Avon and Wiltshire Mental Health Partnership NHS Trust

Quality Report

Jenner House
Langley Park Estate
Chippenham
SN15 1GG
Tel: 01249 468000
Website: www.awp.nhs.net

Date of inspection visit: 10-13 June 2014
Date of publication: September 2014

Core services inspected	CQC registered location	CQC location ID
Acute Wards	Callington Road Hospital	RVN4A
	Fountain Way	RVN9A
	Green Lane Hospital	RVN6A
	Hillview Lodge	RVN2A
	Longfox Unit	RVN4B
	Sandalwood Court	RVN8A
	Southmead AWP	RVN3N
Rehabilitation	Brentry Site	RVNEB
	Callington Road Hospital	RVN4A
	Elmham Way	RVN4M
	Sandalwood Court	RVN8A
	Whittucks Road	RVN5J
PICU	Callington Road Hospital	RVN4A
	Fountain Way	RVN9A
Section 136 Place of Safety	Fountain Way	RVN9A
	Green Lane Hospital	RVN6A
	Sandalwood Court	RVN8A
	Southmead AWP	RVN3N
Services for Older People – Wards and Community Services	Callington Road Hospital	RVN4A
	Fountain Way	RVN9A
	Longfox Unit	RVN4B
	St Martin's Hospital	RVN2B
	Victoria Centre, Swindon	RVNCE
	Trust Headquarters	RVN1H

Summary of findings

Community-Based Crisis Services	Trust Headquarters	RVN1H
Adult Community-Based Services	Trust Headquarters	RVN1H
Forensic Services	Blackberry Hill Hospital	RVN3Q
	Trust Headquarters	RVN1H
Specialist Services	Blackberry Hill Hospital	RVN3Q
	Callington Road Hospital	RVN4A
	Green Lane Hospital	RVN6A
	Southmead AWP	RVN3N
	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 mental health services at this provider

Are mental health services safe?	
Are mental health services caring?	
Are mental health services effective?	
Are mental health services responsive?	
Are mental health services well-led?	

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We found that there are some areas of improvement needed to ensure the delivery of a safe, effective and responsive service.

While the board and senior management had a clear vision with strategic objectives, and a clearer management structure had been put in place, staff did not feel fully engaged in the improvement agenda of the trust.

The trust told us that executives and board members had been involved in a number of initiatives to engage with staff and give staff the opportunity to talk directly about issues that affect them. However, staff told us that leadership from above ward level was not visible or accessible to all staff.

We found that while performance improvement tools and governance structures had been put in place, these had not always facilitated effective learning or brought about improvement to practices.

We found that both staff and patients knew how to make a complaint and most were positive about the response they received. There had been a number of positive initiatives to engage service users, carers, and wider stakeholders in the development of the trust. However throughout this inspection we heard from service users, carers and local user groups who felt that they had not been effectively engaged by the trust in planning and improvement processes.

We had a number of concerns about the safety of this trust. These included unsafe environments that did not promote the dignity of patients; insufficient staffing levels to safely meet patient's needs; inadequate arrangements for medication management; and safety and fire equipment that was not fit for purpose.

We were also concerned that while the trust had systems in place to report incidents, improvement was needed to ensure that all incidents were reported, investigated and learnt from, and that changes to practice were made as a result. We found a number of concerning incidents across the trust that had not resulted in learning or action.

Some staff had not received their mandatory training and many staff had not received regular supervision and appraisal. However overall we saw good multidisciplinary working and generally people's needs, including physical health needs, were assessed and care and treatment was planned to meet them.

Most teams were using evidence based models of treatment and made reference to National Institute for Health and Care Excellence (NICE) or other relevant national guidelines. However, we found incidents of restraint and seclusion that had not been safeguarded in line with the guidance of the Mental Health Act Code of Practice.

A lack of availability of beds was a trust-wide issue, with intensive, acute and older people's beds always in demand. This meant that people did not always receive the right care at the right time and sometimes people may have been moved, discharged early or managed within an inappropriate service.

We found that generally there was evidence of different groups working together effectively to ensure that patients' needs continued to be met when they moved between services. Overall, we saw that staff were kind, caring and responsive to people and were skilled in the delivery of care. We observed some very positive examples of staff providing emotional support to people, despite the challenges of staffing levels and some poor ward environments.

It is our view that the trust needs to take significant steps to improve the quality of their services and we find that they are currently in breach of regulations.

Throughout and immediately following our inspection we raised our concerns with the trust. The trust senior management team informed us of a number of immediate actions they had taken to address our concerns.

We have given the trust some Enforcement Actions which gives a strict timescale for them to improve. We will be working with them to agree an action plan to assist them in improving 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?

The trust had systems in place to report incidents. However improvement is needed to ensure that all incidents are reported, investigated and learnt from, and that changes to practice are made as a result. We found a number of incidents across the trust that had not resulted in learning or action.

We were concerned that staffing levels were not sufficient or safe at a number of inpatient wards across the trust.

The trust had policies and processes in place to report and investigate any safeguarding or whistleblowing concerns. However we found that at the time of our inspection 25% of staff had not undertaken required basic safeguarding training. However 85% of required staff grades had undertaken more advanced training. Most staff told us that they were able to raise any concerns that they had but not all were clear that any improvement would occur as a result of their concern.

We found a number of environmental safety concerns across the trust. We found potential ligature points, particularly in bedroom and bathroom areas, in a number of units where people with self-harm issues may be treated. We also found poor design at some services that did not facilitate the necessary observation of patients.

At some units we found that there was not appropriate single sex accommodation in adherence to guidance from the Department of Health and the MHA Code of Practice. At additional wards we had concerns due to unclear arrangements to protect patient's dignity and safety.

We were concerned to find fire safety and lifesaving equipment was missing or not fit for purpose at some units. We raised these concerns at the time of the inspection with the management team who took immediate remedial action.

Arrangements were not adequate for the safe and effective administration, management and storage of medication across the trust.

We found incidents of restraint and seclusion that had not been safeguarded in line with the Mental Health Act Code of Practice.

Are services effective?

People's needs, including physical health needs, were assessed and care and treatment was planned to meet them. Overall we saw good

Summary of findings

multidisciplinary working. However, not all care plans and risk assessment were in place or updated were people's needs changed. People's involvement in their care plans also varied across the services.

In the services we inspected, most teams were using evidence based models of treatment and made reference to National Institute for Health and Care Excellence (NICE) or other relevant national guidelines. The trust had implemented a quality information system (IQ) to assess services against key indicators. The trust also used a number of different outcome measures to benchmark services' effectiveness.

The trust had also participated in a wide range of audit and research and had attained accreditation for a number of services.

We found that staffing levels were not always sufficient to meet the needs of patients and meant that activities, leave and other tasks were not always delivered.

Staff had not all received their mandatory training and the majority told us they had been unable to access more specialist training. Some staff had not received regular supervision and appraisal.

We found that the environment and equipment in a number of units did not reflect good practice guidance and had an impact on people's safety, dignity or treatment.

Systems were in place to ensure that the service complied with the Mental Health Act (MHA) and adhered to the guiding principles of the MHA Code of Practice. However, we found that staff did not always recognise and manage people's restraint or seclusion within the safeguards set out in the MHA Code of Practice.

Are services caring?

Overall, we saw that staff were kind, caring and responsive to people and were skilled in the delivery of care. We observed some very positive examples of staff providing emotional support to people.

We observed staff treating patients with respect and communicating effectively with them. Staff showed us that they wanted to provide high quality care, despite the challenges of staffing levels and some poor ward environments.

People we spoke with were mainly positive about the staff and felt they made a positive impact on their experience on the ward. However, some people were concerned at the lack of time staff had to spend with them.

Summary of findings

Most people we spoke with told us they were involved in decisions about their care and treatment and that they and their relatives received the support that they needed. We found a range of information available for service users regarding their care and treatment.

However we found a numbers of concerns across the trust where people's privacy and dignity had not been maintained.

People spoke about the impact that bed pressures had on their care meaning that beds were often provided away from people's home area, meaning people found it difficult to maintain the support of loved ones.

Are services responsive to people's needs?

The trust told us that they had developed strong relationships with local communities, the people who use the services, NHS commissioners, GP Commissioners, other health providers and local authorities over the last year. The trust hoped to build on these relationships to help develop open and honest conversations about how they can deliver a better quality of care.

The trust told us about many initiatives to involve stakeholders in the planning of the service and we heard of good examples of engagement. However some service users, carers and local user groups felt that they had not been effectively engaged by the trust in the planning of services.

We found that generally there was evidence of different groups working together effectively to ensure that patients' needs continued to be met when they moved between services.

The availability of beds appeared to be a trust-wide issue, with intensive, acute and older people's beds always in demand. Staff worked with other services in the trust to make arrangements to transfer or discharge patients. However, a lack of available beds meant that occasionally people may have been moved, discharged early or managed within an inappropriate service.

We also found that bed availability had an impact on people being treated within their local area. Some people told us that they had been moved during their care, which had an impact on their recovery.At a number of units we also found that there was not appropriate single sex accommodation in adherence to guidance from the Department of Health and the MHA Code of Practice, to protect the privacy and dignity of patients.

We found that both staff and patients knew how to make a complaint and many were positive about the response they received.

Summary of findings

Are services well-led?

The senior management told us that there had been a change in the most senior leadership of the trust, and the trust had restructured the management and governance arrangements and embarked on a programme of service improvement. We found that the board and senior management had a clear vision with strategic objectives, and there was a clear management and governance structure in place.

The trust told us that executives and board members had been involved in a number of initiatives to engage with staff and give staff the opportunity to talk directly to board members about issues that affect them.

Staff we spoke with were aware of their roles and responsibilities but staff knowledge of the trust's values and objectives varied. Most staff felt supported by the managers at ward level, and they also valued the support of their team. However leadership from above ward level was not visible or accessible to all staff.

There had also been a number of positive initiatives to engage service users, carers and wider stakeholders in the development of the trust. However throughout this inspection we heard from service users, carers and local user groups who felt that they had not been effectively engaged by the trust in planning and improvement processes.

There is a trust-wide information system called IQ. This measures compliance with key indicators such as the service user experience, quality and safety information, records management and supervision rates. The information is used throughout the governance structure to indicate performance improvement and is accessible to all staff.

However, we are concerned that despite the development of governance and performance improvement systems our findings indicate that that there is room for improvement in the trust to ensure that lessons are learned from quality and safety information and imbedded in to practice.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Professor Chris Thompson, Consultant Psychiatrist

Team Leaders: Julie Meikle, Head of Inspection

Lyn Critchley, Inspection Manager

The team of 70 people included CQC managers, inspection managers, inspectors and support staff, and a variety of specialists including: consultant psychiatrists, specialist registrars, psychologists, registered nurses, occupational therapists, social workers, Mental Health Act reviewers, advocates, governance specialists and Experts by Experience.

Why we carried out this inspection

We inspected this trust as part of our comprehensive Wave 2 pilot mental health inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, 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?

The inspection team always looks at the following core services at each inspection:

- Acute admission wards
- Health-based places of safety
- Psychiatric Intensive Care Units
- Services for older people
- Adult community-based services
- Community-based crisis services
- Forensic service
- Specialist services

We initially visited the mental health services of Avon and Wiltshire Mental Health Partnership NHS Trust between 10 and 13 June 2014. Before visiting, we reviewed a range of information we held about the provider and asked other organisations to share what they knew.

