CareQuality Commission

Avon and Wiltshire Mental Health Partnership NHS Trust

Community-based crisis services

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Trust HQ	RVN1H	South Gloucestershire intensive service	BS16 2EW
Trust HQ	RVN1H	Swindon intensive service	SN3 4WF
Trust HQ	RVN1H	Wiltshire North intensive service	SN10 5DS
Trust HQ	RVN1H	Wiltshire South intensive service	SP2 7FD
Trust HQ	RVN1H	BaNES intensive service	BA1 3NG
Trust HQ	RVN1H	North Somerset intensive service	BS23 4TQ
Trust HQ	RVN1H	Bristol intensive service	BS4 5BJ

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

Summary of findings

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

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

Summary of findings

Ratings

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

Avon and Wiltshire Mental Health Partnership NHS Trust has seven intensive support teams, which provide rapid assessments and treatment to people aged 18 or over, who are experiencing an acute breakdown in their mental health. The service was available 24 hours a day, 365 days of the year.

The services provided by the intensive teams required some improvement. We saw that staff shared information well at a local level and that learning from incidents was shared at both trust and local level. However, some staff told us that learning was not always shared effectively. Also, there were not always appropriate arrangements in place for managing and disposing medicines.

Overall, the intensive teams had enough staff, with the right mix of skills to provide effective services. However, two teams, South Gloucestershire and BaNES, told us that there were staffing vacancies that sometimes had an impact on the team's capacity. Improvements should be made to the out-of-hours medical cover in the North Somerset and Bristol intensive support teams, to make sure that it is adequate to meet people's needs.

Most of the people who used the service received effective care and treatment by competent staff. We also saw that staff received regular clinical and management supervision, but some staff were concerned that the opportunities for training and professional development had decreased. There was also little on offer in addition to core mandatory training.

There were some good examples of people being involved in decisions about their care and contributing to their care plans. However, we also found occasions where staff found this hard to achieve or where this was not happening consistently. Most people were treated with dignity and respect, although some people told us that the received inconsistent and uncaring responses.

People could not always speak to someone when they needed to. Calls to six of the intensive support teams were taken by a call centre outside of office hours and messages passed on to the appropriate team. A large number of service users, carers and staff were concerned that people could not speak with someone quickly enough in a crisis. The teams did not have any clear guidance to tell them how quickly to respond to messages they received. In addition, this system was not monitored and evaluated for effectiveness.

We saw good examples of local leadership in all of the services we visited. The staff we spoke with felt well supported by their immediate line manager and were aware of the senior leaders in their local areas. There were mixed views from staff, working in different locations, about how effective they felt communication from board was.

Summary of findings

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

Are services safe?

The trust had a system of governance in place, which team managers used to monitor and support the services they provided. However, the sharing of information and outcomes from incidents with staff varied across the trust.

Overall, the intensive teams had enough staff, with the right mix of skills to provide effective services. However, two teams, South Gloucestershire and BaNES, told us that there were staffing vacancies that sometimes had an impact on the team's capacity.

Improvements should be made to the out-of-hours medical cover in the North Somerset and Bristol intensive support teams, where cover was provided by doctors who were also on call for the inpatient wards across Bristol and North Somerset. We were told that this could cause some delay to assessment.

Most staff had received mandatory training on safeguarding, and knew how and where to report safeguarding issues. Staff felt confident in raising concerns and knew how to escalate them if necessary.

Staff were also aware of the trust's lone worker policy and we saw that, in line with this policy, they provided details on their whereabouts. Where necessary, staff undertook joint visits and other precautions, which were supported by team discussions and risk assessments.

We saw that staff prioritised work according to risk and identified people's needs through risk management and through reviewing caseloads on a daily basis. Appropriate systems for sharing information with other services were also in place.

In the South Wiltshire, North Somerset, Swindon and South Gloucestershire teams, we found that there were no clearly defined procedures for managing medicines.

Are services effective?

Most of the people who used the service received effective care and treatment by competent staff. We also saw that staff received regular clinical and management supervision, but some staff were concerned that the opportunities for training and professional development had decreased. There was also little on offer in addition to core mandatory training. Some staff had not received training in the application of the recovery star model.

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.

The trust used a number of different outcomes to benchmark services' effectiveness. However, we did not see much evidence that service provision, and the associated outcomes, were reviewed at local level to make sure that services across the trust were consistent. We found that while some teams used rating scales, these were not used across the trust's intensive services. We also saw evidence that two services, Bristol and South Gloucestershire, were accredited by the Royal College of Psychiatrist' home treatment accreditation scheme.

Are services caring?

Most people using services told us that they were treated with kindness, dignity and respect, and did not raise any concerns about how staff treated them. However, there were mixed views of the Swindon intensive team. While some said they had a good experience of using their services, others reported an inconsistent, and sometimes unhelpful and uncaring, response when they contacted the team.

Overall, we found that staff assessed and planned care in line with individuals' needs. We also found that they were good at involving people, family and friends in their care; although some carers told us that they did not always feel listened to.

Are services responsive to people's needs?

The teams had the systems in place and the capacity to respond effectively to routine and urgent referrals. Urgent assessments could be arranged within four hours. Quality assurance information also showed that the teams were generally keeping within this target.

Some people said they had raised concerns about not being able to access help quickly enough outside of office hours. They were particularly concerned about how long it sometimes took for teams to make contact with people after they had left messages at the call centre. In addition, not all teams provided 24-hour access to the intensive support services. For example, Bristol operated their own crisis telephone service, while calls to the South Gloucestershire team were diverted to an inpatient ward at night.

