policy, national institute for health and care guidelines or the Mental Health Act code of practice when using rapid tranquilisation orally.

However:

Requires improvement

Are services safe?

- The trust had made significant improvements to staffing levels and practice across the Bristol community mental health teams. At this inspection we were able to lift the warning that we served in December 2015.
- Environmental security at the forensic and secure services had improved significantly since our inspection in June 2014.
- The majority of areas in the trust were safe and clean.
- With the exception of the health based places of safety, some acute and some older peoples ward ligature risk were managed well and completed regular completed risk audits
- The majority of wards that were mixed sex had separate facilities for men and women and staff were managing the mixed sex environment well.
- With the exception of the Devizes health based place of safety, all wards and clinical areas had emergency medical equipment
- The majority of the wards had good medication management processes in place.
- In the majority of services across the trust arrangements for reporting,investigating, monitoring and manging incidents was in place. There was evidence of learning from incidents, including changes in learning practices.
- The majority of staff had completed their mandatory training. Staff received training in restraint and recognised that using any kind of physical intervention, even passive holds was classed as restraint. The trust was taking a proactive approach to recruting and retaining staff.
- There was generally a low use of blanket restrictions across the trust
- The majority of staff knew about the principles of the duty of candour and an audit of the implementation had been conducted in 2015

Our findings

Safe environments

- The majority of areas in the trust were safe and clean with the exception of some of the acute mental health wards and the health based places of safety suites across the trust. Patient-led assessments of the care environment' (PLACE) survey results for 2015 showed that the trust scored 98.7%, which is 1.2% above the national average (97.5%).
- Wards for patients with dementia were not dementia friendly with the exception of ward four in Bath. However, environmental security in the forensic and secure services had improved significantly since our inspection in June 2014 and risk were managed well at both a ward level and individual patient level.
- We had serious concerns about the safety of the environment at the health based places of safety across the trust. The place of safety suit at Devizes had only been opened the week prior to our inspection. In June 2014 we had told the trust that the place of safety suite was not suitable for use in but the 'old' place of safety had remained in use until the week before our inspection in May 2016. The suite did not have suitable furnishings or a clear emergency response system in place. For example, in the event of a medical emergency or serious violent incident staff on the suite would sound an alarm to alert staff on a nearby ward that support was needed. However, staff responding from the nearby ward would have to go through a number of locked doors and into the next building. In addition, there was no emergency equipment in place, including first aid kit or ligature cutters. The trust addressed this immediately when we raised it. There were on-going environmental issues with legionella at the Mason unit in Bristol, although the trust were implementing the recommended monitoring and management procedures. As a result the Mason unit could not accept patients prone to infection and was impacting on the trusts plans to address known ligature risks. We identified multiple ligature points (environmental features that could support a noose or other method of strangulation) and poor lines of sight in three of the suites in the trust. There was no access to outside space at the Swindon place of safety suite.

Requires improvement

Are services safe?

- An interim protocol dated 1 June 2016 stated that in the event that the Mason unit place of safety was full, adult patients would be taken to Southmead or Bristol Royal Infirmary emergency departments (ED) to wait for assessment.. The emergency staff raised concern about the limited space available in ED and the potential impact on other staff and patients. Routinely using ED was not an appropriate alternative to the lack of a dedicated health-based place of safety. The emergency departments were not a designated place of safety and would not be suitable for vulnerable patients due to the area containing free standing equipment, cords and a number of ligature points. We reviewed crisis concordat meeting minutes over the past 12 months, and these showed that the concerns about using the ED facilities had repeatedly been raised.
- Within the Wiltshire place of safety documentation there was no recorded evidence that personal searches were conducted on detention by the police. However, all staff we spoke with were assured that police did undertake searches. There was also no process or record that ward staff carried out additional person or personal belonging searches on arrival to the suite.
- Seclusion practices at Callington Road hospital were not safe and Silver Birch ward did not have adequate resources or facilities to care for people requiring seclusion. Silver Birch ward at Calllington Road hospital did not have a seclusion room. The ward was only meant to admit patients that were considered low risk. However, we found a high level of mental health acuity and dependence in the patient group being cared for on the ward at the time of the inspection. When seclusion was required, patients were escorted under restraint out of the ward and across the grounds of the hospital to an available seclusion room. Female patients would go to Elizabeth Casson ward. Male patients would go to Hazel ward. If neither seclusion room was available, patients would be taken to Lime ward. As a result, restraint was often prolonged and staff were sometimes restraining patients whilst taking them across the hospital grounds at night with poor lighting. We considered that escorting patients in this way posed significant risks and did not preserve patient privacy or dignity. The trust told us that Silver Birch ward used secure transport to transfer patients. However, the secure transport often took in excess of five hours to respond. Concerns had been escalated by the ward and matron but little action had been taken. Elizabeth Casson, Oakwood, Lime and Hazel ward all had seclusion rooms that did not allow free access to toilet facilities. If it was considered high risk to end seclusion to allow patients to use the toilet facilities safely; patients would be provided with disposable bowls to use. Not all seclusion rooms had two way communication systems. The seclusion room on Lime ward had an unpleasant odour; when we bought this to the attention of the ward manager we were advised that a new mattress had been purchased.
- With the exception of the health based places of safety and some acute inpatients wards, ligature risks were well identified throughout trust and all areas had up to date and complete ligature audits with actions. Where lines of sight were obscured, the majority of wards had taken action to mitigate risks through the use of wall mounted/ceiling mounted mirrors.
- The majority of the wards that were mixed gender had separate facilities for men and women. Staff were managing the mixed sex environment well and there was a female only lounges on all wards that were mixed sex. The trust had a policy to allow wards to admit patients to beds allocated to the opposite gender in an emergency. This specified what actions managers had to take to ensure that the trust did not breached single sex accommodation guidelines. However, on two wards in the long-stay/rehabilitation mental health wards bathrooms were located in the female area, meaning that male patients required staff supervision when taking a bath. Whittucks Road had double doors that separated male and female corridors and windows that looked out onto the garden. At the time of the inspection, the double doors were open and the windows had no privacy screens, which meant male patients, could see in to the female corridor.
- With the exception of the Devizes health based place of safety all wards and clinical areas had clinic rooms and emergency medical equipment. Emergency equipment was generally checked on a weekly basis and we saw records to show this. However, we did find that some equipment on a small number of wards that was out of date. We bought this to the attention of the ward staff and this was replaced immediately.

Requires improvement

Are services safe?

Safer staffing

- The trust faced major challenges with maintaining safe staffing levels but was working hard to address these. In some services, particularly in crisis services the trust had difficulty providing data outlining the staffing establishments and when it did provide this it provided different information prior to inspection, during inspection and directly from the teams. This made it difficult to understand the staffing arrangements of the teams but all the data reflected that there were significant numbers of vacancies in some teams. For example, Bath and north east Somerset BaNES), intensive team's establishment staffing level was 16.92 full time equivalents (FTE) with a vacancy rate of 18%; north Somerset had an establishment of 22.59 FTE and 9.7% vacancies; Swindon had an establishment of 23.6 FTE with 6.6 vacancies (28%); north Wiltshire 21.4 FTE establishment with 18.7% vacancy rate. The teams were actively trying to recruit. South Gloucestershire intensive team had received additional funding for staffing following a period of difficulty due to staff leaving and long term sickness, and had sufficient staff to fill shifts without using agency staff. Staff at the long stay/ rehabilitation services at Whittucks Road also managed the calls for the intensive service at night. This had made staff feel vulnerable and meant that patient safety on Whittucks Road could be at risk, because staff could be diverted to answer phone calls.
- The trust had undertaken a review of staffing levels on inpatient wards and for most staffing levels increased. This had resulted in a number of vacancies but the trust was proactively recruiting to fill these. In community and crisis teams, the trust had commissioned a review of working practices and caseloads and as a result staffing numbers had been reduced in some teams, for example the Wiltshire crisis team. Staff were not happy about this and reported that they felt there were not always enough staff to safely meet the needs of the service. In the specialist drug and alcohol services there had been a treatment system funding reduction and staffing redesign. This had resulted in some reductions in staffing in some areas. However, we found this had not impacted negatively upon the safety of the service delivered, and there were sufficient staff to meet the needs of the clients. The trust was monitoring staffing levels and the ability to deliver safe care closely.
- There were high vacancy, turnover and sickness rates in a number of services including, forensic, acute inpatient and psychiatric intensive care, older people's wards and substance misuse services. All areas used bank and agency staff but all areas tried to use the same staff to ensure continuity of care. Ward managers and team leaders were able to adjust staffing levels when bank staff were required. If bank staff were not available, ward managers and team leaders had to seek authority to use agency from service managers.
- In December 2015 when we issued the trust with a warning notice as we had concerns about safe staffing across the three Bristol community mental health teams. During this inspection visit we found that considerable improvements had been made; enough to lift the warning notice. A service manager had been appointed to cover the three Bristol teams and all three teams now had a team manager in place.. Staff commented positively about improvements in staffing levels and although many felt these improvements were quite new and tentative, they were able to recognise that the trust had responded swiftly to the concerns raised by CQC. The new model of care and staffing levels was working particularly well in the central and south Bristol teams. However, we had some concerns about the north Bristol team, particularly in regards to the use of the recovery navigators and the size and complexity of their caseloads.
- All staff, in all areas had access to appropriate mandatory training. The trust used an electronic system called 'our space' to record when staff had completed each of the 25 mandatory training programmes, which included training on topics such as safeguarding, Mental Health Act and Mental Capacity Act, prevention and management of violence and aggression, health and safety, life support and medicines management. Information about completion of training could be accessed at individual staff level, team, service, locality and organisational level. The trust had a target 85% of all eligible staff completing the training for each of the 25 courses. The trust as a whole, across all courses had achieved a completion rate of 87.3%, with community learning disability services staff achieving the lowest completion rate at 80.3% and staff in the crisis and health based place of safety teams achieving the highest rate of completion at 97.6%.

Requires improvement

Are services safe?

Track record on safety

- The trust reported a total of 7385 incidents to the National Reporting and Learning System (NRLS) between 1 December 2014 and 1 December 2015. When compared with other similar trusts the trust were in the middle 50% of reporters of incidents. Of the incidents report to NRLS 74% of incidents (5,475) resulted in no harm, 24% (1,812) of incidents resulting in low harm, 0.4% (27) in moderate harm, 0.1% (8) in severe harm and 0.8% (62) in death. The NRLS considers that trusts that report more incidents than average and have a higher proportion of reported incidents that are no or low harm. It considers the trust to have a maturing safety culture.
- Of the incidents reported to NRLS, 40% were related to disruptive aggressive behaviour, 18% to self-harming behaviour and 17% to patient accidents.
- NHS trusts are also required to report serious incidents to Strategic Executive Information System (STEIS). These include 'never events' (serious patient safety incidents that are wholly preventable). The trust reported 122 serious incidents between 15 March 2015 and 17 March 2016. None of these were never events.