Before our inspection, we also met with ten different groups of people who use the services, or care for someone who uses the service, provided by the trust across Bristol, South Gloucestershire, Swindon, Wiltshire and North East Somerset.

We also carried out unannounced visits between 24 and 26 June 2014.

We visited all of the trust's hospital locations and sampled a number of community mental health services. We inspected 39 wards across the trust including 14 adult acute and rehabilitation services, three psychiatric intensive care units (PICUs), ten secure wards, nine older people's wards, and specialist wards for eating disorders, mother's with babies and drug and alcohol. We looked at four places of safety under section 136 of the Mental Health Act and the two electroconvulsive therapy (ECT) suites based at the trust. We inspected 27 community services including all of the trust's intensive services, four recovery teams, three early intervention teams, seven older people' complex intervention teams and the psychiatric liaison service based at the Great Western Hospital in Swindon. We also inspected specialist teams for people with forensic needs, people with ASD, people with ADHD and people with additional deafness needs.

During our visit, the team:

- Talked with patients, carers, family members and staff.

Summary of findings

- Held focus groups with different staff members such as nurses, healthcare assistants, senior and junior doctors, allied health professionals and non-executive directors.
- Interviewed board members and the executive team
- Met with the management teams for all business units at the trust.
- Looked at the personal care or treatment records of a sample of patients.
- Observed how staff were caring for people.
- Interviewed staff members.

- Reviewed information we had asked the trust to provide.
- Attended multidisciplinary team meetings.
- Attended home treatment and assessment visits.
- Collected feedback using comment cards and telephone interviews.

The team would like to thank all those who met and spoke with us during the inspection and were open and balanced about their experiences and their perceptions of the quality of care and treatment at the trust.

Information about the provider

Avon and Wiltshire Mental Health Partnership NHS Trust provides services for adults with mental health needs and those whose needs relate to drug or alcohol dependency across Bristol, Wiltshire, Swindon, South Gloucestershire, North Somerset, and Bath and North East Somerset. They also provide secure mental health services across South West England and work with the criminal justice system. A number of specialist services are delivered including an eating disorder service, a mother and baby unit and assessment services for people with ADHD, autism and hearing difficulties. There is also a small diagnostic service that provides assessment for children and adolescents in partnership with other local providers.

The trust has a total of 15 locations registered with CQC. The trust operates from 124 buildings, including 23 inpatient buildings, six community houses and 71 community service locations.

In 2012/13, the trust staff saw 36,659 individuals from over 36,852 referrals and admitted 2,225 people into inpatient units. Community teams had more than 445,000 contacts with service users.

The trust employs 4,490 staff including nursing, medical, psychology, occupational therapy, social care, administrative and management staff. It had a revenue income of £186 million for the period of April 2013 to March 2014.

The catchment area of the trust is highly diverse. There is a large urban area around Bristol, some small towns such as Swindon and Devizes, as well as traditional rural communities across Wiltshire and Somerset. Similarly deprivation levels vary across the area from highly

deprived areas such as Bristol and parts of Swindon to extremely affluent areas such as South Gloucestershire, Bath and rural Wiltshire. Ethnicity rates also vary from 16% of the population in Bristol being from non-white backgrounds to just 3% of people in Wiltshire.

Following recent reorganisation the trust operates in eight separate geographically or speciality based business units serving:

- Bristol
- Wiltshire
- Swindon
- South Gloucestershire
- Bath & North East Somerset (BaNES)
- North Somerset
- Forensic services
- Specialist services

Avon and Wiltshire Mental Health Partnership NHS Trust has been inspected 28 times since registration in April 2010. At the time of our visit there were a number of compliance actions in place from the findings of our previous inspections. These were:

- Hillview Lodge – we had last visited this location in November 2013 and it was found to be non-compliant in five areas. These were: respecting and involving people who use services, meeting nutritional needs, safety and suitability of premises, staffing and records.
- Callington Road - we had last visited this location in February 2014 and it was found to be non-compliant in two areas. These were: assessing and monitoring the quality of service provision and records.

Summary of findings

- Fromeside, the medium secure unit at Blackberry Hill Hospital, was inspected in January 2012 when we took enforcement action on the provider's failure to ensure suitable staffing. Following this we found in March 2013 that the provider had taken steps to respond to this positively. In October 2013 we issued compliance actions for unsuitable premises and records. We followed up all of these issues at this inspection.
- Victoria Centre - we had last visited this location in September 2013 and it was found to be non-compliant in relation to staffing levels.

- Trust-wide community services – we reviewed recovery services in June 2012 and again in May 2013 and had a number of concerns. We returned in May 2013 when we saw some improvements regarding previously highlighted issues however we also found further areas of non-compliance. In February 2014 we re-visited and made compliance actions in relation to staffing and care and welfare of service users.

During this inspection we reviewed all of these areas of previous non-compliance.

What people who use the provider's services say

The Care Quality Commission community mental health survey 2013 was sent to people who received community mental health services from the trust to find out about their experiences of care and treatment. Those who were eligible for the survey were people receiving community care or treatment between 1 July 2013 and 30 September 2013. There were a total of 226 responses, which was a response rate of 28%. Overall, the trust was performing about the same as other trusts across most areas. However respondents stated that the trust was performing worse than other trusts overall in relation to crisis care. This specifically related to questions about whether or not the respondent got the help they wanted the last time they called their local mental health service out of hours phone number.

A review of people's comments placed on the 'patient opinion' and 'NHS choices' websites was conducted ahead of the inspection. 38 comments were noted of which 68% were partly of wholly negative. Issues raised were about response in a crisis, staff attitude, and the environment at some units.

The trust launched the Friends and Family Test in April 2013. The Friends and Family Test seeks to find out whether people who have used the service would recommend their care to friends and family. At June 2014 almost 6000 responses had been received. The latest results show some improvement and that overall 89% of respondents were likely or extremely likely to recommend the trust's community services to friends and family if they needed similar care or treatment. 75% of respondents were likely to recommend the inpatient services.

Prior to the inspection we met with services users and their carers across the trust. This included three focus groups facilitated by an independent user led local organisation and attendance at seven user and carer groups linked to the trust. During these sessions we heard both positive and negative comments about the trust services. Generally people stated that staff were caring however a number of people stated that access to services, particularly in a crisis, was difficult. People told us of a shortage of beds and that people were often sent a long way from home if they needed inpatient care.

During our inspection we received 71 comment cards completed by service users or carers. We also received a large number of phone calls and emails directly to CQC from service users, carers and voluntary agencies supporting service users. Throughout the inspection we spoke with a large number of people using inpatient services and some people in receipt of community treatment.

People who use adult inpatient services generally felt safe and supported. However at some units people told us that staff shortages meant that they did not always feel safe and could impinge on the availability of activities and access to leave. Some patients within the psychiatric intensive care units praised the staff for managing some very difficult situations. People also told us that access to inpatient care close to home was not always possible, with people receiving care from out of area services. People told us they found it difficult when they were out of the area as they had limited access to family and friends.

Summary of findings

Within the forensic service some patients told us they were sometimes concerned about the low numbers of staff, as they felt it put both patients and staff at risk. We were also told that the staffing levels had been improved before the inspection and since patients had been able to go out on leave more. We were told that the occupational therapy service was good. Patients on one ward said they did not always feel safe. Other patients commented that the frequency of alarms going off caused them to feel anxious.

In general, people were positive about the later life services provided by this trust. Generally people told us that staff were very kind and supportive, and that they were treated with respect. People were usually informed about their care and treatment and some told us that staff were good at explaining things to them. Usually people received a copy of their care plan and a list of emergency contact numbers if needed. Carers also told us that they felt well supported by the service and found that staff were responsive and kind. However a number of carers told us that while the Bath and North East Somerset (BaNES) complex intervention team was very good, the service their loved one had received was stopped suddenly and alternative arrangements had not been put in place.

All of the people we spoke with in specialist services were positive about the services provided by these teams. They told us that they felt involved in their care and treatment at all stages. They also said that the services they received were safe and effective, staff were caring, and communicated well with them.

Most people using the community teams were positive about the service provided. Some people told us that staff had been very kind and supportive and that they

had been treated with respect. However, other people were concerned about access to services and the lack of continuity between the different care co-ordinators who were supporting them.

Although most people who had used intensive services were positive about their contacts with staff, some people told us they received an inconsistent and not always caring response. Some people also said that they could not always speak with someone when they needed to outside of office hours. They said that calls were not always returned, or may only be returned several hours after they had initially made contact. Some people said that they found it difficult seeing a number of different staff. They also said that support for transitioning back to their care co-ordinator or primary care services was poor. Some carers were frustrated about not always being listened to and having to go over things a number of times, even if the person was well known to local mental health services and had used the intensive service before.

Following the inspection we were provided with the results of a questionnaire undertaken by a local service user group in Swindon with the assistance of the local Healthwatch. 56 people had completed the survey. Of these the majority had made recent contact with the intensive service. People who completed the survey were generally unhappy with the level of care they received in Swindon, particularly with the standard of care, support and access to the intensive service. We asked the trust to provide us with detailed information about user and carer engagement in this locality. We were supplied with information indicating that a number of initiatives had been put in place to gain the views of people who use the services, including an open forum attended by the management team and a carer forum.

Good practice

Forensic and secure services:

- We found a good service being delivered on Teign Ward – the women's service. Staff worked within an integrated multi-disciplinary team with shared goals of improving people's health and wellbeing. Nursing staff

were supported by the psychology team to work within an 'attachment model' and could engage in training and reflective practice to implement this model effectively.

Section 136 place of safety:

- There was a two hour target to complete assessments of young people at Mason place of safety service in Bristol. This target was being met both in the day and

Summary of findings

out of hours. Young people under the age of 18 years old were nursed automatically on 1:1 observations and had a separate part of the unit to access if required.

Services for older people:

- We found that the later life mental health liaison service for Bristol and South Gloucestershire was a good example of an innovative and effective service. This was provided in collaboration with other key stakeholders and delivered a bespoke service to address the mental health needs of older people in the local NHS acute hospitals.

Community-based crisis services:

- The South Gloucestershire intensive team had an excellent, comprehensive handover tool to support their daily discussions around care, treatment and risk management plans. This was displayed on a whiteboard and updated by the allocated shift co-ordinator throughout the day. It contained clear information about the team caseload, including obtaining consent, care plans and when this was shared with the person. It also incorporated a 'traffic light' risk rating system.
- We found that the Bristol intensive service was introducing the crisis team optimisation and relapse prevent (CORE) project. This was an innovative project that involved peer support workers and included a personal recovery book. There were clear guidelines in place for evaluating this project.

- We found that the Bristol intensive service had employed a recovery co-ordinator as a carers' champion. This had significantly improved carers' involvement in the care and treatment of their relative.
- A trust-wide intensive support service good practice network had recently been established to share national policy developments, address local priorities and share good practice.

Adult community-based services:

- We found that the Swindon psychiatric liaison service was working well with the local acute NHS hospital trust to manage individuals' distress. It was also working together with the local suicide prevention project.
- We found evidence that demonstrated that the trust was reaching out effectively to 'hard to reach' groups, for example black and minority and ethnic (BME) and homeless groups.