While staff knew how to manage complaints, feedback about local complaints varied between the teams. The trust were aware of a number of complaints relating to the Swindon intensive service.

Summary of findings

Staff told us that it was very difficult to find a bed locally if a person needed to be admitted to hospital, particularly to a psychiatric intensive care unit (PICU). Staff said that they could spend a significant part of their shift trying to locate a bed. This meant that people sometimes had to be admitted to a hospital that was not close to their home or family.

The trust had recently established a number of forums to improve engagement with staff, people and their representatives. These included holding open listening events to hear the views of people who use the services and the wider community. There was a service user and carer involvement co-ordinator for each area, whose role it was to promote people's involvement. Some people told us that they had the opportunity to get involved in a number of projects that contribute to shaping services.

Are services well-led?
We saw that service developments were being made with consideration for local needs and were monitored for risks. In the services we visited, we saw good examples of local leadership. Staff also told us that they felt well supported by local managers and that there were clear lines of accountability. Most of the teams had good staff morale.

The trust had developed a local management team for each area as part of the restructuring of the senior management team. Each local management team consisted of a managing director, a clinical director and a head of profession and practice. How supported and listened to staff felt by senior management teams, however, varied between areas.

Summary of findings

Background to the service

Avon and Wiltshire Mental Health Partnership NHS Trust has seven intensive support teams. These are located across the trust to make sure that everyone served by the trust has access to this service.

The aim of the service is to provide rapid assessments and treatment to people aged 18 or over, who are experiencing an acute breakdown in their mental health. The service is available 24 hours a day, 365 days of the year. The intensive support teams aim to provide people with the most suitable and least restrictive treatment possible. A key part of their role is to monitor and coordinate the acute adult mental health inpatient beds available in their local area, by deciding who should be admitted to hospital. Where possible, the intensive support teams provide an alternative to being admitted

to hospital by providing home treatment and supporting people to stay at home. The teams also work closely with inpatient wards to offer home support and to help people leave hospital more quickly.

The multidisciplinary teams comprise mental health nurses, social workers, doctors, occupational therapists and mental health support workers. The intensive support team assesses people's needs and agrees a plan. This includes the use of support, advice, medicines and a range of therapeutic interventions, which are all specifically designed for those in crisis or experiencing an acute breakdown of their mental health. The intensive teams also work with family, friends and carers. They have a good knowledge of local services and can help people learn from their experience, in terms of crisis prevention and management.

Our inspection team

Our inspection team was led by:

Chair: Professor Chris Thompson, Consultant Psychiatrist

Team Leaders: Julie Meikle, Head of Hospital Inspection

Lyn Critchley, Inspection Manager

The team included CQC managers, inspection managers and inspectors 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 core service 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?

Before visiting these services, we reviewed information which was sent to us by the provider and considered feedback from relevant local stakeholders, including advocacy services and focus groups. We also reviewed feedback sent to us directly by people who use the service or their representatives.

We carried out unannounced visits to the services on 10, 11, 12 June 2014. We spoke with 18 people who used the service and we visited three people in their homes, with

Summary of findings

their permission and accompanied by trust staff. We spoke with five carers by telephone, and were sent a survey of the intensive service undertaken by one of the local service user networks in Swindon, which contained the views of 26 people.

We spoke with managers, frontline staff, pharmacy, administrative support staff, service managers and

doctors. We attended multidisciplinary handover meetings at each location and team meetings at two locations and reviewed care and treatment records at each location in detail. We also reviewed the trust's systems for obtaining feedback from other people who had contact with the service. This helped us to obtain a view of the experiences of people who use the services.

What people who use the provider's services say

People who use the service and their representatives were asked for their views about their care and treatment by the trust. We were told that surveys were sent out by the trust to all people who use the service. Although there was not a good level of response from these surveys, the feedback they had received was largely positive.

Although most people we spoke with were positive about their interactions with staff, some people told us they received an inconsistent and not always caring response from staff. 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 who use the service 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.

Good practice

The South Gloucestershire 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. The network aims to meet every other month.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must protect people who use services against the risks associated with the unsafe use and management of medicines.
- The trust must make sure that there are enough staff, including medical staff, to manage the intensive support service.
- The trust must make sure that all staff have received mandatory training, including managing conflict and basic life support.

- The trust must make sure that staff have received training in how to use assessment tools.

Action the provider SHOULD take to improve

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

Avon and Wiltshire Mental Health Partnership NHS Trust

Community-based crisis services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
South Gloucestershire Intensive Service	Trust HQ
Swindon Intensive Service	Trust HQ
Wiltshire Intensive North	Trust HQ
Wiltshire Intensive South	Trust HQ
BANES Intensive Service	Trust HQ
North Somerset Intensive service	Trust HQ
Bristol Intensive service	Trust HQ

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act (MHA) 1983. We use our findings as a determiner in reaching an overall judgement about the provider.

We were told that the teams attended all MHA assessments and, where possible, would offer an alternative to hospital admission. We were told that 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 sometimes 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.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) 2005 was not fully reviewed under this core service but was considered through our review of inpatient services. However, intensive service staff demonstrated that they had received training in the MCA and Deprivation of Liberty Safeguards and were aware of these principles.

Are services safe?

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

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

Summary of findings

The trust had a system of governance in place, which team managers used to monitor and support the services they provided. However, the sharing of information and outcomes from incidents with staff varied across the trust.