Learning from incidents

- In the majority of services across the trust arrangements for reporting incidents were in place. Staff had access to an online electronic system to report and record incidents. All incidents reported were overseen by the manager of the service and then went to the risk and compliance team for scrutiny. Staff had received mandatory safety training which included incident reporting and were able to describe their role in the reporting process.
- We saw how incidents were thoroughly investigated using a root cause analysis process to investigate, recommendations for improvements in practice were made and lessons were learned from incidents.
- Where incidents had occurred, staff told us that they received information and feedback following the events. Other information was cascaded through the trust newsletters, through emails and shared during staff meetings; we saw records across the services to show that this was the case. Learning from incidents was also discussed at the trust wide "good practice network" meeting.
- Staff that we spoke with across the trust told us that they received support and opportunity for debrief following serious incidents. Staff were able to access one to one support and attend group debriefs sessions when necessary.
- However, we had some concerns that not all staff working in older peoples wards would report all incidents that occurred. For example, a patient with a long history of aggression needed three staff members to provide them with personal care. Only a small number of incidents involving this patient had been reported over a six-month period. When asked about this, staff confirmed that there was a culture that this kind of aggression in the elderly was expected so staff didn't report all incidents which could result in under reporting of incident in this service.
- In addition, we were concerned that the trust was not able to identify incidents that occurred in the health based places of safety in Wiltshire and Swindon as these were only recorded as part of the in-patient ward incident data. So it was unclear how lessons specifically related to health base places of safety were identified and shared.
- In December 2015 we issued a warning notice as we had concerns across the three community mental health teams in Bristol. The trust had failed to make improvements to care planning and risk assessing which it had clearly identified as needing improvement following a number of serious incidents. During this inspection (May 2016) we found that improvements had been made. The majority of patients had detailed care plans and robust risk assessments. Staff we spoke with knew how to recognise and report incidents on the trust's electronic recording system. All incidents were reviewed by the manager, given a risk grading and forwarded to senior managers and the trust's patient safety team for further review. The system ensured that senior managers within the trust were alerted to incidents in a timely manner and could monitor the investigation and response to these. The action taken by the team manager was also recorded on the electronic system.

Requires improvement

Are services safe?

Safeguarding

- The director of nursing and quality was the executive director with a lead for safeguarding. The trust had recently reorganised the way it managed safeguarding to ensure a more cohesive approach. It had appointed a lead for safeguarding adults and one for safeguarding children with a named nurse for each of these. Most staff knew who to contact and what process should be followed if they had a safeguarding concern. Staff understanding of safeguard procedures and processes was good overall. Staff were able to describe situations that would constitute abuse and could demonstrate how to report concerns
- The trust had clear policies in place relating to safeguarding and whistleblowing procedures. Safeguarding guidance was available to staff via the trust's intranet. We saw guidance on how to effectively report safeguarding concerns throughout the trust. Staff were aware of the trusts policies surrounding safeguarding and knew where and how to access them.
- The trust's mandatory training programme included safeguarding adults and children level 1, safeguarding children level 2 and 3 and required staff to complete these if relevant to their roles. Ninety one percent of staff had completed level 1 training, 87% had completed level 2 and 82% of relevant staff had completed safeguarding children level 3; this was below the trusts target of 90% of relevant staff having completed training.
- The trust had made 28 safeguarding alerts directly to CQC between March 2015 and March 2016. The trust informed us that it did not currently record data on the safeguarding referrals that it made to local authorities. Although it did identify that it had a system in place in Bristol, whereby all referrals from the Bristol area were tracked by the central safeguarding team.

Assessing and monitoring safety and risk

- Between 1 October 2015- 31 March 2016 there were 542 incidents of restraint reported across the trust, 205 of these involved restraint in seclusion and 328 of these involved prone restraint. The majority of these occurred in the acute inpatient wards and psychiatric intensive care units. The highest use of was on Ashdown ward at Fountains Way, which reported 73 incidents involving the use of restraint. Of these 73 incidents, in 35 of the incidents patients also required rapid tranquilisation.
- There were 71 incidents of seclusion across the trust; again the highest use of seclusion was in the acute inpatient wards with 11 of these occurring in forensic services.
- The trust did not have effective systems in place to monitor the health-based places of safety across the trust and to assess the impact of gaps in service provision. We were concerned that the trust was not able to identify incidents that occurred in the health based places of safety in Wiltshire and Swindon as these were recorded as part of the ward incident data. The trust could not provide specific incident, restraint, rapid tranquilisation or seclusion data for the Wiltshire and Swindon places of safety; or for those patients detained under in police cells in Avon and Somerset. We noted from monitoring data that a patient had required seclusion at Fountains Way in Salisbury place of safety in October 2015, March 2016 and April 2016.
- We reviewed care records across the trust and found that generally staff completed a risk assessment of patients on admission, which was reviewed regularly. Where risks had been identified these had been aligned with plans of care. The majority of risk assessments were robust, although risk assessment were of variable quality in the north Bristol community mental health team. In forensic services all patients were risk assessed using the HCR-20, a recognised risk assessment tool. Each patient's HCR-20 was updated every four months by the psychologist attached to the patient's ward. Risk assessments were detailed, comprehensive, completed to a high standard and staff updated assessments after every incident. Staff on Ladden Brook at Fromeside had introduced collaborative positive response plans which had been developed with patients. Plans included what things upset individuals and things that helped, how people could know if the patient was stressed or in crisis and what helps. Both staff and patients were very positive about these behavioural risk management plans.
- There were 818 incidents of restrictive interventions between October 2015 and March 2016; 25% of all restrictive incidents involved incidents of both seclusion and restraint. The majority of these occurred on the acute in patient ward and psychiatric intensive care units across the trust.

Requires improvement

Are services safe?

- All staff on all wards were able to articulate their understanding of least restrictive practices. We found evidence in care records and on incident report records to show that staff always attempted to deescalate situations and only used restraint as a last resort. For example, all older peoples in-patient wards had implemented the 'safe wards' initiative to reduce the level of risk within the ward environment and used a number of tools such as calm down boxes and positive words to reduce agitation and conflict.
- Generally, across the trust we found a very low use of blanket restrictions. Managers, staff and patients at Fromeside were engaged in a program of reduction of blanket restrictions. The head of therapies told us that 170 blanket restrictions had been identified and that these had already reduced to 70. The service aimed to reduce blanket restrictions to 49. Patients were encouraged to lead in this program. Overall the number of incidents had reduced as rules which led to potential conflicts had been removed. There remained a blanket restriction to gardens on Fromeside. Security staff explained that there was the potential for psychoactive substances to be thrown over the perimeter fence or deliver them over this fence by other means. Staff gave us one example of the use of a drone to attempt to deliver illegal psychoactive substances to patients on Fromeside.
- There were no blanket restrictions in place on acute in patient and psychiatric intensive care wards. The trust had introduced a service wide garden protocol following a serious incident on Juniper ward. The local protocol outlined what access restrictions were in place and what level of observation was required whilst the garden is occupied. All informal patients we spoke with on all wards told us that they were able to leave the ward. All patients we spoke with told us that they understood that they still may be subject to a pre leave risk assessment and understood the reasons why. There were good practice protocols in place for searching patients on return from leave and staff were able to describe how these were implemented to ensure the dignity and privacy of patients was maintained during searches.
- Whittucks Road (long stay/rehabilitation) had some blanket restrictions in place that included, asking patients not to watch the television after midnight, patients being asked not to leave the premises after 10pm and a locked kitchen, which meant patients always had to ask staff to access drinks.
- Generally, medicines management was good across the trust with medicines being stored appropriately, regular auditing and pharmacist input. However, not all wards acute and psychiatric intensive care ward that we visited were adhering to trust policy or best practice guidelines in line with the national institute for clinical excellence (NICE) when using rapid tranquilisation. Staff recognised intramuscular (IM) use of rapid tranquilisation medicines as a rapid tranquilisation event, but not for oral administrations of the same medicines. Furthermore, staff across all wards were not monitoring or recording physical health observations before and after a rapid tranquilisation event. Failure to do this leaves the patient at risk of developing serious health complications.
- Flumazenil, which is a medicine that reverses the potential effects of respiratory distress, (which can be a symptom of taking Lorazepam medication), was kept on all wards. All staff we spoke to knew where Flumazenil was stored. However, not all staff knew what it was used for. Forensic services had excellent practice for monitoring patients on clozapine. Patients' clozapine levels from blood tests were recorded on their medicine charts which meant this information was always available to staff but there was no community clozapine titration protocol available. The trust`s April 2016 pharmacy audit showed that the oversight of clozapine was described as a red risk. The trust advised us that they had re-written the clozapine procedure and it was due to be ratified at the time of inspection. The trust had also developed a database for the patients prescribed clozapine, but the pharmacy department wasn't due to 'go live' with the database until July 2016. The action plan stated that the rest of the services would have access to the database in October 2016.The substance misuse 'rapid prescribing' team service for clients on the day of their release from prison or discharge from hospital and for rapid access of opioid substitute prescribing for extremely vulnerable people, including street sex workers or pregnant women.

Requires improvement

Are services safe?

- There were effective systems in place to ensure staff safety when working alone. Each team had local procedures in place for lone working and staff were aware of and adhered to the lone working policy.

Duty of Candour

- The majority of staff knew about the principles of the duty of candour and the importance of openness and transparency when things go wrong. Not all staff were familiar with the term 'duty of candour'. However, once explained, all were able to provide examples of when they have been open and honest with patients and their families when things have gone wrong.
- The trust undertook an audit of the implementation of the duty of candour which was presented to the critical incident overview group in March 2015. This concluded that the duty of candour was being interpreted differently by staff undertaking root cause analysis investigations and, as a result, the reports did not always address the specific standards of the duty of candour. It noted that more clarity was needed in terms of who the duty of candour applied to and the steps required meeting it. A new approach to capture this information was recommended and the trust approach to both implementing the duty of candour and recording that it had recently been changed. From April 2016 template letters were introduced to support a process and the responsibilities of the ward/ team manager, quality director and person chairing the root cause analysis where clarified and communicated. The importance of the duty of candour had been reinforced to staff throughout the trust with the publication of 'quality factsheet 5' (published April 2016) and the trust's pledges (published March 2016). Learning from investigations was captured centrally and cascaded throughout the organisation using the safety matters bulletins and red top alerts to ensure continual learning.

Good

Are services effective?