Specialist services:

- The manager of the ADHD team described how the team had responded to a large waiting list for assessments, which had been in excess of 18 months. They had refocused the team's priorities and created a substantial amount of new assessment appointments. The current waiting time for an appointment was just over eight weeks.
- The STEPS eating disorder unit manager has been instrumental in developing and publishing research into this area on a national scale.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the trust MUST take to improve

- The trust must ensure that ligature and environmental risks are addressed and that effective risk management is in place until they can be removed.
- The trust must ensure that there are sufficient staff to safely meet the needs of patients.
- The trust must ensure there are sufficient numbers of skilled and experienced staff to support newly qualified nurses.

- The trust must ensure that all staff have completed relevant mandatory training including safeguarding, management of aggression and life support.
- The trust should ensure that staff have received training in how to use assessment tools.
- The trust must ensure that all staff receive supervision and appraisal.
- The trust must ensure that all incidents are reported, investigated or learnt from and that learning from incidents is shared with staff at ward level and embedded in ward practices.

Summary of findings

- The trust must ensure that individual patient risk assessments are reviewed and updated following changes in people's needs and risks.
- The trust must ensure that all wards meet Department of Health guidance on mixed sex accommodation.
- The trust must ensure that the privacy and dignity of people using the service is fully protected.
- The trust must ensure that the medication management and administration procedures are safe and effective and that checks are undertaken to ensure the integrity of medication.
- The trust must ensure that seclusion is recognised and managed within the safeguards set out in the Mental Health Act Code of Practice.
- The trust must ensure that there is no restrictive practice leading to a deprivation of liberty.
- The trust must ensure that emergency lifesaving equipment is readily available and fit for purpose.
- The trust must ensure that there are clear procedures for managing fire safety and that equipment is readily available.
- The trust must ensure that people's physical health needs and monitored and any concerns are managed appropriately.
- The trust must ensure that care and care planning is person-centred.
- The trust must ensure that discharge arrangements are clear and effective.
- The trust must ensure that patients' views are sought and included in decisions about the environment and service delivery.

Forensic and secure services:

- The trust must ensure that the carpet in the bedroom corridor at Bradley Brook is replaced and that all flooring is appropriate and clean.

Summary of findings

Psychiatric intensive care units and health-based places of safety

- The trust must improve medical cover for the PICUs in Bristol.

Community and crisis services

- The trust must ensure that care and treatment plans for people receiving care and treatment under community treatment orders are reviewed.

Action the trust SHOULD take to improve

- The trust should ensure leadership is improved and that there is effective communication between the 'triumvirate', senior managers and staff at ward level.
- The trust should provide better access to training for staff.

Summary of findings

Specialist services:

- The trust should reduce the waiting list for people to access the BASS service.

Psychiatric intensive care units and health-based places of safety:

- The trust should improve recording by nurses of patients in seclusion to include physical observations.
- The trust should ensure the section 136 protocol is consistent and meets the MHA Code of Practice.

Community-based crisis services:

- The trust should ensure that access to intensive support services outside of office hours is consistent.
- The trust should work with commissioners to ensure that there are enough inpatient beds that can be accessed quickly, or that there are alternatives to hospital admission available.
- The trust should ensure that there patient outcome measures are reviewed consistently.

Avon and Wiltshire Mental Health Partnership NHS Trust

Detailed findings

Are services safe?

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

Summary of findings

The trust had systems in place to report incidents. However improvement is needed to ensure that all incidents are reported, investigated and learnt from, and that changes to practice are made as a result. We found a number of incidents across the trust that had not resulted in learning or action.

We were concerned that staffing levels were not sufficient or safe at a number of inpatient wards across the trust.

The trust had policies and processes in place to report and investigate any safeguarding or whistleblowing concerns. However we found that at the time of our inspection 25% of staff had not undertaken required basic safeguarding training. However 85% of required staff grades had undertaken more advanced training. Most staff told us that they were able to raise any concerns that they had but not all were clear that any improvement would occur as a result of their concern.

We found a number of environmental safety concerns across the trust. We found potential ligature points, particularly in bedroom and bathroom areas, in a number of units where people with self-harm issues may be treated. We also found poor design at some services that did not facilitate the necessary observation of patients.

At some units we found that there was not appropriate single sex accommodation in adherence to guidance from the Department of Health and the MHA Code of Practice. At additional wards we had concerns due to unclear arrangements to protect patient's dignity and safety.

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

Are services safe?

We were concerned to find fire safety and lifesaving equipment was missing or not fit for purpose at some units. We raised these concerns at the time of the inspection with the management team who took immediate remedial action.

Arrangements were not adequate for the safe and effective administration, management and storage of medication across the trust.

We found incidents of restraint and seclusion that had not been safeguarded in line with the Mental Health Act Code of Practice.

Our findings

Track record on safety

Prior to the inspection we reviewed all information available to us regarding the trust including information regarding incidents.

A serious incident known as a never event is where it is so serious that it should never happen. The trust had not reported any never events since April 2011. We did not find any incidents that should have been classified as never events during our inspection.

Since 2004, trusts have been encouraged to report all patient safety incidents to the National Reporting and Learning System (NRLS) and since 2010, it has been mandatory for them to report all death or severe harm incidents to the CQC via the NRLS. At a presentation ahead of the inspection the trust told us that they had worked hard to encourage incident reporting and that this had improved. There were 141 serious incidents reported by the trust between April 2013 and March 2014 which was within the expected range for a trust of this type and size. Overall, the trust had improved its reporting rates and been a good reporter of incidents during 2013/14 when compared to trusts of a similar size.

Arrangements for reporting safety incidents and allegations of abuse were in place. Staff we spoke with were able to describe their role in the reporting process and said that they were encouraged to report incidents and near misses. Most staff confirmed they had received mandatory safety training and most felt supported by their manager following any incidents or near misses. Some staff told us that the trust encouraged openness and transparency and

there was clear guidance on incident reporting. We saw that staff had access to an online electronic system to report and record incidents and near misses. Where serious incidents had happened we saw that investigations were usually carried out. Some teams confirmed clinical and other incidents were reviewed and monitored monthly and discussed by the management team and shared with front line staff. However, other staff told us that information following incidents was not always shared with them.

However we found a number of concerns regarding the management of incidents at the trust which meant incidents were recurring and risks remained unaddressed. At Juniper ward we found some incidents of self-harm that had not been reported and at Beechlydene we found that incidents had not always been reviewed in a timely manner. At other units incident reporting was not always sufficiently detailed. We found a number of occasions where there was no apparent learning or action taken as a result of incidents.

Between April 2013 and March 2014 there had been 17 serious incidents relating to slips, trips or falls at the trust. The NHS Safety Thermometer which is a method for surveying patient harm showed that during the same period the trust's rate of falls was above the national average and the actual rate of falls has climbed throughout the same period. The trust confirmed that work was underway to reduce the number of falls. An audit of falls was carried out annually at trust level and a falls working group was in place. Work had been started to look at the link between prescribing and falls. Some staff told us that the trust was now linking with the regional falls network as a means to address this issue.

Every six months the Ministry of Justice publishes a summary of Schedule 5 recommendations (previously rule 43) which had been made by coroners with the intention of learning lessons from the cause of death and preventing further deaths. In the latest report covering the period from October 2012 to March 2013 one concern regarding the trust was raised relating to the death of a patient at Fromeside. We looked at the investigation and learning the trust had taken in response to this death and found that not all learning from this had been acted upon.

Learning from incidents and Improving safety standards

The trust has a governance system in place to review and improve safety standards. Safety information is overseen by

Are services safe?

the monthly quality and standards committee and on a quarterly basis the integrated quality and safety plan is reviewed by the board. The trust also has a critical incident overview group who take the lead responsibility for overseeing the investigation and learning from any serious incidents at the trust.

The trust told us that improvements in quality and safety were their highest priority. The trust had implemented a quality information system (IQ) in April 2014. We were told that the approach was developed to act as an early warning system for identifying risks to the quality of services and highlight areas where improvements were needed. The trust had also began 'quality huddles' were clinical directors and senior managers meet to review the IQ data enabling real time identification and resolution of safety and quality issues. Data provided by the trust indicated that there had been an overall improvement in safety and outcome measures since this was implemented.

Throughout the inspection we reviewed incident information and looked at whether this had resulted in any learning. While we found some positive examples of learning and changes to practice at a local level we were concerned that some serious incidents had not led to positive learning and action, for example:

We reviewed the circumstances of four deaths that had occurred in acute and forensic inpatient units since April 2013. Each of these deaths had been due to hanging through the use of a ligature. While investigation had been undertaken following each of these incidents we were concerned that the findings of these investigations had not always highlighted the significance of the presence of ligature points or led to changes in the environment or practice either locally or across the trust services. In many inpatient units we found potential ligature points in patient bedrooms and bathrooms, we were particularly concerned to find these in the secure services and acute wards were there deaths had occurred.

There was a high level of falls at the trust which had resulted in injury. We were told that work was underway to look in to how falls may be reduced however we noted at Laurel, which is an older persons ward, there had been a very high incidence of falls compared to similar trusts. We heard about a number of initiatives to work with individuals at risk to prevent falls however we were told that no audit had been carried out at the ward level across all falls to identify trends and learning outcomes. When we

asked staff about this, they said that the flooring in the ward was very slippery and this was possibly contributing to the number of falls. We observed this floor to be slippery, in contrast to the adjacent ward where the floor was non-slip and there had been fewer falls.

While some learning had taken place at Callington Road Hospital following some incidents where patients had gone absent without leave (AWOL) this was not the case on Silver Birch ward where there had been three recent instances of patients going AWOL. Since the original incidents the height of the external fence had been increased but the design and layout of garden furniture still enabled patients to exit the garden area.

At Beechlydene staff told us that incidents kept recurring. Staff gave the example of a patient setting small fires in their bathroom. We looked at the incident reporting for this and found the forms lacked detail and the risk assessments had not been reviewed or additional safeguards put in place.

At Hillview Lodge staff told us about a recent incident where a patient had climbed a tree in the garden and climbed on to the roof. They told us that the tree had already been identified as both a ligature risk and a means of escape. We found that prompt action had not been taken to remove or cut back the tree to eliminate this risk.

On Bradley Brook there was a serious incident which resulted from a needle-phobic patient being given medication by injection rather than in tablet form as recommended by staff. This resulted in such a high level of aggression in the patient that the police had to be called and the patient was tasered. Had the patient need and concerns of staff been taken into account this incident may have been prevented.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

The trust policies and procedures were accessible via the trust's intranet site.

The trust had clear policies in place relating to safeguarding and whistleblowing procedures. Additional safeguarding guidance was available to staff via the trust's intranet. We found that while most staff knew about the relevant trust-wide policies relating to safeguarding and were able to describe situations that would constitute abuse, not all staff had received their mandatory safeguarding training.

Are services safe?

We found that emergency resuscitation and lifesaving, fire, lifting and safety equipment was not always readily available, maintained or fit for purpose at a number of locations.

Most services we visited were clean and well maintained however we found that the standard of cleanliness was not sufficient at Hillview Lodge and Bradley Brook unit at Fromeside secure service. On some units there were not clear arrangements for ensuring that there was single sex accommodation in adherence to guidance from the Department of Health and the MHA Code of Practice, to protect the safety of patients.

The use of restraint and seclusion were defined as reportable incidents at the trust and arrangements were in place to monitor such incidents. Incidents were recorded on a database and would be discussed and monitored at safety and risk meetings. A report had recently been submitted to the trust's quality and standards committee outlining the trust's response to the Department of Health's recently published 'Positive and Proactive Care: reducing the need for restrictive interventions'. It was noted that the trust had recently re-established an expert violence reduction group. Generally this practice was observed to be good however we found that restraint was being used at the Amblescroft unit, and seclusion at Hillview Lodge and Elizabeth Casson House, without being recognised as such, recorded or safeguarded as required under the Mental Health Act Code of Practice.