Overall, the intensive teams had enough staff, with the right mix of skills to provide effective services. However, two teams, South Gloucestershire and BaNES, told us that there were staffing vacancies that sometimes had an impact on the team's capacity.

Improvements should be made to the out-of-hours medical cover in the North Somerset and Bristol intensive support team, to make sure that it is adequate to meet people's needs.

Most staff had received mandatory training on safeguarding, and knew how and where to report safeguarding issues. Staff felt confident in raising concerns and knew how to escalate them if necessary.

Staff were also aware of the trust's lone worker policy and we saw that, in line with this policy, they provided details on their whereabouts. Where necessary, staff undertook joint visits and other precautions, which were supported by team discussions and risk assessments.

We saw that staff prioritised work according to risk and identified people's needs through risk management and through reviewing caseloads on a daily basis. Appropriate systems for sharing information with other services were also in place.

In the South Wiltshire, North Somerset, Swindon and South Gloucestershire teams, we found that there were no clearly defined procedures for managing medicines.

Our findings

South Gloucestershire intensive service
Track record on safety
The team 'IQ dashboard' and the trust risk register were used to identify and monitor risks. The trust held data

relating to incident reporting. The team had a shift co-ordinator, part of their responsibility was to delegate work effectively and ensure they are aware of the whereabouts of all staff. Staff also detailed their whereabouts in line with the lone working policy.

Learning from incidents and Improving safety standards
Staff had access to the trust safety alerts and resources on the intranet. Learning from incidents was shared within the team meetings and in individual management supervision. We were shown an example of incident reporting and the outcome. Staff felt confident in raising concerns and how they would escalate it if necessary. We saw from trust incident reporting data that there was a low level of incident reporting in the team.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse
Staff had received their mandatory safeguarding training and knew about the relevant trust wide policies relating to safeguarding. Staff demonstrated knowledge on how and where to report safeguarding issues. There was a designated lead on safeguarding identified within the team. Safeguarding concerns were also discussed during the multidisciplinary team meetings and at handover. There was no available data held locally, relating to numbers of safeguarding referrals made in the team and there were no current safeguarding issues at the time of inspection.

There was an identified medication lead in the team. We found that there were not appropriate facilities in place to monitor, store and dispose of unwanted medication. We saw three sealed pharmacy buckets containing waste medication on the side in the clinic room, which could easily be removed. The current waste bucket was in a locked cupboard as recommended. Concerns around storage and disposal of unwanted medication were raised with the Chief Pharmacist.

Assessing and monitoring safety and risk
There was evidence of comprehensive information sharing between the team members. The team had a detailed handover board with a 'traffic light' risk rating system, which flagged up a wide range of care and risk issues for daily updating and discussion.

Are services safe?

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

We reviewed three patient`s records, who were on the team caseload at the time of our inspection. We saw that people`s needs and risks were assessed and clearly documented. The risk assessments we looked at were up to date and reflected current individual risks and relevant historical risk information.

Understanding and management of foreseeable risks

The manager reported that staffing numbers had been affected by sickness and three key senior staff seconded to different parts of the trust or training. Staff had not been replaced. The team had been managing this by relying on staff working flexibly and extra hours, also using bank staff where indicated.

People who use the service did not have a direct contact number for the team after 5pm. Calls to the team were initially taken by call centre staff. These non-clinical staff took a message and passed information on to the intensive service. After 9.30pm, calls were put through to an inpatient ward for telephone advice and support.

Swindon intensive service

Track record on safety

The manager told us that they used the team 'IQ dashboard' and the trust risk register to identify and monitor risks. The team had a shift co-ordinator and part of their responsibility was to delegate work effectively and ensure they are aware of the whereabouts of all staff. Staff also detailed their whereabouts in line with the lone working policy. The manager had introduced a number of process maps which clearly identified actions to be taken for a number of risk management issues that may arise within the team. This folder was kept in the team office and staff signed to confirm they had read and understood them.

Learning from incidents and improving standards

We saw that there was shared learning from incidents at both trust and local level. Staff were encouraged to report their concerns and were able to tell us how they did this. We saw an example of a root cause analysis (RCA) report following a serious incident. Recommendations to address concerns about poor care records, particularly care plans and risk assessments had been put into place. We were shown an action plan for staff to be supported in this area by the team manager and psychologist. We heard this being discussed further in the team meeting.

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

Staff received training on safeguarding adults and children. There was a designated lead on safeguarding identified within the team. Staff were aware of who the lead was and felt able to discuss concerns with them. Staff demonstrated knowledge on how and where to report safeguarding issues. The manager told us that safeguarding concerns were also discussed during the multidisciplinary team meetings. There were no current safeguarding issues at the time of inspection. The team indicated a low level of safeguarding concerns being reported and did not have a system in place to monitor this.

We found that there were not appropriate facilities in place to monitor, store and dispose of medication. The pharmacist had a limited number of sessions with the team. The locked medication cupboard was kept within a large cupboard, with access by all staff via a key-code. There were not lockable storage facilities for unwanted medications and we saw sealed pharmacy buckets on the shelf, containing medications. These could be easily removed. There was not an accurate record completed to indicate what medications were to be disposed of. Concerns around monitoring, storage and disposal of unwanted medication were raised with the Chief Pharmacist.