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

Summary of findings

We rated 'effective' as good because

- Generally, patients could access services quickly and care records were of good quality. The majority that we looked at were holistic, recovery orientated and personalised and reviewed regularly
- In the crisis teams were clear clinical pathways to support effective assessment, management and treatment of clinical needs and effective, collaborative working with other services and external agencies.
- At Ladden Brook and Cary wards at Fromeside Hospital staff had developed excellent positive behavioural support plans in partnership with patients
- All babies on the New Horizons mother and baby perinatal mental health unit had their own care plans
- Staff in in-patient units monitored the physical health of patients well. Physical healthcare was discussed alongside mental health issues in ward rounds and documented appropriately
- The majority of teams were made up of a wide range of professionals
- Staff understood and had received training in the Mental Health and Mental Capacity Acts and generally these were applied. Patients had access to independent advocates and staff were familiar with obtaining consent appropriately and recognised when a patients autonomy needed to be respected
- Staff received regular supervision, appraisal and training. Staff in the teams reported working well with other teams within the trust, and with external services.

However:

- Staff did not complete care plans for patients admitted to the health based places of safety under section 135 or 136 of the Mental Health Act. Little information was recorded in electronic records of the detention in the suites at Salisbury and Devizes
- There were significant delays in the assessment of patients admitted to the health based places of safety and significant delays in accessing a bed if a patient needed to be admitted. A significant majority of individuals were detained far exceeding the timelines recommended within the Mental Health Act Code of Practice guidance. There were multiple, and often simultaneous, reasons for lack of access to the places of safety, delays in beginning and completing assessments and finding suitable placements for people following an assessment.
- There was no overarching policy for delivering physical health care in community services and none of the crisis teams were assessing, monitoring and planning for the physical health care needs of patients on their caseloads
- Over half of the caseloads of staff in the north and south Wiltshire intensive (crisis) teams were patients waiting for discharge to the community mental health teams but the teams didn't have enough capacity to take patients which meant that the intensive teams caseloads were difficult to manage
- In wards for older people there was little access to psychology at Swindon and occupational therapy across the service. In community learning disability services neither of the two teams had access to the full range of professional disciplines
- Staff in older peoples community mental health teams felt career progression was limited and were concerned that skills were being lost due to joint working and sharing of roles between nursing staff and social workers.

Good

Are services effective?

Our findings

Assessment and delivery of care and treatment

- There were no operational expectations to initiate relevant care plans or risk assessments for those admitted under section 135 or section 136 to the place of safety suites. We found there was little information following detention in the suites at Salisbury and Devizes recorded on the individual electronic records we reviewed. The trust electronic records did not incorporate access to the child and adolescent mental health service provided by another trust, or the general practitioner records. The Mason unit had access to general practitioner patient summaries for additional information to aid the assessment process. The street triage team based in police control rooms had access to both the trust electronic patient record system and the police database.
- There were significant delays in the assessment of patients admitted to the health based places of safety across the trust. The crisis care concordat states that significant delays in assessment at a place of safety can impact negatively on the health and wellbeing of people, and possibly increase the likelihood of an inpatient admission. The units we inspected generally tried not to use medication prior to assessment which could increase the level of agitation and distress. Staff told us that people could become increasingly frustrated with the length of time they had to wait to be seen and a decision made about whether they could go home and waiting for an appropriate bed to become available.
- However, generally patients in accessing other services were assessed quickly and care records reviewed were generally of good quality. They were up to date, need specific, recovery orientated and personalised. Most were holistic, with information regularly reviewed and with up to date risk assessments with a small number of exceptions with care plans missing in the crisis teams in Wiltshire and Bristol, care plans not as personalised as they could have been on some acute in-patient wards and some care plans that had not been uploaded onto the electronic record system (RiO) in community learning disability services. At Ladden Brook and Cary wards in Fromeside hospital staff had developed excellent positive behavioural support plans in partnership with patients. All babies on the New Horizons mother and baby unit had their own care plan and had an allocated nursery nurse responsible for their care plan. Some community teams had developed standard formats for care records when paper records were used to take out to patients. This included standard headings, such as new information, intervention, mental state examination, changes in medication, and client/carer view. This made the notes easy to navigate and meant that any member of staff could quickly access current information about a patient. In community learning disability services we saw that staff did not have all the information needed to provide the care needed. The electronic note system, used by the intensive support team, did not have a risk assessment or a standard place for risk information to be kept. Staff had access to the main trust electronic record system on a read only basis and we were shown examples of where information on the main trust system was not always on the system used by the intensive support team.
- Patient records showed that staff across the trust undertook physical health assessment on admission to in-patient services and the physical health of patients was monitored well. Staff recorded when patients refused physical health checks and continued to offer these. Staff initiated care plans during the admission process. Wards used a recognised tools such as national early warning scores (NEWS) to assess patients' physical health. Staff discussed physical health during ward rounds and documented this in patient's records. However, there was no overarching policy for delivering physical health care by the community healthcare teams. In older people's community services physical healthcare assessments were carried out by general practitioners; there were good relationships between the teams and general practitonaires and the teams received detailed information to support care delivery. In community learning disability services when receiving a referral staff checked there had been a physical health assessment. The services would refer to the local community teams if additional physical health assessment was required or if a physical health need had changed. In substances misuse services risk assessment also included information around mental and physical health crisis management. However, none of the intensive (crisis) teams were routinely taking a

proactive approach to assessing, monitoring or care planning for general physical health of patients on their caseloads. The Swindon team had identified this as an area for improvement and had a plan in place to improve its approach to physical healthcare. They had bought equipment such as scales in order to undertake routine physical health checks and had identified a lead practitioner for physical health within the team.

- We found that the majority of staff teams had comprehensive daily handover meetings. These meetings were used to discuss and update risks and formulate plans, and included discussion of new referrals, admissions, changes to care and discharge.

Outcomes for people using services

- Care and treatment across the trust was generally delivered in line with relevant national guidelines, such as those produced by the National Institute for Health and Care Excellence (NICE). Staff knew that up to date guidelines were available electronically but could not always access them. In substance misuse services staff supported people in line with 'drug misuse and dependence: UK guidelines on clinical management (2007)' during detoxification treatment, and followed the trust's 'operational guidelines for alcohol and opioid prescribing' as well as the Royal College of General Practitioners guidelines (1st edition 2011). All the guidelines for interventions and prescribing pathways were adapted from appropriate NICE guidelines.
- Overall, NICE guidelines were followed for prescribing medication and the management of medicines across the trust was good. The CQC pharmacy inspector reviewed medicines management practices and found that medicines were stored correctly and overall monitoring of medications, sell by date and stock checks, were undertaken regularly by the pharmacists.
- With the exception of the north Wiltshire intensive (crisis) team and patients using the north Somerset older peoples community team, patients generally had access to a range of psychological therapies, including, cognitive behaviour therapy, mentalisation based therapy, dialectical behaviour therapy, schema focused therapy, family interventions, art therapy and other supportive psychotherapy. In addition, social skills training, was available across the majority of services. In substance misuse services the majority of interventions were offered by the third sector parties in collaboration with the specialist substance misuse teams. Rehabilitation services used the model of human occupation (MOHO) and Allen's cognitive levels (ACLs) as part of the rehabilitation and recovery based practice.
- Programmes and interventions were planned to meet individual's needs. Staff were able to explain where they had used parts of a treatment package to meet individual patient need. Many services used recognised outcome measures such as health of the nation outcome scales and clustering tools. Other outcome measures were not routinely used to measure the effectiveness of the service. In community learning disability services neither team used a recognised outcome measure to review their input. However, the forensic team did send out a questionnaire before and after an episode of care to assess the effectiveness of the service.
- In the crisis teams the average length of time that someone would receive home treatment was four to six weeks. Bristol central and east kept cases for the shortest amount of time (an average of 12 days) and south Gloucestershire the longest (31 days). All teams were able to offer at least two visits a day, and three visits per day in some circumstances. However, at the time of inspection, over half of the caseloads at the north and south Wiltshire intensive teams were people who were ready to be discharged to the community mental health teams (CMHTs). The lack of capacity within those CMHTs meant they were unable to accept additional people. The Wiltshire community services manager was aware of these issues and a recent review had been undertaken to develop a service model to address capacity issues.
- We found significant problems with the availability and robustness of the data collected to monitor the operation of places of safety in Wiltshire and Swindon. The Mental Health Act Code of Practice 2015, 14.86 recommends that: "local recording and reporting mechanisms should be in place to ensure details of any delays in placing patients, and the impact on patients, their carers, provider staff and other professionals are reported to commissioning and local authority leads. These details should be fed into local demand planning". The trust reported that no audit or review of practice against its own policy had been completed, or was planned for the future. Without this information, the trust could not effectively monitor their operation of

places of safety or provide assurance about the care they provide to people subject to section 136. Effective collecting and analysis of this information should also inform needs assessments and highlight shortfalls in the commissioning of services.

- The north Somerset community mental health team were taking part in a pilot study and initiative using the, 'structured clinical management model' to work with people with a diagnosis of personality disorder. The allocated staff member worked between primary care and secondary care. Over 30 people were actively receiving treatment and therapy as part of this programme. Additionally in this team people, their friends and carers were offered personality disorder awareness and education training sessions. This initiative culminated in the team being interviewed by a local radio station, thereby increasing awareness about mental health issues within the local community.
- The trust had a programme of seven local audits in progress which included, how the trust responded to staff concerns and whistle blowing, health rostering and monitoring staffing levels, acute care pathway and managing quality improvement. In addition, clinical staff were involved in 19 local and national clinical audit across all areas of the trust, including the national audit of prescribing and a number of medication audits, national audit of schizophrenia, discharge monitoring in the mother and baby unit, the five year therapeutic review of suicides of people in contact with the trust, rapid tranquilisations and seclusion practice.