Assessing and monitoring safety and risk

In a presentation prior to the inspection, the trust highlighted the challenges and improvements they needed to make. Throughout our inspection, we identified both similar and additional concerns as those identified by the trust. The trust had risk registers in place held at different levels of the organisation which were reviewed at directorate meetings and the board. We reviewed the overarching risk register sent to us prior to the inspection and noted that while some of the concerns we found had been highlighted others, such as ligature and environmental risks, staffing levels and medication management issues, had not been flagged.

Regular health and safety checks of the environment were undertaken across the trust. The trust had a policy for the assessment of environmental ligature risks in inpatient settings. The policy required that ligature risk assessments must be reviewed annually, on significant change or after a

serious adverse event involving a ligature. The policy also required that daily inspections take place to check for any new ligature points, risks or any loss of safety controls. However in forensic, PICUs, adult acute and older peoples inpatient services we found a number of challenges within the ward environment, including potential ligature risks and poor design, which was affecting patients' safety and dignity. While these issues had been noted in the local assessments in some cases the risks had been considered as low grade risks and in other cases no specific action had been taken to mitigate the identified risk. We also noted that the environmental issues we found at Fromeside had been highlighted as a serious risk by the Quality Network for Forensic Mental Health Services review in September 2013.

A review had recently been undertaken of the staff establishment at the trust to ensure safe staffing levels were established. Since, the trust has published both the planned and actual staffing levels on their website. This indicated that during April and May 2014 there had been a number of times when actual staffing fell below the required level. Other data supplied by the trust for April 2014, stated that 23 incident forms were submitted where a clinical risk was identified as a result of staffing levels. Of these, 3 were assessed as a moderate clinical risk.

Processes were in place to request additional staff where required. However we found that while staffing levels in the community teams were generally acceptable, at a number of inpatient services staffing levels were not consistently maintained at optimum levels. In some units temporary bank and agency staff were regularly used to achieve the required levels of staff. However on some units we found that temporary staff were not used and staffing was insufficient; staff were unable to take breaks, worked additional hours or were unable to complete necessary tasks. We were particularly concerned about staffing levels at Fromeside, Elizabeth Casson Unit and Hillview Lodge. Patients told us of the impact this had on their care and treatment and that they did not always feel safe. Patients often told us that staff did their best but were under significant pressure. We also found that out of hours medical cover was insufficient in the Bristol and Weston Super Mare areas where on-call junior doctors were covering a large number of units and crisis services.

Are services safe?

Individual risk assessments were looked at across all the services we inspected. Generally these were in place and addressed people's risks however on acute wards we found that risk assessments were not always being completed for people going on leave or following incidents of concern.

Understanding and management of foreseeable risks

The trust had necessary emergency and service continuity plans in place and most staff we spoke with were aware of the trust's emergency and contingency procedures. Staff told us that they knew what to do in an emergency within their specific service. However we found that lifesaving and fire equipment was not always readily available, maintained or fit for purpose should this be required.

Systems were in place to maintain staff safety in the community. The trust had good lone working policies and arrangements and staff in community teams told us that they felt safe in the delivery of their role.

Medicines management

At 13 inpatient units and seven community teams we found that there were not appropriate procedures in place for the administration, management, storage and audit of medications. On additional inpatient units we found that temperature checks necessary for ensuring the integrity of medications had not been undertaken.

The pharmacy service had reconfigured in September 2013 when a hub pharmacy was opened to bring the supply of medications in house. The chief pharmacist told us that this has had an impact on the clinical pharmacy service provided to the trust. A gap analysis had been undertaken which demonstrated that the team was not providing the clinical service that they would like to. A review of clinical pharmacy visits dated May 2014 demonstrated that the desired level of service is only being provided regularly on some wards and at none of the community teams. The chief pharmacist confirmed that the trust had not audited itself against the Royal Pharmaceutical Society Professional Standards for Hospital Pharmacy Services, as the trust wanted to focus on getting the basics right first.

On some wards staff reported good support from pharmacy, with regular visits from pharmacists or pharmacy technicians. We found some good examples where patients were able to access advice form a pharmacist about their medication and its effects. However

at a large number of wards, and at some community team bases, we found there were not appropriate procedures in place for the administration, management, storage and audit of medications. Issues found included:

- Fridge temperatures were not routinely checked or recorded, or where issues were found these had not resulted in the medication being removed.
- At the ECT suite at Callington Road we found two items in the emergency drug boxes that had expired, four items in the psychiatric and medical emergency box that had expired, and nine items on the stock list that had expired.
- At some units we found that there was no recording system for the receipt or management of stock medicines on the ward and there was no evidence of auditing of medication related paperwork.
- At some units open bottles of liquid medication had no dates on them meaning that the ward could not ensure they were disposed of within the recommended timescale.
- At Juniper ward controlled drugs were not being checked daily in line with trust policy.
- At Beechlydene and Whittucks Road we found delays in medication being given.
- Staff also told us that the recent change in pharmacy supply meant that obtaining medication was now time consuming and lengthy.
- At additional units we found that clinic room temperatures were very high and may have damaged the integrity of medications.

We found that there was confusing information for staff in the rapid tranquilisation (RT) policy. It informed nurses that increased monitoring was needed following intramuscular administration of RT but did not mention oral medication. Our pharmacist found staff had not increased observations following administration of oral RT. The need for monitoring post oral RT was mentioned in appendix of the policy but this was confusing.

The trust was not always following NICE guidelines on medicines. We found at Fromeside that the patient group directions were out of date and there was no list of nurses authorised to use them. We also found that there were no care plans in place for the management of 'as required' (PRN) medicines to guide nursing staff.

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

People's needs, including physical health needs, were assessed and care and treatment was planned to meet them. Overall we saw good multidisciplinary working. However, not all care plans and risk assessment were in place or updated were people's needs changed. People's involvement in their care plans also varied across the services.

In the services we inspected, most teams were using evidence based models of treatment and made reference to National Institute for Health and Care Excellence (NICE) or other relevant national guidelines. The trust had implemented a quality information system (IQ) to assess services against key indicators. The trust also used a number of different outcome measures to benchmark services' effectiveness.

The trust had also participated in a wide range of audit and research and had attained accreditation for a number of services.

We found that staffing levels were not always sufficient to meet the needs of patients and meant that activities, leave and other tasks were not always delivered.

Staff had not all received their mandatory training and the majority told us they had been unable to access more specialist training. Some staff had not received regular supervision and appraisal.

We found that the environment and equipment in a number of units did not reflect good practice guidance and had an impact on people's safety, dignity or treatment.

Systems were in place to ensure that the service complied with the Mental Health Act (MHA) and adhered to the guiding principles of the MHA Code of Practice. However, we found that staff did not always recognise and manage people's restraint or seclusion within the safeguards set out in the MHA Code of Practice.

Our findings

Assessment and delivery of care and treatment

The Care Quality Commission community mental health survey 2013 found that overall the trust was performing about the same as other trusts in the areas of care planning and care reviews. 7 out of 10 respondents stated that they had been involved in their care plan, while 6 out of 10 said they had received a review of their care in the last 12 months. 7 out of 10 people had said they had a **plan** covering what to do if they had a crisis.

The trust told us that ensuring that service users have clinical assessments which identify their treatment, care, and physical health needs was a key priority. The trust had established a system of local self-assessment against core Care Plan Approach (CPA) standards, including regular local audits of the care record. Performance data provided by the trust indicated that there had been improvement in staff completing records following significant events, service users receiving a review and the timeliness of service users being seen following first referral. The trust was also meeting the target regarding follow up of discharged inpatients in 99% of cases.

In the services we inspected, most teams were using evidence based models of treatment and made reference to National Institute for Health and Care Excellence (NICE) guidelines. We saw that people in the community generally received care based on a comprehensive assessment of individual need using the Health of the Nation Outcome Score (HoNOS) assessment. We found that in most cases individual care and treatment records for community service users reflected the assessed needs of people and how they were being met. However we found at the Swindon, Chippenham and Bristol recovery teams that some care plans lacked clear information for staff who may be unfamiliar with the person, meaning people may not always receive appropriate care. At the Wiltshire intensive services we found that there were no crisis contingency

Are services effective?

plans in place. The records of community team service users' showed us that people's physical healthcare needs were usually assessed and addressed in partnership with the person's GP.

In most inpatient services we found that people's care needs and risks were fully assessed and care plans had been put in place. However at Beechlydene, Hillview Lodge, Juniper ward and Ashdown some care plans had not been fully completed, or updated following changes to people's needs, and risk assessments had not always been updated. At Fromeside all patients had a care plan and risk assessment, which we saw had been reviewed regularly, however we did not see any care plans of risk assessments related to ligature risk for individuals.

At inpatient units we found that generally people's physical health needs were assessed. Physical health examinations and assessments were usually documented by medical staff following the patient's admission to the ward. Nurses were usually completing baseline physical health checks on patients although this practice was inconsistent for some patients on Silver Birch ward. Any abnormal readings were reported to medical staff for further investigation and specialist healthcare was being accessed for patients when needed. At Fromeside secure service there was good physical healthcare within a dedicated area in the hospital. Patients could see a local GP or practice nurse as needed. However at Hazel PICU we found two occasions were baseline observations had not been recorded while a person was in seclusion. Some medical staff told us that there were some issues with staff managing people's physical health needs at Imber ward.

Outcomes for people using services

The trust had implemented a quality information system (IQ) in April 2014. The system worked at team level and relied on self-assessment against key indicators including measures of the service user experience. The trust also used a number of different outcomes to benchmark services' effectiveness.

During 2013 the trust had implemented the use of the National Early Warning Score (NEWS) in all inpatient units. NEWS is used to assess the severity of acute illness and as a surveillance system for tracking the clinical condition and any deterioration of a patient, to enable a timely clinical response.

At community teams we observed that during the referral process information using the Health of the Nation Outcome Scale (HoNOS) was collected. HoNOS is a measurement tool which identifies a person's mental health, well-being and social functioning and is rated by clinicians at known points in the care pathway for example, admission, review and discharge. By comparing records at these points, the impact, or clinical outcome, of the care and treatment provided for an individual patient can be measured.

We found that some intensive and community teams used rating scales, such as Patient Reported Experience Measures (PREMS) and Patient Reported Outcome Measures (PROMS) although these were not used across all the trust's intensive services. Community teams also used the recovery star model and the 'wellness recovery action plan' (WRAP) to assess individual outcomes for people. However we found that staff administering these tools had not all received training in their application.

The trust had participated in a number of the Royal College of Psychiatrists' quality improvement programmes. Services that were accredited included the PICUs, the trust's two ECT suites, four acute wards, and the forensic services at Fromeside and Wickham. The Bristol and South Gloucestershire intensive teams were accredited by the Royal College of Psychiatrist' home treatment accreditation scheme and we were told that other intensive teams are working towards accreditation.

We looked at the accreditation reports for Fromeside from May and September 2013. Recommendations from May 2013 were that the trust prioritises feedback from service users, improves carer involvement and ensures identified ligature risks are placed on a risk register or removed. The peer review report dated September 2013 found that patient focus and environment and amenities were the areas most in need of improvement. These recommendations had not been implemented.