Assessing and monitoring safety and risk

We reviewed four people`s records, who were on the team caseload at the time of our inspection. We saw that people`s needs and risks were assessed and clearly documented. The risk assessments we looked at were up-to-date and reflected current individual risks and relevant historical risk information. However, it was not always clearly documented what action had been, or should be, taken relating to identified risk. An outcome of recommendations from a serious incident referenced the need for the team to improve on assessing and clearly recording risks. The staff were being supported through in-house record keeping training and care notes audit, from the team manager and psychologist, to ensure improvements were made in this process.

The team operated a `traffic light` risk rating system to clearly identify risk levels on their caseload. We observed part of a shift handover and saw that people`s risks were discussed. For example, staff identified where there may be elevated risk and that staff should visit in pairs.

Are services safe?

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

Understanding and management of foreseeable risk

Some staff told us that they did not think that staffing levels were always safe, although other staff felt there were problems with the way the shift was organised rather than a lack of staff. The manager had introduced a clear 'process map', which outlined how the shift co-ordinator should assess the numbers required for a shift, for example, if extra staff may be required due to increased workload. We observed bank staff being contacted to support the team when an increase in caseload needs was identified during the morning shift we were there.

Staff worked across four shifts, with maximum staffing numbers available between 2pm and 5pm. We observed discussion in the team meeting about potentially altering shift patterns to make more staff available in the evenings.

Wiltshire North intensive service (Green Lane)
Track record on safety

There were mechanisms in place to report and record safety incidents, concerns and near misses. The trust wide evidence provided showed us that the trust was reporting concerns through the National Reporting and Learning System (NRLS).

The service managers confirmed that clinical and other incidents were reviewed and monitored monthly. We saw that the risk registers were updated and regularly reviewed by the managers. The trust's electronic system had a 'red top' alert which notified staff of any alerts with regard to a serious incident. Staff also received feedback on incidents at their team meeting which was evidenced in the records read.

We saw that people's records identified their previous risks and behaviours as well as current assessed concerns and risks. We observed the evaluation of the risk register during the multidisciplinary handover meeting which included the consultant psychiatrist.

Learning from incidents and improving safety standards

Staff confirmed they were encouraged to report incidents and 'near misses'. Both the staff and managers confirmed that the trust had an online reporting system to report and record incidents and near misses. We saw the monthly clinical incident reports which were reviewed and discussed by the management teams. The report outlined the impact to the service; the underlying cause as well as

the risk and governance team's comments. People who use the service told us that they were able to voice their concerns to staff although they had not had to do so. Staff confirmed that they had received mandatory safety training and that they felt supported by their manager following any incidents or near misses.

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

Staff were aware of the trust's safeguarding policy. The records seen showed us that staff had received their mandatory safeguarding children's training at Level 3. The records within the electronic system identified any potential safeguarding concerns. Staff we spoke with confirmed they were aware of their responsibilities to safeguard children and adults and to report any concerns which, if required, included the local authority that had responsibilities to investigate safeguarding matters. Staff were aware of the trust's whistleblowing policy and confirmed they felt able to raise concerns with their manager.

The service we visited were clean and well maintained with up-to-date environmental risk assessments in place which included for example; ligature risk assessments and slips, trips and falls.

We reviewed the management of medicines within the service. We saw that the pharmacists visited the service and managed the medicines regularly. The pharmacy conducted stock checks and audits and maintained the stock for out-of-hour's services. The manager for the unit was a prescriber and we reviewed the trust's guidelines. The manager confirmed that they were unable to administer medicines if they had been the prescriber. All medicines were identified on the trust's electronic system. The intensive support team also manage the section 136 suite alongside the ward. The manager confirmed they were able to prescribe and administer medicines but did not use rapid tranquillisers. We found no issues or concerns identified with the management of medicines.

Assessing and monitoring safety and risk

We observed a staff handover with the multidisciplinary team. Areas addressed included; the discharge of people to different services, the transportation of a person out of area and the planned referral of a person to a drug and alcohol services. We observed that time was also spent discussing the ten caseloads they had acquired from the recovery team. The manager told us they had acquired the

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caseloads to support the recovery team during the absence of a manager. However, due to the re-alignment of the boundaries four of the recovery caseloads were to be transferred to Wiltshire East and the manager confirmed they were in negotiation with the manager for that area. We found no communication or correspondence between the recovery team and the intensive support team regarding the well-being of the ten people. Overall this meant that staff might not be aware of people's needs and associated risks.

The manager told us that they were currently two senior nurses down and were actively recruiting. We reviewed the staffing rotas for May 2014 which showed us that the staffing levels were adequate and any shortfalls were covered by the trust's own bank staff. The consultant for the intensive support team said the work was manageable as it was an "unpredictable pattern of work" which was confirmed by staff we spoke with. The consultant said that the handover meetings were a good place to "ventilate" and feel a part of the team. They said that the team had very competent nurses and reliable staff with a good team spirit.

Understanding and management of foreseeable risks

Staff told us they were aware of the lone working policy and the guidance in it. The service had a record of staffs whereabouts and a coded message system to identify support needs when visiting people in the community. Staff were aware of the trust's emergency contingency plan. A risk register was in place and this identified the current risks to the service.

South Wiltshire intensive service (Fountain Way)
Track record on safety

There were mechanisms in place to report and record safety incidents, concerns and near misses. The service manager confirmed that clinical and other incidents were reviewed and monitored monthly. We saw that the risk registers were updated and regularly reviewed by the managers. The trust's electronic system had a 'red top' alert which notified staff of any alerts with regard to a serious incident. Staff also received feedback on incidents at their team meeting which was evidenced in the records read.