Staff skill

- In December 2015 we issued a warning notice as we had concerns across the three Bristol community mental health teams, not only about the lack of safe staffing levels but also the skill mix and competence of staff within the teams. During this inspection (May 2016) we found improvements had been made. All 11 teams had a range of fully integrated professions, including doctors, nurses, recovery navigators (In Bristol only), support workers, social workers, occupational therapists and psychologists. Teams also had access to a separate team of psychologists and occupational therapists which could be accessed on a referral basis, called the 'complex psychological team'. Additional funding had been secured from local commissioners for child and adolescent transition workers. In addition, in north Somerset, for example, a practitioner specialising in perinatal mental health provided support to parents with mental health needs which included facilitating a drop in support group for parents and their children. Staff told us that they had received specifically tailored training to be able to deliver skilled care to people. For example, senior practitioners in the south Gloucester teams were trained in the Thorn initiative and had a dedicated day to provide people with cognitive behaviour therapy, supervised by the complex psychological therapy team. All teams had undergone a, 'skills mapping' exercise to ensure there were specifically trained staff to undertake leadership and training roles in a variety of areas.
- Substantive and temporary staff received an appropriate induction prior to starting work in the community teams. Newly qualified nurses were offered an extended period of preceptorship (This is a structured period of transition for newly registered nurses when they start their first job). We looked at the Bristol teams' induction booklet and found it detailed and comprehensive. We spoke to staff about their induction programmes and the feedback was overwhelmingly positive.
- The majority of teams across the trust were made up of an appropriate variety of skilled and expereinced staff, except in the older people wards where the was a lack of occupational therapists and the community learning disability teams were neither team had a full range of professional disciplines. However, each team was able to access additional support, such as occupational therapy, psychology and psychiatry, via the local community mental health team. The learning disability intensive support team had been developed as a pilot project and was in the process of reviewing its mix of disciplines and banding of staff. At the time of the inspection, the commissioners had agreed funding for qualified and unqualified nurses in permanent positions. The service had a locum social worker in post and the service manager felt that this had added to team skills. Patients accessing the services of all other teams also had access to psychological therapies, occupational therapy, speech and language therapy and physiotherapy when required. In addition, staff were skilled to deliver many group activities including leisure based activities which were well thought out on all wards. Some community and crisis teams had non-

medical prescribers and all substance misuse teams had non-medical prescribers. Pharmacist made regular visits to wards and were available on the telephone during working hours. Administrative and domestic staff also worked on each ward and in community teams.

- All staff underwent the trust's induction and teams had devised their own local inductions. Staff generally could access specialist training to support them to do their job. For example, in substance misuse services there were plans to train staff in dialectical behaviour therapy (DBT) and therapists in forensic services had been supported to gain master's degree level in their respective therapeutic disciplines of art, music and drama. However, we spoke to two staff in older peoples community teams who felt career progression was limited and were concerned that skills were being lost due to the joint working and sharing of roles within the team (between social workers and nursing staff). Team leaders, ward managers and deputy ward managers were accessing leadership and management training and some staff had received solution focused management training.
- Band 4 health care assistants were eligible to apply for support for their nurse training if they already had a degree in a health or social science subject, although some staff felt it was unfair that they could not access the training if they possessed the required entry qualifications but not a degree. Band 4 staff (healthcare support workers) had opportunities to undertake the care certificate.
- The NHS staff survey for 2015 showed that 91% of the trust's staff had received an appraisal in the last 12 months (equal to the nationa average for mental health trusts). The score was the same as that of the 2014 staff survey. The trust scored 2.9 (compared to the national average of 3.1) when staff were asked about the quality of appraisal.
- The trust has indicated that the overall revalidation rate for the last 12 months was 30% (correct at 12 February 2016).
- The trust has set a target of 85% of its staff having received clinical supervision. The trust provided data for 295 teams across the trust; of these 120 teams failed to reach the trust target between August 2015 and January 2016. However, the average clinical supervision rate trust wide over the 6 months period was 86.38%. The majority of staff across the trust told us that they received regular monthly supervision. In community mental health services clinical supervision included as session on staff welfare alongside looking at key performance indicators using the caseload waiting tool and an audit of five of the staff member's care records.

Multi-disciplinary and inter-agency working

- Across the trust we saw examples of positive multidisciplinary working. Staff held regular multidisciplinary meetings and supported one another. Community teams worked well with in-patient wards and held monthly link meetings. Staff across the trust said that there was good communication within teams and between teams both verbally and in the written documentation. The majority of staff told us that there was good communication with the triumvirate (clinical director, quality director and managing director of the service).
- Staff reported positive working relationships between various professionals and stakeholders. For example, the police and mental health liaison teams. There were locally agreed pathways with the intensive teams that they would accept referrals made by the mental health liaison team who worked within the acute hospitals. There were a range of multi-agency meetings in each area to help address complex case discussion and identify quality or safety issues with service delivery. Community mental health teams had strong working relationships and excellent communication with primary care and social services. In north Somerset, Weston Super Mare regular and effective meetings took place with north Somerset council, chaired by the assistant director of social services. The meeting took account of issues such as the effectiveness of joint working arrangements, safeguarding, the Mental Health Act, key performance indicators and appropriate care planning for people.
- Local authorities could not supply enough approved mental health practitioners (AMHPs) to meet local need. Prior to our inspection, we held engagement events that invited key crisis stakeholders to discuss local service provision across organisations. Feedback from attendees suggested that there were serious concerns about the availability of AMHPs and S12 doctors to undertake assessments. AMHPS from the local authority

told us that there were delays in doctors attending the places of safety, and in particular a shortage of doctors in the north of Wiltshire. They informed us that they were having issues getting doctors to attend outside of working hours; therefore the person in the place of safety could wait between 12 and 24 hours to be seen, more if it was a weekend or bank holiday. Staff at the places of safety confirmed that this was a significant issue, and data containing information about how long people can wait for assessment further reflected serious capacity issues. A factor highlighted in a recent death of a patient highlighted was that the delays in accessing a S12 doctor led to the assessment being delayed for two days. The emergency duty team that covered the Mason unit advised us that there were only two AMHPs to cover the whole region for all out of hour's requests, including child protection, which meant they therefore, had to prioritise. This could mean that a person arriving on a Friday afternoon may not be seen until Sunday or Monday.

- Swindon locality was still integrated with the local authority and reported less significant delays in both undertaking the Mental Health Act assessment, and finding an appropriate acute in-patient bed. The place of safety was on the same site as the AMHP service, the intensive team and the in-patient unit, and all reported working well together to reduce the length of time people were in the place of safety suite. However, we still found unacceptable delays of over 24 hours. There were also delays in the attendance by the child and adolescent mental health (CAMHS) service (provided by another trust) when there was an admission of a young person. One young person was detained under Section 4 of the Mental Health Act due to the lack of availability of a second doctor to undertake an assessment at the place of safety. Section 4 applies when there is a crisis and someone needs urgent help but there is not enough time to arrange for an admission under Section 2 or Section 3.

Information and Records Systems

- The trust used the a secure electronic patient record system. All staff had individual identification cards, staff generally used the system well and information was stored securely.
- However, the community learning disability intensive support teams used an electronic notes system but this did not have a place for risk assessment information to be kept so staff did not have all the information needed to ensure they delivered safe care all of the time. Staff had access to the main trust electronic record system on a read only basis and there was information on the main trust system which was not on the system used by the intensive support team. The electronic note record system would generate an email to advise staff that a new piece of information had been added to a patient's record. However, this would be emailed to the team's email address so individual staff would not necessarily receive this information. Care plans had not always been uploaded on the main electronic system.
- In the crisis teams staff took paper copies of care plans out to see patients and then brought a signed copy back to the office to be scanned on to the electronic records, but we could not always find signed scanned copies on the electronic records. The trust electronic records did not incorporate access to the child and adolescent mental health service, provided by another trust, or the general practitioner records. The Mason unit in Bristol had access to electronic patient treatment plans and general practitioner patient summaries to aid the assessment process. The street triage team based in police control rooms had access to both the trust electronic patient record system and the police database.

Consent to care and treatment

- Staff were familiar with obtaining a person's consent but recognised that people using community services had a high degree of autonomy to determine many aspects of their daily lives, including contributing to their risk assessments and care plans.
- Staff recorded consent to treatment and to share information with relevant parties, such as other professionals and family. This was updated as required.
- Staff had a good understanding of the Mental Capacity Act and were able to explain the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions. People had access to independent mental capacity advocates if required.
- Between 1 October 2015 and 31 March 2016 the trust had made 50 Deprivation of Liberty Safeguards (DoLS) applications and indicated that only one application

Good

Are services effective?

was granted. CQC did not receive any Deprivation of Liberty Safeguarding Applications (DoLS) from the trust between the same period (1 October 2015 and 31 March 2016).

Good

Are services caring?

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

Summary of findings

We rated 'caring' as good because

- Patients were treated with kindness and respect, and we saw positive and warm engagement between staff and patients. We observed therapeutic, compassionate and relaxed relationships between staff and patients.
- Community meetings were held regularly and some wards held drop-in sessions for family members.
- Patients informed us they felt safe and without exception patients and carers spoke positively about the care they received.
- Patients were involved in planning their care, managing their physical health care needs, and in the discharge planning process where possible.
- Wards displayed posters for advocacy services to protect their patients' rights.
- In community-based mental health services for people with learning disabilities and autism, there was a forum which allowed people to be involved in service development and recruitment.
- Consent to share information with carers was clearly documented and patients were given opportunities to change their minds about their consent should they wish
- Some teams had carers champions and specific carers pack were available

Our findings

Dignity, respect and compassion

- We observed high quality care in the vast majority of the interactions we observed on inspection. We observed therapeutic, compassionate and relaxed relationships between staff and patients. Staff were respectful and caring. Staff asked patient's permission to access patient's personal space and their rooms on wards. However, in older people wards at Callington Road, Bristol an inspector observed a member of staff asking a patient to stop acting in a childlike manner whilst eating and a member of staff rebuking a patient in an abrupt manner.
- Without exception, patients and carers spoke positively about how staff treated them and the care they received. Patients and carers held staff in very high regard and said they were always approachable and nothing was too much trouble. For example, at Whittucks Road rehabilitation unit patients said doctors were easy to approach and patients were able to book their own times to see medical staff on the ward. In substance misuse services patients said they were treated as individuals at all times and staff were non-judgemental. All staff we spoke to were passionate about their job and all strived to do their best for patients and their carers.
- However, the ensuite bathroom at the Devizes health based place of safety contained multiple ligature risks and only a bath. This meant that the dignity and privacy of people was compromised by the need for staff to constantly watch patients whilst using toilet or bathing facilities in order to mitigate the ligature risks.
- The 2015 PLACE score for the trust for privacy, dignity and wellbeing was 92%, which was above the England average of 86%. Of all the sites within the trust, Long Fox unit in Weston-Super-Mare was the only site to score below the England average, scoring 84%.

Involvement of people using services

- The vast majority of records showed that patients had been involved in decisions about their care. Patients and carers told us they were involved in the care planning approach process and they felt their opinions were valued when determining the appropriate course of treatment. For example, in substance misuse services staff involved clients throughout their treatment pathway. Recovery care plans were created with clients, who told us they felt empowered to contribute to their treatment. We saw many good examples of individual and personalised holistic care plans. We saw evidence of care plans linking directly to risk assessments and the

Good

Are services caring?

majority of care plans had patient views and opinions clearly documented. However, not all patients had received a copy of their care plan in some services and at Whittucks Road (long stay/rehab) care plans were basic and did not always include patient views. For example some stated, 'discussed with patient' but there was no detail of what was discussed in the patient views part of the document. .