The trust had participated in all relevant national clinical audits including: the National Audit of Schizophrenia in 2011, the National Audit of Psychological Therapies for Anxiety and Depression in 2013, and Prescribing Observatory for Mental Health (POMH - UK) audits for monitoring of patients prescribed lithium, prescribing of anti-dementia drugs and prescribing for substance misuse, and the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. The trust also

Are services effective?

carried out a large number of local ongoing audits as well as one off audits where they wanted to look at a specific issue. We reviewed a number of local audits and found these to include clear findings and recommendations, and to feed in to relevant governance processes.

In addition, the trust had a very active clinical research programme. Between April 2013 to March 2014 the trust participated in 96 studies and held Department of Health contracts to host the West Hub of the Mental Health Research Network and the South West Dementia and Neurodegenerative Diseases Research Network.

Staff, equipment and facilities

In the 2013 NHS Staff Survey, the trust scored within the worst 20% of mental health trusts for key findings relating to staff satisfaction, appraisals and staff experiencing harassment, bullying or abuse. The trust scored within the best 20% on key findings relating to effective team working, receiving job-relevant training or development and for the staff working extra hours. The trust stated that they had recognised the need for improvement to ensure staff felt valued and fully supported, and so had undertaken a number of initiatives to address this. The trust had recently appointed a health and wellbeing manager and improved occupational health resources, revised appraisal and supervision processes, and begun a leadership development programme.

Trust 'IQ' data indicated that there had been an increased level of staff satisfaction and that sickness absence rates had fallen since the staff survey was completed.

All staff received an induction on commencing employment at the trust. The trust supplied us with details of their set mandatory training requirements and regarding the uptake of mandatory training. This evidenced that not all regular staff had received mandatory training and there was particularly low uptake for training in patient handling (31%), management of aggression (68%), physical emergency response training (63%), the Mental Health Act (60%) and food safety (36%).   Only 75% of relevant staff had undertaken basic safeguarding training. However 85% of required staff grades had undertaken more advanced safeguarding training. The trust supplied an action plan setting out how they would address these issues.

We spoke with a large number of staff during the inspection. Many stated that they were up to date with their mandatory training. However at some units staff told us

they were not up to date with their training and at Beechlydene one member of staff who had been working on the ward for several months told us they had not completed their mandatory training due to time pressures and access to the computer at work. Staff at the South Wiltshire complex intervention team and some community teams had not received training in the application of the assessment tools that they work with. Staff at Hillview Lodge had necessary training in observation training or life support, as recommended following investigation of a serious incident. Issues of travel and time were stated as barriers to accessing some training, as face to face training occurred on other sites in the trust which were difficult to access. While some staff told us that they do get access to mandatory training they said there was a lack of developmental training.

The trust's IQ data includes details of levels of supervision and appraisal received by staff. At June 2014 this stated supervision rates had fallen to 69.9% and appraisal rates had risen to 88.3%. Staff told us that supervision was used to manage performance issues and development however a number of staff told us that lack of staffing and service pressures meant that they did not regularly receive supervision and therefore performance feedback.

We found that the environment and equipment in a number of units did not reflect good practice guidance and had an impact on people's safety, dignity or treatment. On some units there were not clear arrangements for ensuring that there was single sex accommodation in adherence to guidance from the Department of Health and the MHA Code of Practice, to protect the safety and dignity of patients. On a number of wards, including at PICUs, older people's wards, acute wards and at the forensic service, we found a large number of potential ligature risks that had not been effectively mitigated or managed.

Other issues of concern about the environment and equipment that we found included:

- At Juniper and Dune wards the fire extinguishers had been removed from the wards and signage for alerting a fire was inaccurate.
- At Juniper ward and at Hillview Lodge we found areas of the ward and grounds were staff could not easily observe patients.
- At Hillview Lodge and Ward 4 at St Martins we found that design and decoration of the ward did not support a therapeutic environment.

Are services effective?

- At Hillview Lodge and Fountain Way emergency life support equipment was not properly maintained or suitable for its purpose.
- The bedroom corridor on Bradley Brook ward had a carpet which was stained, sticky in places, and smelt of stale urine.
- At Fountain Way lifting and safety equipment had not been serviced and was not fit for purpose.

Multi-disciplinary working

On all of the wards we visited we saw good multi-disciplinary working, including daily ward meetings and regular multi-disciplinary meetings to discuss patient care and treatment. At most wards there were effective handovers with the ward team at the beginning of each shift. These helped to ensure that people's care and treatment was co-ordinated and the expected outcomes were achieved.

We noted that social workers were now working within the local authority and not based in the trust. We saw that staff from the trust were covering traditional social work tasks in order to provide personalised comprehensive care for their patients.

At most units we saw input from occupational therapists, psychologists, pharmacy and the independent advocacy services. Medical cover was generally acceptable, except for the Bristol and North Somerset area where one consultant and specialist middle grade doctor was shared between three rehabilitation units. Out of hours medical cover was also an issue in these areas.

We saw that community teams usually attended discharge planning meetings and patients told us this was really beneficial to them, making the process of leaving the wards feel safer. At the intensive teams we saw that the service worked well with other teams and services to meet people's needs. Staff also worked well with other professionals, using the care programme approach process. The trust had recently established local care pathway meetings and trust-wide good practice networks. These were forums for teams to meet and share concerns and ideas.

Mental Health Act (MHA)

We visited all of the wards at the trust where detained patients were being treated. We also reviewed the records of people subject to community treatment and people who had been assessed under section 136 of the Mental Health Act. We also looked at procedures for the assessment of people under the Mental Health Act.

At the inpatient units systems were in place to ensure compliance with the Mental Health Act (MHA) and adherence to the guiding principles of the MHA Code of Practice. Legal documentation was routinely scrutinised within the trust. We reviewed a large number of records for patients who were detained under the MHA. All paperwork was in place and appeared in order. Treatment appeared to have been given under an appropriate legal authority. We generally saw good evidence of regular testing of capacity to consent for treatment. However improvement was needed in the recording of discussions with the Second Opinion Appointed Doctor (SOAD).

We saw that in most cases staff had regularly explained their rights to detained patients. Advocates, including independent mental health advocates, were available to people, and in most cases their use was actively promoted. Most people we spoke with were usually aware of their rights under the MHA. A standardised system was in place for authorising and recording section 17 leave of absence. We did however at one service find arrangements for the 'authorisation' of leave for informal patients.

Seclusion was practiced at a number of the services we visited. Generally seclusion paperwork was completed and indicated that the safeguards required within the Mental Health Act Code of Practice had been adhered to. However at Hillview Lodge we found staffs' understanding about the practice of seclusion to be lacking and evidence of practices that may amount to seclusion without the necessary safeguards being in place. We also found incidents of patients being nursed on a one to one or two to one basis in the de-escalation areas in the PICUs in Bristol and being prevented from leaving that area. These incidents were not recorded as episodes of seclusion as required by the MHA code of practice. At Amblescroft we found that patients had been restrained without this being recognised as such and the necessary safeguards in place as required by the MHA code of practice.

We reviewed care and treatment records for people subject to community treatment. These showed us that where required, legal documentation was being completed appropriately by staff. However we noted within the Bristol recovery team that there was no evidence of people's rights

Are services effective?

being explained under their 'community treatment order' (CTO). There was limited evidence of specific care plans linked to individual community treatment orders for people who required this. At Southmead hospital we noted that improvement was needed in the recording of the approved mental health professional's decision to support the revocation of a CTO.

We were told that the intensive teams attended all MHA assessments and, where possible, would offer an alternative to hospital admission. During office working hours the teams were able to access the appropriate professionals to undertake a Mental Health Act assessment if required. However, staff reported they did have difficulty sometimes securing an out-of-hours assessment, stating that they had been advised by the local authority emergency duty service to ensure bed availability before an assessment would be undertaken. Staff told us about significant difficulties in accessing inpatient beds and of limited opportunities for alternatives to hospital.

Mental Health Act assessments following a section 136 were often delayed out of hours, on bank holidays and at weekends. We also saw some significant delays in people moving on to the appropriate service once their assessment had been completed. We noted that two different section 136 protocols were being used in the different places of safety, one of which contained a set target time for people to be assessed as required by the MHA Code of Practice and one which did not.

Are services caring?

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

Summary of findings

Overall, we saw that staff were kind, caring and responsive to people and were skilled in the delivery of care. We observed some very positive examples of staff providing emotional support to people.

We observed staff treating patients with respect and communicating effectively with them. Staff showed us that they wanted to provide high quality care, despite the challenges of staffing levels and some poor ward environments.

People we spoke with were mainly positive about the staff and felt they made a positive impact on their experience on the ward. However, some people were concerned at the lack of time staff had to spend with them.

Most people we spoke with told us they were involved in decisions about their care and treatment and that they and their relatives received the support that they needed. We found a range of information available for service users regarding their care and treatment.

However we found a numbers of concerns across the trust where people's privacy and dignity had not been maintained.

People spoke about the impact that bed pressures had on their care meaning that beds were often provided away from people's home area, meaning people found it difficult to maintain the support of loved ones.

Our findings

Kindness, dignity and respect

Overall, we saw that staff were kind, caring and responsive to people and were skilled in the delivery of care. Generally staff were knowledgeable about the history, possible risks and support needs of the people they cared for. We observed many instances of staff treating patients with

respect and communicating effectively with them. Staff showed us that they wanted to provide high quality care, often despite the challenges of staffing levels and some poor ward environments.

People we spoke with were mainly positive about the staff and felt they made a positive impact on their experience on the ward. However, some people were concerned at the lack of time staff had to spend with them. Other people were concerned about the welfare of staff who they perceived as overworked.

We heard that the trust had developed a number of initiatives to meet people's spiritual needs including a trust-wide network and a spirituality conference planned for October 2014. We were told that staff respected people's personal, cultural and religious needs. In most units we found a space had been allocated for prayer and reflection. Food was available at all units to meet people's personal or cultural dietary needs. We met with the two chaplains who work at the trust and heard that they were able to provide their service in Bristol and Swindon and on an on-call basis. In Bristol we found that arrangements had been made for the Imam to visit when required. However we were told that there was no capacity to extend the chaplaincy service to the wider trust area.

The trust had volunteered to be one of the pilot sites for 'Patient-Led Assessments of the Care Environment' (PLACE). This is a self-assessment process undertaken by teams including service users and representatives of Healthwatch. The results to the end of March 2014 indicated that the trust scored above the national average for the category of privacy, dignity and wellbeing. We found some good examples of staff protecting people's privacy and promoting dignity. However we found a numbers of concerns across the trust were people's privacy and dignity had not been maintained. These included:

- At Imber ward, Hillview Lodge and Green Lane place of safety we found external bedroom windows having clear glass and no window covering.
- At Hillview Lodge we saw a female patient wandering along the corridor in her underwear, in full view of male patients. On Cove ward we were very concerned to find

Are services caring?

a female patient whose dignity was seriously compromised. On Dune ward and Juniper ward we observed patients wander in to the bedroom areas of the opposite gender.

- At Juniper ward bedroom doors were fitted with a clear glass panel for observation and not all were fitted with a means of ensuring privacy. At Applewood vision panels were locked in the open position.
- At Oakwood the patient status board in the nursing office included details of the patient's MHA status which could be observed from outside the office by other patients and visitors.
- On Dune Ward we saw that staff served pieces of cake to patients directly onto the table without either a plate or a napkin.
- At Ward 4 and Juniper ward some patients were not happy with the lack of privacy due to shared rooms.