We saw that people's records identified their previous risks and behaviours as well as current assessed concerns and risks. We observed the evaluation of the risk register during the multidisciplinary handover meeting.

Learning from incidents and improving safety standards

Both the staff and manager confirmed that the trust had an online reporting system to report and record incidents and near misses. We saw the monthly clinical incident reports which were reviewed and discussed by the management teams. The report outlined the impact to the service; the underlying cause as well as the risk and governance team's comments.

Staff confirmed they were encouraged to report incidents and 'near misses'. The manager confirmed that staff had recently undertaken incident training and all incidents were discussed at supervision which was confirmed within the records read. People who use the service told us that they were able to voice their concerns to staff although they had not had to do so.

Staff confirmed that they had received mandatory safety training and that they felt supported by their managers following any incidents or near misses. The trust encouraged openness and transparency and there were clear guidance on incident reporting. All staff could describe their role in the reporting process.

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

Staff were aware of the trust's safeguarding policy. The records seen showed us that staff had received their mandatory safeguarding children's training at Level 3. Staff we spoke with confirmed they were aware of their responsibilities to safeguard children and adults and how to report any concerns. Staff were aware of the trust's whistleblowing policy and confirmed they felt able to raise concerns with their manager.

The records and evidence seen showed us that the trust ensured that adequate staffing, equipment and facilities were available to promote the effective delivery of community care and treatment for the people who use the service.

The service we visited were clean and well maintained with up to date environmental risk assessments in place which included for example; slips, trips and falls.

We reviewed the management of medicines within the service. We noted the pharmacy did not visit daily and staff within the service maintained the medicines. We found that

Are services safe?

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stock checks were not completed, although a stock check that we undertook did not identify any concerns. We reviewed the last audit completed by pharmacy which did not identify any issues or concerns.

We observed within the metered dosage system that one person's tea-time and evening medicines were administered and given at tea-time. We found no evidence within the records read that this practice had been discussed or authorised by the doctor or consultant. The service did not have clear procedures in place to protect people who use the service against the risks associated with the unsafe use and management of medicines. This was brought to the attention of senior trust staff during the inspection.

Assessing and monitoring safety and risk

We observed a staff handover with the multidisciplinary team, which included the doctor. Areas addressed included; the discharge of people to different services and the transportation of a person out of area.

The manager told us they were in negotiation with their line manager regarding staffing and funding. We reviewed the staffing rotas for May 2014 which showed us that the staffing levels were adequate and any shortfalls were covered by the trust's own bank staff.

Understanding and management of foreseeable risks

Staff were aware of the lone working policy. The service had a record of staffs whereabouts and a system to identify support needs when visiting people in the community. Staff were aware of the trust's emergency contingency plan. A risk register was in place and this identified the current risks to the service.

BANES intensive service
Track record on safety

There were systems and policies in place and staff told us they knew how to report concerns and were encouraged to do so.

Learning from incidents and improving safety standards

Staff had access to the trust safety alerts and resources on the intranet. Some staff told us that they had not been sufficiently involved or given clear feedback following the root cause analysis investigation into recent serious incidents on the inpatient ward.

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

The team was not fully staffed. There were four healthcare assistant vacancies. Bank and agency staff were used to fill gaps in the rota. A staff member told us that, whilst not unsafe, staffing shortage sometimes caused problems as there was no cap on demand and this meant having to prioritise. An induction checklist had been developed to ensure that all new temporary staff had the necessary knowledge and competencies. Two consultants supported the team Monday to Friday (half a week each) and out-of-hours a consultant was available on call. There was no direct access to psychology but referrals were made to the recovery service. The consultant told us that people usually waited two to four weeks to access psychology services.

Records confirmed that all staff were trained in safeguarding. Staff we spoke with demonstrated a good understanding of their responsibilities to report concerns.

Assessing and monitoring safety and risk

Risks relating to specific individual needs were discussed and recorded at every handover meeting. The team operated a risk rating system to clearly identify and monitor risk.

Bristol intensive service
Track record on safety

There were mechanisms in place to report and record safety incidents, concerns and near misses. The trust wide evidence provided showed us that the trust was reporting concerns appropriately through the National Reporting and Learning System (NRLS). The data provided for the trust showed a downward trend of incidents over the last year.

Senior managers confirmed that clinical and other incidents were reviewed and monitored monthly. We saw that the local risk register was updated and regularly reviewed. The trust's electronic system had a 'red top' alert which notified staff of any alerts with regard to a serious incident. Staff also received feedback on local and trust wide incidents at their weekly team meeting.

We saw that individual care and treatment records identified previous risks and behaviours as well as current assessed concerns and risks. We observed this being evaluated as part of the lunch time multidisciplinary handover meeting.

Are services safe?

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

The evidence seen demonstrated to us that the service had a proven track record on safety and had learnt from incidents that had happened.

Learning from incidents and improving safety standards

Staff confirmed that the trust had an online reporting system to report and record incidents and near misses. We saw the monthly clinical incident reports which were reviewed and discussed by the management teams. The report outlined the impact to the service; the underlying cause as well as the risk and governance team's comments.

Staff confirmed that they had received mandatory safety training and that they felt supported by their managers following any incidents or near misses. For example, we saw post incident management plans in place. People who used the service told us that they were able to raise any concerns about their care with staff.

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

The records and evidence seen showed us that the trust ensured that adequate staffing was available during the day to promote the effective delivery of community crisis care and treatment for people who used the service. . However 'Out-of-hours' psychiatric medical care was provided by trust employed psychiatrists who also covered the acute admission wards and other services in Bristol. We were told that this could some delay to assessment.