- All patients said that there was a community meeting which they could attend and that they felt comfortable to discuss any concerns. Staff in the North Somerset and South Gloucestershire older people's community teams told us about a post dementia diagnosis group that they ran. This group provided support to carers as well as patients with dementia. Staff on Alder ward (long stay/ rehab) told us that the ward manager was the carers champion for the Bristol area and he worked with carers groups for all the Bristol services.
- Consent to share information with carers was clearly documented and staff ensured that patients were given the opportunity to change their consent if they wanted to.
- Some teams had carers "champions" and we observed references to the triangle of care in patients' notes. The triangle of care guide was launched in 2010 as a joint piece of work between the Carers Trust and the National Mental Health Development Unit, emphasising the need for better involvement of carers and families in the care planning and treatment of people with mental ill-health. The trust website contained information for carers and teams had carers' packs.
- All patients had access to advocacy. Most patients received information, such as a patient's handbook, on admission which contained information about the advocacy service and patients' right to have and advocate present during care reviews and care programme approach (CPA) meetings.

Good

Are services responsive to people's needs?

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

Summary of findings

We rated 'responsive' as good because

- The trust was piloting a number of street triage projects with the aim of helping police officers make appropriate decisions about whether a person was potentially suffering from a mental illness so leading to a better outcome for patients and a reduction on the use of section 136 (detention in a health based place of safety)
- In community-based mental health services, there were clear criteria for referrals within the teams. There was the option for services to visit patients within their homes, and for out-of-hours appointments.
- In most services, there were a range of psychological, educational and recreational activities to meet patients' needs. There was access to a range of spiritual support if needed.
- The majority of the areas were care was delivered were appropriate, well maintained and had appropriate furnishings. There was access to outside space and private areas to receive visitors.
- There was a good range of leaflets and information available in all services, patients had access to advocacy services and d Patient Advice and Liaison Service (PALS).
- Patient knew how to complain if they wished to and there was evidence of learning from complaints at a local and trust wide level. Staff responded positively to general feedback from patients and made changes accordingly in a timely manner.
- In community-based mental health services, there were clear criteria for referrals within the teams. There is the option for services to visit patients within their homes, and for out-of-hours appointments.

However:

- Often, the police could not take a person who was detained under section 136 of the Mental Health Act to a health based place of safety because the health based places of safety were already in use. Patients were regularly taken to police cells (used as health based places of safety) because of the lack of availability of beds in the trust's health based places of safety. The Mental Health Act Code of Practice states that police cells should only be used in exceptional circumstances. We had serious concerns with the timeliness of Mental Health Act assessments for people detained in the places of safety. Children and young people spent long periods of time in the Mason unit health based place of safety due to complex aftercare arrangements. Adult could not be admitted to the Mason unit when a child or young person was being cared for reducing capacity even further. There was a lack of system in place to monitor the health based places of safety across the trust in order to identify gaps in service provision.
- All the crisis teams and places of safety staff we met told us that lack of bed availability caused significant issues and that the delays had a serious impact on staff capacity (taking a clinician a whole shift to locate a bed) and on care for some patients.
- In the acute wards and psychiatric intensive care units bed availability caused significant issues. Patients were regularly cared for in beds outside the trust (sometimes a long way from home).
- Wards for patients experiencing dementia in Salisbury, Bristol and Weston-Super-Mare had few adjustments made to make them dementia friendly.
- In community-based mental health services for older people, targets on waiting times for assessment were not always being met. And in services for people with learning disabilities and autism, there was no information kept in relation to waiting times.

Good

Are services responsive to people's needs?

Our findings

Planning and delivery of services

- The trust's services were commission by six clinical commissioning groups and it worked with six local authorities. This presented a number of challenges for the trust resulting in the trust having to operate a number of service models for the same service, differences in services provision across the trust and different working relationship models. For example, crisis services were provided by 'intensive' teams in all areas except Bristol where a hub and spoke model was in operation. North Somerset had recently received funding for a specialist dementia crisis service. However, there was no out of hour's specialist dementia services in south Gloucestershire, BANES or Swindon. However, the trust had worked hard to develop effective relationships at a strategic level and we saw good local working practices and partnership working with all partner organisations.
- The trust was piloting a number of street triage projects across different geographical areas. Mental health professionals provided on the spot advice to police officers who were dealing with people with possible mental health problems. This advice included an opinion on a person's condition, or appropriate information sharing about a person's health history. The aim of street triage is, where possible, to help police officers make appropriate decisions. This should lead to people receiving appropriate care more quickly, leading to better outcomes and a reduction in the use of section 136. Local universities were reviewing the impact of these services, but informal feedback from staff, police and other stakeholders was very positive.
- We identified significant concerns relating to the capacity of the health based places of safety provided by the trust. We have taken separate enforcement action, serving a warning notice that requires the trust to make significant improvements. However, several of the issues identified will require a multi-agency approach and response to ensure adequate and appropriate provision, planning and delivery of services in the future. We had serious concerns with the timeliness of Mental Health Act assessments for people detained in the places of safety. A significant majority of individuals were detained within a trust designated health based place of safety far exceeding the timelines recommended within the Mental Health Act Code of Practice guidance. There were multiple, and often simultaneous, reasons for lack of access to the places of safety, delays in beginning and completing assessments and finding suitable placements for people following an assessment.
- Police stations should only be used as places of safety for patients experiencing a mental health crisis in exceptional circumstances. The Mental Health Act Code of Practice 2015 (paragraph 16.38) states that a police station should be used as a place of safety only on an exceptional basis. However, patients were regularly being held in police custody as there was no available space at the places of safety.
- The trust did not have effective systems in place to monitor the health-based places of safety across the trust and to assess the impact of gaps in service provision. We found significant problems with the availability and robustness of the data collected to monitor the operation of places of safety in Wiltshire and Swindon. This meant that the trust could not monitor capacity, quality and safety effectively, plan service delivery in the future or highlight shortfalls in the commissioning of services.
- The majority of the trust premises from which care was delivered were clean, well maintained and had appropriate furnishings. All had access to outside space. The trust's overall score during their patient led assessment of the care environment assessments was better than the England average for other similar trusts for cleanliness, condition, appearance and maintenance. However, at the time of the inspection the health based places of safety required improvements to environments. For example, at Devizes the provision of appropriate furnishing, there was no outside access at Swindon. . Minimal adjustments had been made to Laurel ward(Callington Road Hospital) and Amblescroft ward (Fountains Way) to make then dementia friendly; both were bleak and sparse with little in the way of decoration and no dementia friendly signage. Staff on Dune ward (Weston-Super-Mare) had added some tactile artwork, appropriate signage and brightly coloured furniture. Ward four in Bath included a number of features to make the ward more comfortable for people experiencing dementia. There were orientation

boards for patients, themed picture displays and dolls for attachment theory work. They also had artwork completed by patients, dementia appropriate signage and red toilet seats that assisted in allowing patients to self-care. However, the bedrooms at Amblescroft north, Amblescroft south, Liddington and Hodson wards did not have privacy film on their windows to protect patients' privacy and dignity.

- All acute inpatient wards had areas that were used to provide group and one to one activities. Sycamore (Hill View Lodge) had access to a large gymnasium. Ashdown ward had a 'safe box' and Beechlydene (both Fountains Way) had a calm box, which contained items that were useful in engaging agitated or distressed patients. For example, there was access to a foot soak and a soft blanket. There was a full range of rooms and equipment on each rehabilitation ward to support treatment and care. Patients could access a number of small rooms to spend time alone or to meet with staff. Each ward had activity rooms with access to games equipment. Whittucks Road had a beautiful, well-kept garden with covered outdoor seating. They had raised vegetable beds and a gardening group and patients were able to grow their own vegetables.
- Wards had different methods of accommodating visitors. Some allowed patients to have visitors in their rooms and was risk assessed first. Some used quiet lounges on the wards for visitors to use. Others had access to rooms off the ward to use. Inpatient wards had appropriate child visiting policies which staff adhered to. In forensic services patients were able to meet visitors in the reception area and a family room was available. This room was also equipped with observation equipment for both supervised visits and family therapy sessions.
- Payphones were provided to enable patients to make a phone call. Patients could also use their own mobile phones, following a risk assessment.
- Most patients told us that the food was good. However, the trust score for food on the patient led assessment of the care environment was below the England average for similar trusts.
- Patients were seen in appropriate and private facilities in community services.

Diversity of needs

- Both community settings and inpatient services were fully accessible for people requiring disabled access. This included the provision of wheelchair access to bedrooms and assisted bathrooms.
- Patient information leaflets were readily available across the sites we inspected. Information was provided in languages other than English which could be printed quickly when required by staff. Information leaflets in other languages were updated on the internal internet system as were those written in English. This system appeared easy for staff to navigate so patients did not need to be kept waiting for written information if appropriate to the patient's needs.
- Details of advocacy and interpreting services were readily available. Staff did not require managerial approval to book an interpreter. Translation services were also available if required.
- There was a trust wide chaplaincy service to support patients with a diverse range of spiritual and religious needs. At inpatient services multi-faith rooms were available for patients to use.
- There was a range of choices provided in the menu that catered for patients dietary, religious and cultural needs.
- Information packs/documentation was routinely given to patients. These included important information to support their recovery and independence within the community settings.

Right care at the right time

- All of the teams we met with told us that bed availability caused significant issues and that the delays had a serious impact on staff capacity (taking a clinician a whole shift to locate a bed) and on care for some patients. Staff told us about increased length of time waiting in places of safety, deterioration in mental health in the community and patients being transferred multiple times between hospitals or to locations great distances from their homes.
- Some patients remained in the place of safety for hours, or days, after their Mental Health Act assessment due to the lack of availability of beds to admit people to. Data provided from the trust highlighted that between April 2015 and April 2016, 197 out of the 290 recorded delays post assessment in Bristol place of safety were due to the lack of availability of a suitable bed. We noted in

multi-agency meeting minutes from May 2015 that the lack of availability of beds was raised as having a significant impact on the assessment process and place of safety capacity.