People using services involvement

The Care Quality Commission community mental health survey 2013 found that overall the trust was performing about the same as other trusts in the areas of care planning and care reviews. 7 out of 10 respondents stated that they had been involved in their care plan, while 6 out of 10 said they had a copy.

Most people we spoke with told us they were involved in decisions about their care and treatment and that they and their relatives received the support that they needed. Most people said that they were aware of their care plans and were able to take part in the regular reviews of their care. We saw some very good examples of care plans being person centred. However at inpatient services including Beechlydene, Juniper, Hillview Lodge, Amblescroft and the Longfox Unit we found that some care plans were completed without involvement of the patient or carer.

Most people we spoke with were able to discuss their medication and its use. Patient information leaflets about the range of medications were available at most wards. Where appropriate people were offered choice in respect of their treatment including their medication and we were told by staff that positive risk taking was encouraged within the units in association with thorough risk assessment.

Patients had access to advocacy including an independent mental health advocate (IMHA) and there was information on the notice boards at most wards on how to access this service.

Training rates for staff in the Mental Capacity Act were not good with just 58% staff trained at the end of March 2014. However most staff spoken with had an awareness of the Mental Capacity Act. We saw some units where recent capacity assessments and best interest decisions had been carried out if applicable. However we found staff at Imber ward, Laurel and Aspen wards, and Fountain Way had limited understanding of the deprivation of liberty safeguards. At Fountain Way we also found concerns about informal patients being given authorised leave that may lead to a restriction on a person's liberty.

Emotional support for care and treatment

Throughout our inspection we observed some very positive examples of staff providing emotional support to people. Generally people told us that staff were very kind and supportive, and that they were treated with respect. People were usually informed about their care and treatment and some people told us that staff were good at explaining things to them.

We found a range of information available for service users regarding their care and treatment. On a number of wards we found welcome packs that included detailed information about the ward and a range of medication information leaflets. We found that these leaflets were also available publically via the trust website. Many of the leaflets were available in other formats such as easy read and the main languages used within the trust catchment area. A carers pack was available on the trust website.

The Care Quality Commission community mental health survey 2013 found that the trust had the highest rating regarding whether carers were involved in their loved ones care. Some carers told us that they felt well supported. Other carers told us that they did not feel that their loved one received the care that they needed, when they needed it. People spoke about the impact that bed pressures had on their care meaning that beds were often provided away from people's home area. This was said to impact on people's ability to keep in contact and gain support from loved ones. People also told us of frequent changes to care co-ordinators meaning inconsistent support.

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

The trust told us that they had developed strong relationships with local communities, the people who use the services, NHS commissioners, GP Commissioners, other health providers and local authorities over the last year. The trust hoped to build on these relationships to help develop open and honest conversations about how they can deliver a better quality of care.

The trust told us about many initiatives to involve stakeholders in the planning of the service and we heard of good examples of engagement. However some service users, carers and local user groups felt that they had not been effectively engaged by the trust in the planning of services.

We found that generally there was evidence of different groups working together effectively to ensure that patients' needs continued to be met when they moved between services.

The availability of beds appeared to be a trust-wide issue, with intensive, acute and older people's beds always in demand. Staff worked with other services in the trust to make arrangements to transfer or discharge patients. However, a lack of available beds meant that occasionally people may have been moved, discharged early or managed within an inappropriate service.

We also found that bed availability had an impact on people being treated within their local area. Some people told us that they had been moved during their care, which had an impact on their recovery.

At a number of units we also found that there was not appropriate single sex accommodation in adherence to guidance from the Department of Health and the MHA Code of Practice, to protect the privacy and dignity of patients.

We found that both staff and patients knew how to make a complaint and many were positive about the response they received.

Our findings

Planning and delivering services

Senior management told us that serious service failings in 2012 revealed significant shortcomings in the way the trust was governed and managed. Following this there was a change in the most senior leadership of the trust, and the trust began to restructure the management and governance arrangements and embarked on a significant programme of service improvement. The trust told us that following this they had developed strong relationships with local communities, the people who use the services, NHS commissioners, GP Commissioners, other health providers and local authorities over the last year. The trust hoped to build on these relationships to help develop open and honest conversations about how they can deliver a better quality of care.

The trust told us about many initiatives to involve stakeholders in the planning of the service. These include a network of service user groups, service user, carer and staff involvement if the 'Friends and Family Test', consultation events such as those to develop the vision and values of the trust and for the planning of the re-tendering of the Bristol services. The trust had also developed a 'listening in to action' programme to encourage staff engagement, and a 'bright ideas' competition to encourage staff to share their ideas for good practice and improvement.

We spoke to a large number of service users, carers and staff throughout this inspection. While some people felt fully engaged and informed about service development plans, some service users, carers and local user groups felt that they had not been effectively engaged by the trust. This was particularly relevant to plans regarding the reconfiguration and retendering of community and adult services in Bristol.

Right care at the right time

The availability of beds appeared to be a trust-wide issue, with intensive, acute and older people's beds always in demand. The trust monitors both bed occupancy rates and delayed transfers of care. The trusts target for delayed transfers of care is below 7.5%. At the time of our inspection these stood at 7.6% across the trust and at 17%

Are services responsive to people's needs?

in Wiltshire. At December 2013 bed occupancy rates at the trust stood at 92%. By the end of our inspection had risen to 97.9%. We found some services, such as older people's units, where bed occupancy was in excess of 100%.

During our inspection, several senior staff spoke about the challenges posed by the large geographical area of the trust. They told us that patients are often long distances away from their home area due to bed availability and this impacted on the care provided and the potential for families to visit. Staff and patients also reported concerns about the high level of out of area admissions. This also usually meant that patients were subsequently transferred or repatriated, which was sometimes disruptive to the continuity of their care.

Community and intensive team members told us that they spent a lot of time trying to find appropriate inpatient beds for people. Ward staff told us that sometimes they had to admit people in beds where the patient was on leave. We found that older people, some of whom were very frail with limited mobility, were being treated on adult acute wards due to a lack of appropriate beds.

We were told of occasions when a patient had to be nursed in seclusion throughout the day whilst waiting for an intensive bed. We observed during our inspection urgent requests for an intensive bed. As the PICU wards were full this meant that patients were either transferred to an acute bed, sometimes as a 'swap' for a patient needing a PICU, admitted to the other PICUs in a different part of the trust, or admitted to a private provider PICU bed. One such patient was admitted to a PICU in Bradford during our inspection. Staff reported that sometimes patients were transferred from PICUs to acute beds too early due to the pressure on beds. Another patient had been discharged from section by the Tribunal who commented that they had heard in evidence that there were huge pressures on beds in the acute wards and it might be weeks until the patient could be transferred.

Staff worked with other services in the trust to make arrangements to transfer or discharge patients. However staff told us that bed availability in the intensive care units meant that there had been delays on occasion in transferring a patient who needed intensive care. We were told that moving people back from beds provided outside the trust was a priority. We observed that one patient was transferred to Silver Birch Ward from a non NHS mental health provider at 00.20 hours due to a delay in accessing

patient transport. This was potentially disruptive to the patient concerned and others on the ward. Staff told us that at times the transfer process does not get completed fully due to the amount of transfers taking place.

We found that access to the intensive service across the trust was generally good during the day and, where necessary, urgent assessments could be arranged within four hours. Quality assurance information reflected that the teams were generally keeping within this target. A 24 hour service was provided by the teams however all calls out-of-hours, other than in Bristol, went to a call centre that filtered the calls. Telephonists asked a set of questions prior to transferring the call to the intensive support team. One of the managers said that by having a set of questions it had reduced the number of less important calls to the service. We were informed that all calls were monitored for timeliness, however, we found no analytical evidence of calls being responded to by the intensive services in a timely way.

Staff told us that the out of hours service was universally unpopular with staff, people who use the service and carers. Service users in Swindon and BaNES said that they could not always speak with someone when they needed to outside of office hours. They said that calls were not always returned, or may only be returned until several hours after they had initially made contact. We saw minutes from the quality and safety meeting in April 2014 acknowledging this and heard that the locality management teams were aware of this issue and looking at how they can improve the response to people out of hours.

The Bristol intensive service does not use the trust-wide call centre. Instead there was a crisis line staffed by clinicians who provide mental health crisis telephone support and signpost people to the most appropriate service. This had been set up in response to concerns raised by commissioners and stakeholders in Bristol, over accessibility to the intensive service. We saw evidence that this project was being evaluated and was subject to ongoing developments as a result of feedback. Generally people spoken with in Bristol knew how to seek advice and access the services in an emergency. They told us they were able to phone up the service at any time and during out of hours.

At the later life liaison team we saw a good example of a service that understood the support and treatment needs of the people who had been referred to the service. The

Are services responsive to people's needs?

trust actively engaged with referrers from the local acute NHS trust to provide a co-ordinated approach to meet people's needs. For example, we saw evidence of training sessions on mental health care being provided to front line staff on acute NHS hospital wards.

Generally we found that access to the health based places of safety was effective. However we found that Mental Health Act assessments were often delayed out of hours, bank holidays and weekends due to lack of approved mental health professionals as they would not begin assessments if no bed had been identified. Staff told us this led to patient anxiety and frustration. Once assessed we found some delays in people transferring to a bed.

At the time of our visit to Fromeside two wards were swapping premises. This was to enable the service to improve the beds available for patients as there was a lack of enhanced rehabilitation beds and a need for fewer acute beds. We were told that the ward swap would enable patients to move more smoothly along their care pathways.

Care Pathway
We found that generally there was evidence of different groups working together effectively to ensure that patients' needs continued to be met when they moved between services.

The trust provided data regarding the seven day post discharge follow up target. At the time of our inspection this had raised to 99% compliance. The ward teams told us that they worked closely with both intensive services and recovery teams to ensure continuity of care when patients were discharged from hospital. At most wards we found that arrangements for discharge were discussed and planned with the care co-ordinators and other involved care providers and many people told us that they were fully involved in their discharge planning. However some staff expressed concerns about patients from out of area who received few visits from their care coordinator.

At rehabilitation units outreach support was usually provided from the team by nursing staff that supported people with the transition to their new placement and monitored their progress. Staff told us that people were usually discharged from the unit after a period of four to six weeks extended leave, when the responsibility of their care was transferred to the relevant community team.

At community teams we generally saw clear discharge pathways in place with letters going to the GP together with

copies of care plans, a recent Care Plan Approach (CPA) review and a clinical and discharge summary. We noted the 'Step-Down' policy to primary care was clearly visible within the service.

Referrals to the intensive service were accepted from health professionals and other agencies where appropriate. There were weekly care pathway meetings with other teams, where concerns were discussed around access to care or individual experiences. The team undertook in-reach work with individual's on the wards and attended weekly ward reviews where possible. The teams supported referrals to other services where indicated.

Learning from concerns and complaints
A number of community service users, former patients and user groups told us before and during the inspection that the trust did not always investigate their complaints. Some stated that the patient advice and liaison service (PALs) team created a hindrance to making a formal complaint, as they emphasised the need for local informal resolution before moving to a formal complaint. Some people suggested that the trust did not respond to their complaints.