Staff were aware of the trust's safeguarding policy. The records seen showed us that staff had received their mandatory safeguarding children's training at Level 3. Senior staff confirmed that they were in discussion with the trust to obtain clarification of the need for "Prevent" adult safeguarding training as required by law. The trust gave us the flyer for the training which showed that the target audience was clear and that it was a mandatory training, but we heard that this was not understood by all staff.

We found that care and treatment records identified any potential safeguarding concerns. Staff confirmed that they had received their mandatory safeguarding training. They were aware of their responsibilities to report any concerns to the relevant statutory agencies. Staff were aware of the trust's whistleblowing policy and confirmed they felt able to raise concerns with their manager.

The service we visited was clean. However, we noted that some furniture was showing signs of 'wear and tear'. Senior staff informed us that plans were in place to replace this furniture. We saw current environmental risk assessments in place which included for example; fire risk assessments and maintenance arrangements.

Medicines were managed appropriately within the service and we noted an effective medicines stock control and audit system in place.

Assessing and monitoring safety and risk

We observed a lunchtime handover with the multi-disciplinary team. This included a detailed discussion about people who were assessed as requiring additional crisis support. We saw that the team was quick to provide support and guidance to each other.

We found that there were enough staff to meet the needs of the service. The service had recently recruited two trust employed bank staff in order to cover any potential staff shortfalls over the summer. Plans were reported to recruit another three to four whole time equivalent staff by October 2014. Senior staff confirmed that escalation would take place if caseload needs increased. This meant that staff were aware of people's needs and associated risks. Staff told us that the team had good morale and a good team spirit.

Understanding and management of foreseeable risks

Staff were aware of the trust's lone worker policy. We saw that joint visits and other precautions were taken by staff and these were supported by clear risk assessments. The services had a record of staffs whereabouts and a coded message system to identify any concerns when visiting people in the community.

A local risk register was in place and this identified the current risks to the service. Clear contingency plans were in place and staff were aware of these. For example, contingency plans were in place for the breakdown of telephony services and for the emergency evacuation of the building.

North Somerset intensive service
Track record on safety

The service had mechanisms in place to report and record safety incidents, concerns and near misses. The trust wide evidence provided showed us that the trust was reporting concerns appropriately through the National Reporting and Learning System (NRLS).

Are services safe?

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

Senior managers confirmed that clinical and other incidents were reviewed and monitored monthly. We saw that the local risk register was updated and regularly reviewed. The trust's electronic system had a 'red top' alert which notified staff of any alerts with regard to a serious incident. Staff also received feedback on local and trust wide incidents at their weekly team meeting.

We saw that individual care and treatment records identified previous risks and behaviours as well as current assessed concerns and risks. We observed this being evaluated as part of the lunch time multidisciplinary handover meeting.

Learning from incidents and improving safety standards

Staff confirmed that the trust had an online reporting system to report and record incidents and near misses. We saw staff had access to the system via "password" protected computer systems.

We saw the monthly clinical incident reports which were reviewed and discussed by the management teams. The report outlined the impact to the service; the underlying cause as well as the risk and governance team's comments.

Staff confirmed they were encouraged to report incidents and 'near misses'. We found that staff had recently undertaken incident training and all incidents were discussed at their regular supervision. People who used the service told us that they were able to raise any concerns about their care with staff.

Staff confirmed that they had received mandatory safety training and that they felt supported by their managers following any incidents or near misses. For example, we saw post incident management plans in place.

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

The records and evidence seen showed us that the trust ensured that adequate staffing was available during the day time to promote the effective delivery of community crisis care and treatment for people who used the service.

However psychiatric medical care was being provided by two part time psychiatrists and a part-time staff grade doctor and there was no 'out-of-hours' psychiatric medical cover for this service other than the on-call consultant psychiatrist This was discussed with senior staff and the trust during our inspection.

Staff confirmed that they had received their mandatory safeguarding training and were aware of the trust's safeguarding policy. The records seen showed us that staff had received their mandatory safeguarding children's training at Level 3. We found that care and treatment records identified any potential safeguarding concerns. Staff were aware of their responsibilities to report any concerns to the relevant statutory authorities. During our home visits with staff we noted an emphasis on the safety and wellbeing of the person who used the service

Staff informed us that recent changes within the trust had led to the introduction of a centralised pharmacy service. Since this, staff reported delays in obtaining some medication and some dispensing errors. This was brought to the attention of senior staff during our inspection.

Assessing and monitoring safety and risk

We observed a lunchtime handover with the multidisciplinary team. This included a detailed discussion about people who were assessed as requiring additional crisis support. Staff reported that these meetings were used to discuss complex cases were necessary. This showed us that staff were able to meet the individual needs of the people who use the service.

We found that there were adequate staff to meet the needs of the service. We noted that the team had a shared caseload of between 20 and 35. Senior staff confirmed that trust employed bank staff would be used if there was any increase in caseloads.

Understanding and management of foreseeable risks

Staff were aware of the trust's lone worker policy. We saw that joint visits took place and other precautions were taken by staff during home visits and these were supported by clear risk assessments.

Clear contingency plans were in place and staff were aware of these. Senior staff were able to describe the alternative arrangements in place to ensure service continuity. A local risk register was in place and this identified the current risks to the service.