- There were1035 admissions to the Mason unit between 01 April 2015 - 31 March 2016, and 413 instances recorded from 03 April 2015 – 11 May 2016 across the three Wiltshire places of safety. Referrals for admissions were taken directly from the police by staff managing the place of safety. Medical cover was provided from the adjoining wards if required.
- We had serious concerns with the timeliness of Mental Health Act assessments for people detained in the places of safety. There are clearly significant challenges in relation to the capacity and timeliness of Mental Health Act assessments in the place of safety in Wiltshire and Avon and Somerset. These issues are complex and a multi-agency response will be required. The significant number of individuals who were detained in a place of safety far exceeded the recommended timescales in the MHA CoP guidance. The length of time to complete a Mental Health Act assessment ranged from less than four hours to in excess of 24 hours. Data showed that a significant number of people were in places of safety for over 12 hours waiting for assessment, and many for two or three days. There were eight occasions between March 2015 and April 2016 where people were there beyond the legal limit of 72 hours. There were many reasons for delays in beginning and completing assessments. The main reasons for the delays in the process were recorded as:
- awaiting attendance by AMHP
- awaiting attendance by section 12 approved doctor
- lack of availability of beds
- person not medically fit (or intoxicated)
- lack of space at the place of safety
- Capacity to admit adult patients to the Mason unit was reduced when there was an admission of a young person under the age of 18; presenting additional pressure on the service. Aftercare arrangements for children and young people were complex and could involve multiple agencies. This had resulted in some children and young people spending longer in the place of safety. In a report to the board December 2015, it was highlighted that 75% of children and young people remained in the place of safety over twelve hours, citing that 57% of these delays were due to risks, complexity and other teams. The report reflected that only 12.5% required hospital admission.
- The trust provided details of the past six months bed occupancy rates for 37 of its wards. The average bed occupancy rate, across all wards, was 90.1%. Twenty eight out of 37 wards had bed occupancy over 85% across the following services: adult acute in patients, older peoples in patients, psychiatric intensive care units, and medium and low secure services and rehabilitation services. Psychiatric intensive care services had the highest bed occupancy across the trust. The crisis intensive support teams provided the gate keeping function for acute inpatient beds and all staff identified that the lack of bed availability caused significant issues and that finding a bed often took up a substantial amount of time. All of the teams carried bed management caseloads which identified patients who needed repatriation to a local bed.
- There were 262 out of area placements between April 2015 and December 2015, 171 in adult acute inpatients, 82 in psychiatric intensive care and 8 in older people's mental health services. Although, the majority of out of area placements were to locations relatively local to trust area patients requiring acute inpatient beds could be transferred to London and one patient had been transferred to a bed in Bradford, only to be returned virtually on arrival.
- The average length of stay for current patients on wards was higher than the average for the previous twelve months for adult rehabilitation, older people, psychiatric intensive care and adult acute in patient wards. Several wards had seen an increase in length of stay over the last 12 months including Windswept (rehabilitation in Swindon) and Alder ward (rehabilitation, Bristol). Overall, the trust had an average of 310 days length of stay across all wards.
- There were 295 readmissions within 90 days of discharge reported by the trust between 1 October 2015 and 1 March 2016 across 53 wards. The wards with the highest number of readmissions within 90 days were all acute inpatient wards. The highest number of delayed discharges was in older peoples wards.

Good

Are services responsive to people's needs?

- Between February 2015 and January 2016 340 patients incurred a delayed transfer of care. The highest number of delayed discharges was in older people's services and the main reason for the delays was due to patients waiting for care home or residential home placements.
- The trust had set its own targets for the times from referral to assessment for a wide range of its community teams. These included; 95% of patients being seen within four week and 95% of emergency referrals being seen by the crisis teams within 4 hours. As of January 2016 the trust had failed to meet its target within the crisis teams. It also failed to meet its target for referral to assessment and assessment to treatment (95% of patients receiving treatment in 18 weeks) in the Wiltshire Sarum community mental health team, the BANES recovery team and the east, central and north Bristol assessment and recovery teams.
- There were clear criteria for referrals within all community teams. Appointments were mostly between 9am-5pm Monday to Friday but staff could, on a case-by-case basis, organise a visit outside of working hours. Staff told us about the proactive approach they had towards engaging with patients who did not attend appointments. Efforts included making telephone calls and sending letters. More proactive attempts such as welfare home visits were made if the level of risk indicated this was required. We received no adverse comments from patients about the flexibility of appointment times or indeed about cancellation of appointments. We saw that patients were asked about appointments running on time in the family and friends test and that people responded positively to this question.
- The trust recorded that 97.4% of patients on the care programme approach were followed up within 7 days after discharge (January 2015 to March 2016). This was above the England average of 96.9%.
- The trust provided electro-convulsive therapy (ECT) twice weekly from two suites; one at Green Lane Hospital and one at Callington Road Hospital). Waiting lists were well managed and flexible to meet urgent cases. Green Lane Hospital did not treat people with underlying physical health conditions on site. The Green Lane Hospital ECT service held clinics in the local general hospital when providing ECT to patients with physical health problems. This was to ensure optimum safety and ensure that in the event of a physical health emergency, they were able to access assistance immediately. The Callington Road ECT suite did provide treatment to patients with underlying physical health conditions but did consult with the local general hospital if they had concerns.

Learning from concerns and complaints

- The trust received 314 complaints in 2014/2015; an increase of 42 from 2013/2014. One hundred and fifty nine complaints (51%) were upheld, 11 were referred to the Health Service Ombudsmen with one being upheld. Community mental health services for adults of working age received the highest number of complaints with 138 (48%); 86 of these complaints were upheld either fully or partially. One complaint was upheld by the ombudsman and one was ongoing at the time of the inspection. There were no complaints from patients (or carers) receiving community learning disability services.
- The trust operated an effective complaints system. Information relating to complaints past and present were orderly and up to date. The complaints staff were able to speak with knowledge, confidence and transparency of past and present complaints. Staff addressed patients concerns informally as they arose. The trust had a complaintspolicy andprocedure. Managers reviewed staffs' understanding through training, supervision and appraisals. All staff were aware of what to do if patients made a complaint and how to supportthem.All patients we spoke with said they had been told how to make a complaint should they wish. An active patient advice and liaison services was available across the trust to support patients and carers.
- We saw evidence on all wards of robust complaints investigation and resolution and examples of changes made as a result of complaints. For example, older people's services in Swindon a housekeeper had been employed in response to patient complaints about missing clothes.Patients and carers spoke positively about this. We saw that staff also responded positively to general patient feedback. For example, on Alder ward (rehabilitation) staff identified from patient's feedback that they would like access to more musical instruments and bicycles for patient use. Staff and patients worked together to bid for funding to buy these.

Good

Are services responsive to people's needs?

- In addition, for the same time period the trust reports having received 219 compliments across the service. Compliments included how friendly and helpful staff were and how good the food was.

Requires improvement

Are services well-led?

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

Summary of findings

We rated 'well-led' as requires improvement because:

- We have served two warning notices in the past six months which imposed a legal duty on the trust to make significant improvements. On both occasions we found that the trust did not have effective governance arrangements in place to enable it to assess, monitor and improve the quality of services (including the quality of the experience of service users in receiving those services). The trust had little knowledge of either of the issues until we raised these at the respective inspections and as such, we were not assured that governance arrangements and board oversight were robust enough to identify, address and learn from key risks in a timely manner.
- For the health based places of safety across the trust governance arrangements were not effective in identifying and prioritising the provision of safe environments', safety of patients, capacity of the service, gaps in service or the quality of services, including the quality of the experience of patients detained in the health based places of safety. An operational policy and audits for the places of safety were not in place in line the Mental Health Act Code of Practice.
- Staff told us that there were too many initiatives being implemented too quickly at one time. Staff found it difficult to engage and keep up with some of these. We found that there were lots going on, much of which was required. However, the reasons for the initiatives and were not always communicated as effectively as they might have been.
- Significant changes had been made to the board recently with many new appointments, including that of the chief executive. In addition, the chair was coming to the end of his term of office. Once the chair left post an interim chair would cover until a perminant appointment could be made.This had caused significant instability, a lack of clear leadership for some initiatives and some lack of engagement between senior leaders and front line staff. Staff reported that senior management based at the trust headquarters were not as visible as they would like them to be.
- The triumvirates (locality and speciality management arrangements) often appeared to work independently of each other and staff often felt as though the trust worked in silos.
- The trust had not undertaken disclosure and barring checks on non clinical directors and senior leaders.

However:

- The trust had a clear vision and set of values which staff were aware of and recognised how they reflected their teams' values.
- The trust had governance processes in place to manage quality and safety within the services, although these were not totally effective at the time of the inspection. It had mapped its strategic priorities to CQC five key questions and based all its quality improvements on standards set around the five key questions. The trust had made significant improvements to governance systems in place to manage the quality and effectiveness of its community mental health services in Bristol. In December 2014 we served a warning notice and told the trust it must improve these. We were able to lift the warning notice following this inspection. Information on how the trust was performing was presented on a clear dashboard and reported at trust, local delivery (triumvirate) and team/ward level. The IQ system that held this information could be accessed by staff across the trust
- The majority of staff across the trust had completed the required mandatory training, had access to

Requires improvement

Are services well-led?

regular supervision and annual appraisals. Staff understood the trusts' safeguarding, complaints and whistle blowing procedures and felt confident in using them.

- Staff morale was generally good and it was reported that the trust was a good employer. Staff felt listened to and valued and were very complimentary about the support received from their immediate line manager.
- There was a trust wide service user group and a trust wide carers group. These groups were developing a new service user and carer strategy in partnership with staff.
- The trust had invested in developing involvement coordinators at a local level who engaged carers in a range of activities like recruiting staff and evaluating services.
- The trust was committed to quality improvement. It participated in a number of national quality assurance schemes and audits. It also had developed a nationally, well respected research and development department and was involved in over 200 national studies. It had an ethos of 'everyone involved' through which it aimed to involve as many patients as possible in research.

Our findings

Vision, values and strategy

- The trusts described its purpose as 'to provide the highest quality care that promotes recovery. Underpinning this, it had developed a clear vision and set of values to support its strategic priorities for the next five years. The strategic priorities were:

1. to deliver the best care
2. support and develop our staff
3. continually improve what we do
4. use resources wisely
5. be focussed on the future

- The trust set out to achieve the priorities through its values, which were clearly stated in all areas we visited. These were entitled PRIDE and stood for:

1. Passion – doing our best, all the time
2. Respect – Listening, understanding and valuing what you tell us
3. Integrity – being open, honest, straightforward and reliable
4. Diversity – relating to everyone as an individual
5. Excellence – striving to provide the highest quality support

- Staff we met across all levels of the services showed a high awareness of the trust's vision, priorities and commitments. Information was displayed in every ward and every location. Information surrounding the trust's vision was also displayed on the trust intranet page. Staff we spoke with, in the majority were aware of the trust visions and values and thought them to be realistic and in line with their own visions and values.