The trust provided details of all complaints and contacts received by the trust between April 2013 and March 2014. There had been 272 formal complaints, 1631 enquiries to the patient advice and liaison service (PALS) team and 849 items of praise. The analysis of this highlighted key themes as 'safe, high quality co-ordinated care' and 'better information, communications and choice'. The complaints lead informed us that during the period 32% of complaints had been upheld and 31% partially upheld. The trust also provided detailed information about the complaint issues and the actions they had taken as a result of the findings from January 2014. We reviewed this information and saw some good examples of learning from complaints.

At the inpatient services most patients told us that they were given information about how to complain about the service. This was usually contained within the ward information booklet and included information about how to contact the PALS. Information about the complaints process was usually displayed at the wards and was also available on the trust website. Staff informed us that the PALs team provide drop-in sessions at some wards, and will attend to support individual people in making a complaint.

Are services responsive to people's needs?

The PALs team informed us that they will refer people to advocacy where this is more relevant. Patients told us that they had raised any concerns these were usually responded to appropriately.

Complaints were discussed at local risk and safety meetings, and at the trust-wide critical incident overview group and quality and standards group meetings. Complaints information was also sampled at some of the services we visited. Reports usually detailed the nature of complaints and a summary of actions taken in response. Generally complaints had been appropriately investigation and included recommendations for learning. At some units we saw actions that had occurred as the result of complaints. However at other units' staff we spoke with did not have any awareness of the themes of complaints received about the ward or other inpatient units within the trust.

The inpatient services also used the friends and family test (FFT) to measure patient feedback. Questionnaires were given to patients on discharge. Most wards displayed information about the findings and showed how the trust was responding to patients' feedback. Some people we spoke with told us they also felt able to raise any concerns in the community meetings and that they felt listened to.

Mixed sex accommodation
The trust had declared itself compliant to the Department of Health standards for eliminating mixed sex accommodation. We found that some units that did not meet the definition for single sex accommodation.

At additional units we found arrangements that did not promote people's dignity or protect people's safety. These included:

- On Cove ward one corridor was being used to accommodate men and women. All of the rooms were en-suite and the male bed rooms were clustered together near to the entrance to the corridor however we were very concerned to find that at the far end of the corridor, a female patient was lying on her bed completely naked with the bedroom door open.
- At Dune ward one corridor was used to accommodate both men and women. Doors to the en-suite rooms were lockable from the inside but patients were not provided with keys to their rooms. We observed a female patient wander into a male patients' room.
- At Elmham Way we had concerns regarding gender separation arrangements within the bedroom corridor due to the locking arrangements for the shared assisted bathroom.
- At Juniper ward we found that the sleeping areas on the ward were segregated for male and female bedrooms however a social area was located next to the entrance to the female bedroom area. We observed this area was mostly occupied by male patients which meant vulnerable female patients had to walk past this area to access their bedroom and lounge areas. During the visit, we observed a male patient entering the female bed area.

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

The senior management told us that there had been a change in the most senior leadership of the trust, and the trust had restructured the management and governance arrangements and embarked on a programme of service improvement. We found that the board and senior management had a clear vision with strategic objectives, and there was a clear management and governance structure in place.

The trust told us that executives and board members had been involved in a number of initiatives to engage with staff and give staff the opportunity to talk directly to board members about issues that affect them.

Staff we spoke with were aware of their roles and responsibilities but staff knowledge of the trust's values and objectives varied. Most staff felt supported by the managers at ward level, and they also valued the support of their team. However leadership from above ward level was not visible or accessible to all staff.

There had also been a number of positive initiatives to engage service users, carers and wider stakeholders in the development of the trust. However throughout this inspection we heard from service users, carers and local user groups who felt that they had not been effectively engaged by the trust in planning and improvement processes.

There is a trust-wide information system called IQ. This measures compliance with key indicators such as the service user experience, quality and safety information, records management and supervision rates. The information is used throughout the governance structure to indicate performance improvement and is accessible to all staff.

However, we are concerned that despite the development of governance and performance

improvement systems our findings indicate that that there is room for improvement in the trust to ensure that lessons are learned from quality and safety information and imbedded in to practice.

Our findings

Vision and strategy

The trust board and senior management team had a clear vision with strategic objectives and values. We were told that the he trust developed their motto, vision and values during 2013 following detailed engagement with service users, employees and commissioners. The values were stated as: passion, respect, integrity, diversity and excellence or 'PRIDE'. The vision was stated as:

- to be first choice for service users
- to be widely recognised as the best mental healthcare employer in the country
- to be an established learning, teaching and research organisation
- to be rated as 'outstanding' by regulators and described as excellent by commissioners
- to be a strong partner and a system leader that ensures best quality,
- best value and coherence across complex pathways of care
- to grow around an expanding core of excellent services – consolidate, integrate and expand.

The trust had recently published a clinical strategy setting out the detailed strategic objectives and five year plan for the trust from 2014 to 2019. A Board Assurance Framework is in place which captures the key potential risks to the trust's strategy. Strategic priorities were stated as:

- to deliver the best care
- to support and develop staff
- to continuously improve
- to use resources wisely
- to be future focused

Are services well-led?

Most, but not all, staff we spoke with said they were aware of the trust's vision and values, and strategic objectives. Staff were generally familiar with the trust motto "you matter, we care." We found some evidence of the vision and values on display within the services and this was also available to staff on the trust intranet. Staff told us that they receive regular information and newsletters setting out progress against objectives, however some staff told us they have insufficient time to be able to read these.

Senior management were aware of the strengths and improvement needs of the trust and were committed to ensuring that the trust's vision and strategy was delivered. We found that staff were committed to ensuring that they provided a good and effective service for people who used the services, but did not always feel able to influence change. Most staff were aware of the trust's triumvirate management structure and who their locality managers were. However a number of staff were unclear about who the senior management team were at the trust.

Responsible governance
The trust has a board of directors who are accountable for the delivery of services and seeks assurance through its governance structures for the quality and safety of the trust. The trust told us that they consider quality and safety intrinsically linked and so manage all governance through the quality and standards committee. Reporting to this are sub-committees for clinical systems, critical incidents, health and safety, infection control, physical healthcare and medical devices, and medicines optimisation, mental health legislation, clinical practice and safeguarding. These committees had clear terms of reference, membership and decision making powers. We saw that local governance structures were in place in all the localities and services inspected, which fed in to central governance committees.

A mental health legislation group was in place which has overall responsibility for the application of the Mental Health Act and the Mental Capacity Act, and preforms the role of the 'hospital managers' as required by the Mental Health Act.

Staff were aware of their role in monitoring concerns and assessing risks. They knew how to report concerns to their line manager and most felt they would be supported if they did. However at Fromeside and the Elizabeth Casson Unit we found that staff had been raising safety issues of concern with their managers without any action being taken.

Staff we met with in the Bristol locality, including medical staff, told us that they had not felt fully engaged and informed in the recent processes for the retendering of Bristol community services. We heard similar concerns from staff in the North Somerset and South Wiltshire areas of the trust where similar recommissioning processes are in progress.

Leadership and culture
Senior management told us that serious service failings in 2012 revealed significant shortcomings in the way the trust was governed and managed. Following this there was a change in the most senior leadership of the trust, and the trust began to restructure the management and governance arrangements and embarked on a programme of service improvement. The trust supplied us with copies of two independent reviews, undertaken in April 2013 and April 2014. The former had highlighted the need for significant change. The latter indicated that the trust had made significant progress in governance and management arrangements.

The chief executive told us that the key priority had been to provide more local leadership and accountability. In line with this the trust had moved to eight locality or specialist business units, each managed by a 'triumvirate' management group led by a clinical director who is a practising doctor, supported by a head of profession and managing director.

The trust told us that executives and board members had been involved in a number of initiatives to engage with staff and give staff the opportunity to talk directly to board members about issues that affect them. These included 'listening to you' sessions and attendance at meetings which take place across trust locations. The chief executive told us that he, and other executive team members, regularly work a shift with different teams across the trust to better understand the challenges they face.

Generally most staff told us they knew their immediate management team well and most felt they had a good working relationship with them. Most staff were aware of their locality 'triumvirate' management team and stated there had been opportunities to meet with them. Some staff were aware of the executive team and board members however some staff told us that they did not know of any members of the executive team. While we saw evidence of the senior team visiting specific services, some staff told us that the senior team was not visible within their service.

Are services well-led?

At some services staff told us that there had been too many trust and policy changes and there were many vacant posts that had been unfilled. We heard that morale was poor at some services and also heard complaints from staff that all but basic mandatory training had been cut which was potentially affecting their appraisals and future prospects of promotion. Staff told us these issues had been raised with management but little had changed as a result.

The trust's IQ data includes details of levels of supervision and appraisal received by staff. At June 2014 these stated supervision rates had fallen to 69.9% and appraisal rates stood at 88.3%. Some staff told us that supervision was used to manage performance issues and development however a number of staff told us that lack of staffing and service pressures meant that they did not regularly receive supervision and therefore performance feedback.

Engagement

We saw that there was information available throughout the trust and via its website about how to provide feedback on the specific services received by people.

The trust has a user engagement strategy and a 'family, friends' and carers' charter', which was published in April 2014, that set out the trust's commitment to working in partnership with service users and carers. The trust told us about a number of initiatives to engage more effectively with users and carers. These included the employment of an involvement worker in each locality of the trust and the development of both local and trust-wide engagement groups. The trust had also developed a set of accreditation standards so that teams could demonstrate progress and activity in this area of work. We found that community meetings occurred at the majority of inpatient services that we visited across the trust.

Other initiatives developed by the trust included the use of the 'triangle of care' toolkit which provides an accredited framework to develop carer involvement within local services. Carers' leads had been identified in each locality and carers' champions put in place in each team or ward. Service users and carers have also been elected to sub-committees of the board, involved in employment and training processes, and employed as peer mentors. The trust had also employed an 'inner city mental health worker' to strengthen engagement with black and minority ethnic (BME) groups.

We met with some of the involvement leads and attended a number of the trust led engagement groups and were impressed with the openness of the discussion about required improvements.

Many patients told us that they felt listened to and their requests were listened to. However this was not the case at the forensic service were patients stated they had not been engaged in the redesign of the service or informed ahead of building works which had impacted on their experience.

The trust was an early implementer for the 'friends and family test' (FFT) which they launched in April 2013. The FFT seeks to find out whether people who have used the service would recommend their care to friends and family. At June 2014 almost 6000 responses had been received. The trust could demonstrate active promotion of the FFT and subsequently response rates had increased, particularly in relation to former inpatients. Many of the staff we spoke with were aware of the outcomes of this at their service level and we noted displays of the findings in a number of units visited. The Friends and Family Test seeks to find out whether people who have used the service would recommend their care to friends and family. The latest results show some improvement and that overall 89% of respondents were likely or extremely likely to recommend the trust's community services to friends and family if they needed similar care or treatment. 75% of respondents were likely to recommend the inpatient services.

Throughout this inspection we heard from service users, carers and local user groups who felt that they had not been effectively engaged by the trust. This particularly related to the recommissioning of community services in Bristol. We asked the trust about this and they were able to demonstrate that they had worked closely with user led groups in Bristol in the roll out of this work. Following the inspection we were provided with the results of a questionnaire undertaken by a local service user group in Swindon with the assistance of the local Healthwatch. People who completed the survey were generally unhappy with the level of care they received in Swindon, particularly with the standard of care, support and access to the intensive service. We asked the trust to provide us with detailed information about user and carer engagement in this locality. We were supplied with information indicating

Are services well-led?

that a number of initiatives had been put in place to gain the views of people who use the services, including an open forum attended by the management team and a carer forum.