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

Most of the people who used the service received effective care and treatment by competent staff. We also saw that staff received regular clinical and management supervision, but some staff were concerned that the opportunities for training and professional development had decreased. There was also little on offer in addition to core mandatory training. Some staff had not received training in the application of the recovery star model.

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.

The trust used a number of different outcomes to benchmark services' effectiveness. However, we did not see much evidence that service provision, and the associated outcomes, were reviewed at local level to make sure that services across the trust were consistent. We found that while some teams used rating scales, these were not used across the trust's intensive services. We also saw evidence that two services, Bristol and South Gloucestershire, were accredited by the Royal College of Psychiatrist' home treatment accreditation scheme.

Our findings

South Gloucestershire intensive service
Assessment and delivery of care and treatment
We found that staff assessed and planned care in line with the needs of the individual. We observed that the handover was a comprehensive discussion. Each shift, there was a shift co-ordinator, who would prioritise and delegate contacts required for people who use the service.

Service users were offered a copy of their care plan and consent was obtained and reviewed. Physical health needs were largely managed by the individual`s GP. The team sent a letter to the GP requesting information about current medication and physical aspects of an individual`s care.

Outcomes for people using services
There were systems in place to monitor quality and performance. The trust had a range of audit systems in place which monitored team performance. The team manager also told us that they were monitoring quality and performance through regular individual supervision and care records audit.

People`s care and treatment reflected relevant research and guidance. The team was accredited with The Royal College of Psychiatrist`s Centre for Quality and Improvement, Home Treatment Accreditation Scheme.

Staff, equipment and facilities
We saw that staff received the mandatory training they needed and where updates were required, dates had been set and the manager reviewed these. Staff confirmed that they received regular clinical and management supervision and we saw some supervision records. There was also monthly team supervision and informal peer support available.

We looked in the clinic room and found that equipment was not available to undertake physical checks, such as weight or blood pressure. We were told that a letter was sent to the GP to find out about a person`s physical health and recent checks. We were told that the team planned to obtain a medical bag to support them undertaking more physical aspects of care.

Multidisciplinary working
Staff told us that they worked collaboratively with other health and social care professionals to meet people`s needs effectively. The team was made up of nursing staff, occupational therapists, support workers and a psychologist. The team had 0.6 whole time equivalent consultant psychiatrists and one specialty doctor who undertook home visits if required and attended the team handover daily. There was no access to crisis bed facilities. The psychologist working in the team offered both assessment and planning advice, supporting training staff in risk assessment and formulation.

Mental Health Act (MHA) 1983
We were told that the team attended all MHA assessments and where possible would offer an alternative to hospital admission. We were told that during office working hours the team were able to access the appropriate professionals to undertake a MHA assessment if required. However, staff reported they did have difficulty sometimes securing an

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.

out-of-hours assessment, stating that sometimes they had been advised by the local authority emergency duty service to a ensure bed availability before an assessment would be undertaken.

Swindon intensive service

Assessment and delivery of care and treatment

People who use the service and their carers did not always understand the role of the intensive service or why they had been referred to the team. Some people who use the service reported finding it difficult seeing a number of different staff, although they were advised that they may have contact from different members of the team. The team had recently introduced a keyworker system, to try and ensure that people had a point of contact.

Each shift, there was a shift co-ordinator, who would prioritise and delegate contacts required for people who use the service. The team were being supported to improve how they assessed needs and developed care plans in collaboration with the person. We saw detailed daily progress notes which reflected how people who use the service had engaged with the support and care given.

We looked at care records and saw that most had consent recorded. The team had identified that they were not always clear about ensuring that they had gained and recorded consent, or clearly established who they could share information with. We observed that this issue was discussed in the team meeting. Consent and capacity were not routinely reviewed as part of the daily handover discussion.

Outcomes for people using services

There were systems in place to monitor quality and performance. The trust had a range of audit systems in place which monitored team performance, which team managers had access to. The team manager also told us that they were monitoring quality and performance through regular individual supervision and care records audit. The team was not currently accredited or actively participating in research.

Staff, equipment and facilities

Some staff expressed concern that opportunities for training and professional development had been reduced and that there was little on offer in addition to the core mandatory training provided. The manager had a clear overview of mandatory training requirements for the team.

Staff confirmed that they received regular management supervision and we saw some supervision records. Staff had laptops and mobile telephones to support their work in the community.

Multidisciplinary working

Staff told us that they worked with other health and social care professionals, for example, the wards and community mental health teams, using the care programme approach process. Although the team had social workers and occupational therapists in the team, we were told that at present they functioned in a generic multidisciplinary approach.

There were no current day service facilities or acute occupational therapy pathway which the team accessed or operated. The team had two consultant psychiatrists who undertook home visits if required. They did not attend the team handover daily, although attended a weekly planning meeting and were available at request.

Mental Health Act (MHA) 1983

Staff reported that they attended most MHA assessments. We were told that during office working hours the team were able to access the appropriate professionals for advice or to undertake a MHA assessment if required. However, they did have difficulty sometimes securing an out-of-hours assessment, stating that they had been advised to a ensure bed availability before an assessment would be undertaken. The team also helped to manage the section 136 suite at Sandalwood Court.

Wiltshire North intensive service (Green Lane)

Assessment and delivery of care and treatment

The intensive support team used a variety of guidelines including the Mental Health Act (MHA) 1983 code of practice and the Mental Capacity Act (MCA) 2005. This enabled staff to ensure that people who use the service had the capacity to consent to treatment. We observed three people's records which had the relevant assessments and signed consent forms in place.