Good governance

- The trust board were accountable for the running of the trust and providing the overall strategic leadership. The trust had developed an integrated business plan which described seven enabling strategies, the service development initiatives, the financial forecasts, workforce planning and governance arrangements to support it to achieve its vision.
- The Trust had established a number of board assurance committees (with explicit terms of reference and membership) and advisory groups. Additionally, trust management groups had been set up in 2015/16 to facilitate the provision of management assurance. These arrangements had been reviewed in March 2016 to ensure compliance with best practice and alignment with the quality objectives. There were clear reporting lines in place from the assurance committees via committee chair reporting, and reporting arrangements between committees. In addition, the audit and risk committee and quality and standards committee shared membership to ensure good cross working. The trust board received a monthly quality and performance report, which includes detailed information arising from the trust's IQ system (see below) detailing performance against key quality indicators.
- The trust had developed a comprehensive board assurance framework (BAF) (reviewed 19 November 2015) which provided the detail and risk measures related to each of the strategic improvement priorities, detailed below:

Requires improvement

Are services well-led?

1. to improve service user experience by taking prompt action at ward and team level in response to regular feedback from service users and their carers
2. to improve carers' experience through improved partnership working and carer support
3. to improve their approach to formulation in assessment of service users to help clinical practitioners develop more clinically effective care plans.
4. to improve the effectiveness of care pathways and interventions with service users
5. reduce premature death in severely mentally ill patients and ensure physical health needs are identified and treated.
6. ensuring that discharge summarises are shared with GPs and include comprehensive information including diagnosis, medications, physical health conditions and recovery interventions.
7. to reduce the use and need for restrictive interventions and improve the use of positive and proactive approaches to care.

- We observed a board meeting during the inspection and found that it operated in an open and transparent way with a considerable amount of business covered in the public section of the meeting. The board meeting began with a presentation of a patient story and allowed time for executive and non-executive discussion and to take questions, including from the public. We observed significant, robust but appropriate challenge from non-executives.

- The trust managed quality governance through a number of key groups which ensured ward to board and board to ward monitoring and reporting. The key groups were:

1. the integrated governance group: (IGG): with cross-trust representation, providing executive and director level quality governance oversight
2. the quality forum: responsible for quality improvement and shared learning
3. the CQC programme board
4. the quality improvement group: responsible for monitoring improvement in outcomes and risks

- The trust had mapped its strategic priorities to the CQC five key questions; are services safe, effective, caring, responsive and well-led. It based all its quality improvements on the standards it set for each of the quality themes and set the tasks required to achieve the standards against each of the standards; this allowed it to incorporate CQC inspection recommendations into its business as usual practice. The trust had developed the trust IQ system to measure and monitor quality; there were 80 plus metrics in use through the system at the time of the inspection. The system was the primary mechanism for monitoring quality and ensuring quality information and was available and accessible across the trust. The system provided information from ward to board. One key purpose of the system was to act as an early warning system to all levels of management to focus actions, support and development to improve quality.

- The trust identified that its top three priorities for quality improvement for 2016/2017 as:

1. standardisation of practice across the organisation
2. consistent articulation/delivery of our standards from every member of staff across the organisation
3. service user and carer involvement at all levels.

- Information on how the trust was performing in relation to these was presented on a dashboard and could be reported at trust, local delivery (triumvirate) and team/ward level. Differences in performance of the localities could be seen and was used to monitor performance of each of the localities. In addition, this information was presented at the clinical commissioning groups' contract quality governance meetings.

- The trust managed risk through a risk report, which covers high-level risks identified in three executive (delivery, clinical and business) risk register and one strategic risk registers. The board and executive team said they were clear about the top risks faced by the trust, although missed those relating to the health based places of safety. To ensure it addressed these, the trust had placed the 'clinical voice' at the centre of its devolved local governance arrangements to ensure decision and accountability for quality and for driving change was closer to local communities. Each locality was led by a clinical director, supported by a manging director and a director of quality; referred to as 'the triumvirate'. In addition, there was a triumvirate from secure and specialist services. Triumvirates were

supported by central support teams, such as finance, corporate governance and human resources. Managers and staff members throughout the trust could place items on the trust risk register.

- However, we had serious concerns about the quality of care in the health based places of safety across the trust. Governance arrangements were not effective in identifying and prioritising the provision of safe environments, safety of patients, capacity of the service, gaps in service provision or the quality of the services (including the quality of the experience of service users receiving those services. We were concerned that the trust was not able to identify incidents that occurred in the health based places of safety in Wiltshire as these were recorded as part of the ward incident data. The trust could not provide data for incidents that had occurred within these places of safety. There had been no reviews undertaken into the use of restrictive interventions across any of the places of safety. We found significant problems with the availability and robustness of the data collected to monitor the operation of places of safety in Wiltshire and Swindon. In addition, information was not available that would allow the crisis concordat partners to understand the quality and safety issues found on the inspection. Whilst several of the issues could be addressed by the trust a partnership approach would be required to fully address all of the issues. We asked the trust to take some immediate actions to ensure the safety of patients and staff and served a warning notice that imposed a legal duty on the trust address the issues.
- Staff we spoke with at the locality and speciality team director, manager and matron level described the trust governance structures and reporting systems in detail, and thought the arrangements generally worked well. Staff below this level were not as clear about the wider governance systems although they knew about the local ones.
- In December 2015 when we issued a warning notice as we had concerns, across the three Bristol community mental health teams, that there was a lack of governance systems in place to manage the quality and effectiveness of the service. During this inspection visit we found considerable improvements had been made. The trust and local managers had instigated several systems which meant that managers were now aware of how effectively their teams were performing. Where performance was below the standard expected, managers were alerted in a timely way so that they could plan and take act to correct any poor performance.
- In order to achieve the vision, strategic priorities, build widespread commitment and support the development of a culture of continuous improvement the trust had commenced a development programme. The programme had three aims:

  1. Build shared purpose
  2. Develop transformational leaders
  3. Embed the revised strategy

- A number of initiatives had commenced to support this. For example, executives and senior managers had started undertaking regular 'back to the floor' session; spending time in clinical areas to understand front line pressures, front line staff had opportunities to shadow senior managers, senior leaders had undertaken an in house leadership development programme, a 'bright ideas' was due to commence with funding being made available to teams to develop good ideas a reality, the development of staff recognition awards, celebrating excellence at individual, team and organisational level (an award ceremony will be held in October 2016) and enhanced support for staff health and well-being; the trust was in the process of appointing a health and well-being manager at the time of the inspection.
- The trust delivers mandatory equality and diversity training to all staff (refreshed every 5 years) although the trust could not provide information on the number of staff who had completed the training. The trust had an equality diversity and human rights strategy (2012-15) and workplace race equality standard action plan. At the time of the inspection the trust informed us that it had updated its workforce race equality standard report for 2015 – 2016 but that this had not yet been approved so we were unable to verify that the trusts objectives for meeting the requirements in respect of the equality duties.
- The trust managed the 'learning environment' through an electronic training record system which was used effectively by managers across all teams for ensuring that staff received mandatory training. A monthly report was produced which was reviewed at governance

meetings and team meetings. Staff had access to this system to monitor their own compliance with mandatory training. The trust as a whole, across all courses had achieved a completion rate of 87.3%, with community learning disability services staff achieving the lowest completion rate at 80.3% and staff in the crisis and health based place of safety teams achieving the highest rate of completion at 97.6%.

- The trust had set a target of 85% of staff receiving clinical supervisions; from 161 teams 40 had failed to reach this target although the average rate across the trust was 92%. The majority of staff across the trust told us that they had access to supervision.
- We found the trust had effective systems in place for financial reporting. These along with key performance indicators for all teams ensured the trust management team were aware of the organisation's performance throughout the year.
- We received positive comments about the trust from clinical commissioning groups, local authorities, police and healthwatch groups. They told us the they had, over the last few years, seen a significant improvement in the trusts approach to developing communication, instigated by the previous chief executive and really embraced by the current chief executive. Stakeholder organisations told us that trust was proactive in its local relationships and provided an open and transparent dialogue. However, some third party organisations representing specific patient groups were less complimentary about the trust performance.

Leadership and culture

- The board at Avon and Wiltshire Mental Health Partnership NHS Trust had gone through significant change over the last year. The chief executive had only been in a substantive post for three months prior to the inspection, had been in the interim post for two months prior to this and was previously the medical director. The director of nursing and quality had been in post since March 2015. The trust were recruiting to the medical director post (an interim medical director was in post) and the director of finance post (current director was leaving the trust) and was waiting for a new director of operations to start. In addition, the chair had come to the end of his term of office, an acting chair was about to take on this role at the time of the inspection; this person, who was previously a non-executive director, was also leaving post once the new chair came into post. The trust was working with NHS Improvement to secure the appointment of a new chair, who it hoped would take up post before the end of the year, plus a number of other non-executive directors. The chief executive recognised that this had caused significant instability but saw this as an opportunity to continue the development of a culture of shared responsibility for quality, developing a strong clinical voice in the quality agenda and ensuring new initiatives are embedded.
- The triumvirates, in the localities, secure and specialist services provided a clear leadership framework. However, staff we spoke to across the trust said that whilst they knew what was happing in their services the triumvirates often appeared to work independently of each other In addition, several senior nurses said that the nursing voice had been lost and needed strengthening in this structure. Furthermore, staff in the localities had identified that they did not know who to speak to when things went wrong and there was breakdowns in the quality of patient care. The director of nursing and quality, on appointment, had identified this and the need for clearer accountability. He also identified that nursing and allied health professionals had no identified development or improvement structures. A consultation exercise about a proposed new structure had been undertaken and completed in January 2016. The proposed new structure would bring together, under the nursing and quality directorate, the nursing, quality governance and statutory deliver and allied health and social care professional functions. At the time of the inspection the trust was about to match or appoint staff to appropriate posts. Staff across the trust told us that they felt positive about the changes but some senior staff directly affected by the reorganisation expressed some reservations.
- Board members took an active role in the trust through quality improvement visits to each of the services, providing an opportunity to discuss patient experience, safety and effectiveness concerns with staff, patients and carers. During 2015/16 the Trust has reviewed and strengthened its quality improvement processes to include a wider range of inspection-style visits and reviews to test quality and safety locally. Staff told us that senior managers from the trust visited the wards.

Requires improvement

Are services well-led?

- The trust had carried out staff friends and family tests since April 2014. The trust had a lower response rate than average for mental health trusts in England (6% compared to 11%) but the percentage of staff who would recommend the trust as a place to work was 6% higher than the England mental health trust average (67% compared to 62%).
- We held 11 focus groups with staff, held across nine sites of the trust. These were attended by a wide range of staff which included; nurses, therapists, psychiatrists, junior doctors, support workers, team managers etc. Overall staff told us the trust was a very positive place to work and they felt supported. They also thought the quality of care was good and the trust board provided effective leadership. Many staff told us that the senior team/senior managers were visible around the trust and visited wards and teams but some said that the executive team weren't as visible as they could be. There was a sense that staff wanted the connection with the senior team and wanted to 'belong' to trust but that at present there was some disconnect between what happened in services and what happened at Jenner House, trust headquarters. The executive team were very much aware of this and one of their objectives was to address, what they called, 'the Jenner House effect' and create a culture of belonging and staff feeling part of the solution. Staff did recognise that the culture was changing and that there was more proactive leadership and a real focus on quality and delivering the best care possible to patients. They recognised that many plans had either just been developed or were in the early stage of implementation but they were optimistic about the future.
- The trust had a well-established joint negotiation and consultation committee, which met bi-monthly with locally recognised union representatives. A range of staff issues were discussed and formally recorded. We met with two representatives of this group whom spoke positively of the professional relationship with senior management.