At a presentation by the trust ahead of this inspection they stated that staff engagement was a key priority. In the 2013 NHS staff survey, the trust scored within the worst 20% of mental health trusts for key findings relating to staff satisfaction, appraisals and staff experiencing harassment, bullying or abuse. The trust scored within the best 20% on key findings relating to effective team working and the staff working extra hours. Overall this was a slight improvement on the previous year's survey and particularly to the question of whether staff would recommend the trust as a place to work or receive treatment.

Following this the trust's employee strategy and engagement committee (ESEC) has reviewed the results in detail, and identified key themes to focus on. These include: health, safety and wellbeing at work, appraisals and role clarity, staff feeling valued, senior management communication, bullying and harassment and confidence in reporting of incidents and actions taken by the trust. We saw action plans to address these priorities and were told that improvement is being monitored through a staff response element to the FFT. We were provided with an analysis of the outcomes of this monitoring. At June 2104 over 700 staff had responded. This showed an improvement in positive responses about whether the staff member would recommend the trust to others and whether service user care was the trust's top priority.

Most staff we spoke with felt confident to report to their team management any concerns they had but they did not always feel confident to raise issues at a more senior level. However at Fromeside and the Elizabeth Casson Unit we found that staff had been raising safety issues of concern with their managers without any action being taken.

Staff we met with in the Bristol locality, including medical staff, told us that they had not felt fully engaged and informed in the recent processes for the retendering of

Bristol community services. We heard similar concerns from staff in the North Somerset and South Wiltshire areas of the trust where similar reorganisation processes are in progress.

Performance Improvement

The trust told us that improvements in quality and safety were their highest priority. The trust has a quality account and an integrated quality and safety plan (IQSP) that together set out arrangements for performance improvement. Progress against the IQSP objectives was reviewed by the board and the quality and standards group on a monthly basis. The trust had appointed a director for development to oversee the work programme for this agenda.

The trust had implemented a quality information system (IQ) in April 2014. We were told that the approach was developed to act as an early warning system for identifying risks to the quality of services and highlight areas where improvements were needed. The system worked at team level and relied on self-assessment against key indicators. These include: measures of service user experience, compliance with CQC and records management standards, performance against contractual requirements, CQUIN indicators, supervision and appraisal rates and sickness absence rates.

The trust had also began 'quality huddles' were clinical directors and senior managers meet to review the IQ data enabling real time identification and resolution of safety and quality issues. Data provided by the trust indicated that there had been an overall improvement in safety and outcome measures since this was implemented. However, we are concerned that despite this our findings indicate that that there is room for improvement in the trust to ensure that lessons are learned from quality and safety information and imbedded in to practice.

Throughout and immediately following our inspection we raised our concerns with the trust. The trust senior management team informed us of a number of immediate actions they had taken to address our concerns.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	The registered person had not taken proper steps to ensure that people were protected against the risk of receiving inappropriate or unsafe care. How the Regulation was not being met: • On some units there were not clear arrangements for ensuring that there was single sex accommodation in adherence to guidance from the Department of Health and the MHA Code of Practice, to protect the safety and dignity of patients. • On Juniper ward we evidenced a male patient enter the female bed area. • Individual patient risk assessments had not always been reviewed and updated following incidents of potential or actual harm • On acute units observation practice did not meet the guidance set out by the National Institute for Health and Care Excellence (NICE) • There is inadequate provision of appropriate activities on Sycamore Ward and Juniper Ward as recommended by the Mental Health Act Code of practice • We found delays in transferring patients where an alternative service is required. We found occasions when a patient may have been transferred earlier than there presentation had indicated. • We found that physical health observations were not always carried out when people were secluded • We found some significant delays in people moving on to the appropriate service once their assessment had been completed • There were two policies governing the procedures for section 136 causing confusion. One of these did not meet the guidance set within the MHA Code of practice. • Care plans were not always person centred • Discharge arrangements were not clear and effective at the BaNES complex team • Not all CTO patients had clear care plans or been given their rights under the Mental Health Act 1983

Compliance actions

- Care plans did not always reflect all needs and physical health concerns were not always assessed and met
- Some caseloads in community teams were higher than the national guidance and trust policy

Regulation 9

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	The registered person had not ensured that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises How the Regulation was not being met: • On a number of wards we found potential ligature risks that had not been effectively mitigated or managed • Juniper ward was unsafe because the fire extinguishers had been removed from the female bedroom area and signage for alerting a fire was inaccurate. • At Juniper ward we found areas of the ward and grounds were staff could not easily observe patients • At Silver Birch ward we found that the garden and garden furniture could enable people to abscond easily • At Juniper ward we found that design and decoration of the ward did not support a therapeutic environment • In two section 136 places of safety we found potential ligature risks that had not been effectively mitigated or managed • The environment in the place of safety suites at Fountain Way and Green Lane were not conducive for someone in great distress • Dune ward was unsafe because the fire extinguishers had been removed and signage for alerting a fire was inaccurate. Regulation 15(1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	The registered person did not have suitable arrangements to protect patients from the risk of unsafe or unsuitable equipment:

This section is primarily information for the provider
Compliance actions

How the Regulation was not being met:

- At Hillview Lodge emergency life support equipment was not properly maintained and suitable for its purpose.
- At Fountain Way emergency life support equipment was missing, not properly maintained and suitable for its purpose.
- At Fountain Way lifting and safety equipment had not been serviced and was not fit for purpose.

Regulation 16 (1) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	The registered person had not safeguarded the health, safety and welfare of service users by taking appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity: How the Regulation was not being met: • A number of units were experiencing significant staff shortages which may have impacted on patient care and safety. • A number of community teams were experiencing staff shortages which may have impacted on people's care and safety • Arrangements for medical cover were not always sufficient Regulation 22

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	The registered person did not protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment by regularly assessing and monitoring the quality of the services provided and identifying, assessing and managing risks relating to the health, welfare and safety of service users and others: How the Regulation was not being met:

- We found occasions where the trust had not taken prompt and appropriate action to manage risks identified by serious incidents and concerns
- The trust had failed to have regard to reports prepared by CQC relating to their compliance following a CQC visit to Hillview Lodge in November 2013
- The trust had failed to have regard to reports prepared by CQC relating to their compliance following a CQC visit to Blackberry Hill Hospital in October 2013

Regulation 10

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	The registered person must had not ensured that suitable arrangements were in place in order to ensure that persons employed for the purposes of carrying on the regulated activity were appropriately supported in relation to their responsibilities by receiving appropriate training, professional development, supervision and appraisal; • Staff at Hillview Lodge had not received training in the application of the observation policy and observation practice • Not all staff at Hillview Lodge had received training in advanced life support • Staff at the South Wiltshire complex intervention team had not received training in the application of the assessment tools that they work with • Not all staff had received training in safeguarding, management of aggression and life support • Staff at the Chippenham recovery team had not undertaken mandatory training in health and safety, conflict management, infection control and recovery star assessment • Some staff had not had supervision meetings or appraisals Regulation 23

Regulated activity	Regulation

Compliance actions

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

Treatment of disease, disorder or injury

The registered person had not protected service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines:

How the Regulation was not being met:

- On a number of units we found that there was not appropriate procedures in place for the administration, management and audit of medications
- On additional units we found that temperature checks necessary for ensuring the integrity of medications had not been undertaken.
- In seven community teams we found that there was no appropriate procedures in place for the administration, management, storage, disposal and audit of medications
- In one team we found that the fridge was broken and so the integrity of medications could not be assured
- At the ECT Suite at Callington Road we found a number of out of date medications.

Regulation 13

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	The registered person had not ensured that as far as reasonably practicable there were suitable arrangements to ensure the dignity, privacy and independence of service users and that service users are enabled to make, or participate in making, decisions relating to their care or treatment. How the Regulation was not being met: - Not all patients were involved in the planning of their care and treatment - Information available for patients and their relatives was out of date and incorrect - On Cove ward we evidenced a female patient undressed who could be observed by other patients and visitors. - At Hillview Lodge we saw a female patient wandering along the corridor in her underwear, in full view of male patients.

Compliance actions

> • On Dune ward we saw that patients were served cake which was placed directly on the table in front of them without using a plate or napkin

> Regulation 17—(1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	The registered person did not protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment by regularly assessing and monitoring the quality of the services provided and identifying, assessing and managing risks relating to the health, welfare and safety of service users and others: How the Regulation was not being met: • We found occasions where the trust had not taken prompt and appropriate action to manage risks identified by serious incidents and concerns • The trust had not made changes at ward level which reflected findings from an analysis of serious incidents Regulation 10

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	The registered person had not always made suitable arrangements to ensure that patients were safeguarded from unlawful restraint How the regulation was not being met: • We found that restraint was not always recognised and recorded within the safeguards set out in the MHA Code of Practice • At Callington Road we found that were a Deprivation of Liberty application had been made there was limited evidence of how this decision had been reached • At Callington Road we found that when 'do not resuscitate' notices were in place there was limited information documenting how these decisions had been made. Regulation 11

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	The registered person had not ensured that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises How the Regulation was not being met: At Hillview lodge we found: • The ward did not meet the required level of cleanliness and the design and decoration of the ward did not support a therapeutic environment • Potential ligature risks that had not been effectively mitigated or managed • The garden was not well maintained and contained overgrown trees and shrubs that may have posed a ligature risk or a means of escape • Shower and bathroom facilities were in a poor state of repair • Areas of the ward and grounds were staff could not easily observe patients • The design of the unit did not promote privacy or dignity. Regulation 15(1)

Regulated activity	Regulation
Treatment of disease, disorder or injury	The provider had not ensured that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises How the Regulation was not being met: • At Blackberry Hill Hospital: • On a number of wards we found potential ligature risks that had not been effectively mitigated or managed

- The trust has failed to have regard to reports prepared by CQC relating to their compliance following a CQC visit to Blackberry Hill in October 2013 as on Bradley Brooks we found that the carpet smelt strongly of urine
- The trust has failed to have regard to reports prepared by CQC relating to their compliance following a CQC visit to Blackberry Hill in October 2013 as they had not provided a sheltered outdoor space in the garden.

Regulation 15(1)

Regulated activity	Regulation
Treatment of disease, disorder or injury	The provider had not safeguarded the health, safety and welfare of service users by taking appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity:

How the Regulation was not being met:

- A number of units were experiencing significant staff shortages which may have impacted on patient care and safety.
- Supervision arrangements for new staff were insufficient
- Management arrangements were insufficient

Regulation 22

Regulated activity	Regulation
Treatment of disease, disorder or injury	The provider did not protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment by regularly assessing and monitoring the quality of the services provided and identifying, assessing and managing risks relating to the health, welfare and safety of service users and others:

How the Regulation was not being met:

- We found occasions where the trust had not taken prompt and appropriate action to manage risks identified by serious incidents and concerns

Enforcement actions

- The provider did not assess and monitor the effect of poor staffing levels and the depleting of other wards staffing compliments on the quality of service provided.
- The provider had identified risks from ligature points but had not taken steps to manage these effectively.
- The provider had not made changes at ward level which reflected findings from an analysis of serious incidents
- The provider did not regularly seek the views of service users regarding changes to the environment and service delivery. The provider did not act on the views of staff raising concerns.
- The provider did not act on compliance actions made in respect of Blackberry Hill hospital and Hillview Lodge in 2013.

Regulation 10