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Fit and Proper Person Requirement

- The trust had developed a number of documents to support it to meet the requirements of the fit and proper person regulation including the fit and proper director's policy, fit & proper director's process overview, fit and proper person's requirement checks procedure, fit and proper person's information retention procedure, procedure for responding to concerns regarding fit and proper status of directors.
- We reviewed the personal files of all the executive and non-executive directors' files and found that they generally had all the required documentary evidence to demonstrate the trust had met the requirements of the regulation. However, apart from the directors with a clinical background the trust had failed to update the disclosure and barring checks. When we informed the trust of this it accepted that this was an oversight on its part and took immediate action to apply for disclosure and baring checks. We returned to the trust a number of days later and found that the trust had submitted all the relevant applications; some of which had been returned and were found to be in order. The trust immediately instigated a system to ensure it would be alerted when relevant checks were required in the future.

Engaging with the public and with people who use services

- The trust was committed to further strengthening its engagement and involvement of patients and the public in developing its services. Over the last year it has been working with patients and local involvement coordinators to develop a new strategy for service user and carer involvement. Publication of this was due at the time of the inspection. The group was made up of carers and third sector partner organisations whose role was to monitor and inform the work. The group met every six weeks and was led by the director of nursing. However, we were told that the director of nursing rarely attended, although staff from his team did. This ensured that issues raised were taken forward to the triumvirates or the board with decisions then fed back to group members.
- Locally, the trust had invested in developing involvement coordinators who recruit patients and carers locally to ensure representation at trust level and also to be involved in a range of activities such as recruiting staff and evaluating services.
- In 2014 the trust became a member of the Triangle of Care national scheme. Initially the inpatient, intensive and rehabilitation services made self-assessments

against the six standards in the Triangle of Care which were submitted for national scrutiny. As a result the trust was awarded one star. By May 2015 all the community teams had completed their self-assessments for phase two and gained a second star. Participation in the scheme demonstrates a commitment to working in partnership with family, friends and carers of people using services.

Quality improvement, innovation and sustainability

- The trust had participated in a number of applicable Royal College of Psychiatrists' quality improvement programmes or alternative accreditation schemes including the accreditation schemes for ECT, inpatient wards, home treatment, memory services and the quality networks for forensic mental health services, eating disorder services and perinatal services.
- The trust was committed to participation in research and viewed it as a core activity. It benefited from a nationally well respected research and development department. It had developed good collaborations with three local universities (Bristol, University of West of England and Bath and is recognised as one of the national centres into research prevention. In addition, the trust, with its academic partners, other NHS trusts in the area and local authorities established Bristol Health Partners with the aim of generating significant health gain and improvements in services by integrating and developing research, innovation, education and service delivery. The trust had a research and development strategy and plan and had an 'everyone involved' ethos in which it aims to involve as many patients as possible in research projects. During 2015/2016 the trust was involved in over 200 national studies.
- The trust had developed the 'BEST in Mental Health' clinical question and answering service. In 2015/16 it answered over 120 questions including a number submitted by NHS England national commissioners for secure services. Funding for the next year was being considered at the time of the inspection by local general practitioners (GPs) via the Avon Primary Care Research Collaborative.
- Staff throughout the trust were committed to continuous improvement with many involved in a wide variety of local initiatives such as the confidentiality conference in Bath which had third sector involvement and looked at information sharing from carer's perspectives as well as patients. On Alder ward (rehabilitation) staff identified from patient's feedback that they would like access to more musical instruments and bicycles for patient use. Staff and patients worked together to gain funding to purchase musical instruments and bikes.
- In addition, staff were actively encouraged to publish papers describing their achievements and innovations. For example, at the Victoria Centre in Swindon, the consultant had recently published a paper on the management of aggression in patients experiencing dementia and that staff were encourage to publish two to four papers every year.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Acute and Psychiatric Intensive Care Unit** To ensure that patients using the service are treated with respect and dignity at all times while they are receiving care and treatment. Elizabeth Casson, Oakwood, Lime and Hazel Unit all had seclusion rooms that did not allow free access to toilet facilities. This was a breach of Regulation 10: 1 and 2 (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **Long stay/rehabilitation mental health wards for adults of working age** Ensuring the privacy of the service user: People using services should not have to share sleeping accommodation with others of the opposite sex, and should have access to segregated bathroom and toilet facilities without passing through opposite sex areas to reach their own facilities. The provider must ensure it meets the requirements of the same sex accommodation guidelines. Regulation 10 (2)(a) **Older people's inpatient wards**

This section is primarily information for the provider

Requirement notices

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 10 HSCA (Regulated Activities) Regulations 2014 Safe care and treatment. Patient's privacy and dignity was not protected in all wards. In Amblescroft north and south and in Liddington and Hodson wards patients' bedroom windows did not have privacy film fitted. This enabled other patients and visitors to see into these rooms from car park and garden areas. Patients on Ward 4 slept in single sex dormitories with only a curtain to provide privacy. Female patients on Amblescroft north could see into the bedroom of a male patient through locked dividing doors between corridors. This is a breach of regulation 10 (2)(a).
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Acute and Psychiatric Intensive Care Unit** To prevent patients from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. Silver Birch ward had to access seclusion facilities off the ward. Patients would be taken under restraint into the hospital grounds and to another ward to access seclusion facilities. This was a breach of Regulation 12: 1 and 2 (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12.

This section is primarily information for the provider

Requirement notices

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12: Safe Care and Treatment

To prevent patients from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.

All wards were not adhering to best practice in line with national and local guidance with regards to a rapid tranquilisation event. This was a breach of Regulation 12: 1 and 2 (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12: Safe Care and Treatment.

The trust must have effective governance, including assurance and auditing systems or processes. These must assess, monitor and drive improvement in the quality and safety of the services provided. The systems and processes must also assess, monitor and mitigate any risks relating the health, safety and welfare of patients using services.

All wards had failed to identify areas or items that could be used as ligatures. This was a breach of Regulation 17 1 and 2 (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12.

Older peoples in patient wards

Regulation 12 HSCA (Regulated Activities) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Long stay/rehabilitation wards** Regulation 13 HSCA (RA) Regulations 2014 Staff were not doing all that is reasonably practicable to mitigate risks to both themselves and patients. They did not follow risk assessments related to care plans this placed patients and staff members at risk of harm. The service transferred patients to other wards when patients required seclusion facilities. This compromised patients' safety Patients were not protected as records on wards did not always give clear information as to when a patient's seclusion commenced and who authorised it. Paperwork also did not indicate who had made the decision to end the seclusion. This is a breach of regulation 12 (2) (b). **Community services for adults of working age** Regulation 12 HSCA (Regulated Activities) Regulations 2014 Safe care and treatment The Trust must have a system in place for monitoring uncollected medication from the community team bases.

This section is primarily information for the provider

Requirement notices

Safeguarding service users from abuse and improper treatment

Providers and staff should regularly monitor and review their approach to, and use of, restrictive practices.

Regulation 13(4)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Older People in-patient wards** Patients could not be assured that when they raised an alarm staff members would respond promptly. In Amblescroft south there were had ineffective and intrusive alarms for nursing staff. In Ward 4 there were no nurse call bells in any of the communal areas, patient bedrooms or bathrooms. Cove and Dune ward had not completed a ligature risk assessment since June 2014. In some wards the design and decoration of the ward did not support a therapeutic environment This is a breach of regulation 15 1 (c).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Community services for people with learning disabilities and autism

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17

Ensure that the intensive support team has an effective procedure in place to ensure staff have all available risk information prior to visiting patients.

Information was not stored in a manner that ensured the team had all necessarily information prior to visiting.

Regulation 17: 2(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Older people's inpatient wards

Regulation 17 (1) (2) (a)(b)

HSCA (RA) Regulations 2014

Good Governance.

Patients who were detained under the Mental Health Act were not protected as there were no effective governance arrangements to monitor and review the way the functions of the Act were exercised.

In Cove ward a staff member documented in handover notes that a patient should be detained under Section 5 (4) of the Mental Health Act if they tried to abscond. An informal patient had tried to abscond over the wall of the ward garden as they were not clear about their right to leave the ward.

This section is primarily information for the provider

Requirement notices

Two patients that required Section 58 documentation did not have documentation completed by a Second Opinion Approved Doctor.

The paperwork for a patient detained under the Mental Health Act 1983 had not been sent to the local administrator for 6 days as staff understood the patient to be informal.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Older people's inpatient wards** Regulation 18 (1) (2) (a)HSCA (Regulated Activities) Regulations 2014 Staffing The staff teams did not contain sufficient numbers of qualified, competent, skilled and experienced staff to meet the patients' care and treatment needs. In Hodson and Liddington wards there was no psychology support for the ward. Staff members did not receive sufficient training to enable them to carry out their duties. All staff members had not completed the physical emergency response training or practical patient handling training that would assist them in the safe care pf patients. Managers completed incident investigations without training in root cause analysis. All staff members working with patients with dementia had not completed specialist training This is a breach of regulation 18 (1) (2) (a)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 (1) (2) (a)HSCA (Regulated Activities) Regulations 2014 Staffing
	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Older People in-patient wards** Regulation 15 1 (c)HSCA (Regulated Activities) Regulations 2014 Premises and equipment Patients could not be assured that when they raised an alarm staff members would respond promptly. In Amblescroft south there were had ineffective and intrusive alarms for nursing staff. In Ward 4 there were no nurse call bells in any of the communal areas, patient bedrooms or bathrooms. Cove and Dune ward had not completed a ligature risk assessment since June 2014. In some wards the design and decoration of the ward did not support a therapeutic environment This is a breach of regulation 15 1 (c).

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Section 29A HSCA Warning notice: quality of health care **Mental Health Crisis Services and health-based places of safety** We served a warning notice under Section 29A of the Health and Social Care Act 2008 The trust has failed to ensure that systems and processes are operated effectively to: · monitor and improve the quality and safety of services and · assess, monitor and mitigate risks relating to the quality and safety of service users and others · provide care and treatment in a safe way for service users In all health based places of safety within the trust.