We saw that individual care and treatment records reflected the assessed needs of people who use the service and how they were being met. We observed that care plans had been reviewed and signed by people who use the service. The records showed us that people's physical healthcare needs were addressed by the service and that assessments of their physical health status were recorded.

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.

We saw there were no crisis contingency plans in place within the records read. We were informed this was the responsibility of the crisis team but due to the amalgamation of the teams under the umbrella of the community mental health team (CMHT) we found no guidance as to who was responsible for collating the information. We were informed this was currently in discussion with the trust.

The managers confirmed that trust wide monthly audits were carried out via the internal IQ system and submitted to the head of operations and head of professional practice. We observed these findings were cascaded down and discussed at the monthly Wiltshire performance meeting.

Outcomes for people using services
The records and other evidence seen showed us that the trust was involved in the monitoring and measurements of quality and outcomes for people who use the service. We observed that the service also utilised the Montgomery-Asberg Depression rating Scale (MADAS). MADAS is designed to be used for people with major depressive disorder, both to measure the degree of severity of depressive symptoms, and particularly as a sensitive measure of change in symptom severity during the treatment of depression. The service also used the Hamilton Anxiety Rating Scale (HAM-A). The HAM-A is a psychological questionnaire used by clinicians to rate the severity of people's anxiety. We found no outcome measures benchmarking the outcomes of people and that the two rating scales were not utilised consistently across the trust's intensive services.

We were informed that all people discharged from the ward would have a follow up review by the intensive support team within 48 hours. We did not see any audits or analysis to confirm that this practice and the service were provided within the 48-hour guidelines.

The service used the recovery star model. The recovery star model is used to support people to make and understand changes in their lives.

Staff, equipment and facilities
The records and evidence seen showed us that the trust ensured that adequate staffing, equipment and facilities were available to promote the effective delivery of community care and treatment for the people who use the service. We observed a good working relationship with the consultant during handover who also confirmed staff attended daily ward rounds.

The intensive support team had integrated with the crisis intervention team as of 1 June 2014 as part of the restructure within the trust. The manager raised concerns with regard to older people with mental health and the allocation of beds. Currently the intensive team do not support older people with a diagnosis of an organic illness. The manager told us that since the integration they were receiving many calls for the service to deal with organic illness in relation to bed management which put extensive pressure on the teams to support these people. We found no set guidance in place to establish whose responsibility it was to manage older people with organic illness. We were informed that older people had to wait longer than usual for bed allocations due to the uncertainty of responsibility.

We observed that some staff with specialist skills were continuously asked to address specific areas for example, safeguarding. We found that other staff did not have the same skill and we found no evidence of wider learning to ensure that the relevant skills were available and passed on to all staff.

We reviewed the training matrix and noted the current percentage of identified staff trained was 85%. There was a comprehensive induction programme in place with staff being mentored for six weeks. The trust used the recovery star model but we found no evidence that staff had received training in its delivery. The services did not have a competency framework in place to assess staffs ability to carry out their role with people who use the service. We reviewed the clinical supervision audit on the trust's IQ system which identified that 85% of the staff had received their supervision and 95 % of staff had received their annual appraisal.

Multidisciplinary working
We saw the trust worked effectively with other providers and partners in the provision of the service. Staff told us they felt a part of a team with good leadership. We observed detailed multidisciplinary discussions during handover to ensure people's care and treatment was co-ordinated in line with the expected outcome.

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.

We observed arrangements in place to work with health and care providers to co-ordinate the care that met people's needs. The records reviewed showed us that people, and where applicable, their relatives had been involved in their care.

We saw good evidence of patient care pathways within the service. We saw guidance regarding the early discharge pathway which identified the gate-keeping process. The guidance identified the criteria to be met which included consultation with carers, named nurses and the community mental health team.

Mental Health Act (MHA) 1983

We did not review the Mental Health Act at this service.

South Wiltshire – intensive service (Fountain way)

Assessment and delivery of care and treatment

The intensive support team used a variety of guidelines including the Mental Health Act (MHA) 1983 Code of Practice and the Mental Capacity Act (MCA) 2005. This enabled staff to ensure that people who use the service's had the capacity to consent to treatment. We observed four people's records which had the relevant assessments and signed consent forms in place.

We saw that individual care and treatment records reflected the assessed needs of people who use the service and how they were being met. We reviewed four care plan records and found that the information contained were person-centred. We observed that all four care plans had been reviewed and signed by people who use the service.

The records showed us that people's physical healthcare needs were addressed by the service and that assessments of their physical health status were recorded. Examples included a list of all medicines prescribed, identified allergies, physical health problems or disabilities that need to be accommodated.

We saw there were no crisis contingency plans in place within the records read. We were informed this was the responsibility of the crisis team but due to the amalgamation of the teams under the umbrella of the community mental health team (CMHT) we found no guidance as to who was responsible for collating the information. We were informed this was currently in discussion with the trust. The manager however had utilised the care programme approach's (CPA) review form which incorporated a crisis, relapse indicators / warning signs and contingency plan and was updating the information onto the trust's computerised system after each review.

The manager confirmed that trust wide monthly audits were carried out via the internal IQ system and submitted to the head of operations and head of professional practice. We observed these findings were cascaded down and discussed at the monthly Wiltshire performance meeting.

Outcomes for people using services

The records and other evidence seen showed us that the trust was involved in the monitoring and measurements of quality and outcomes for people who use the service. We observed that during the referral process information using the Health of the Nation Outcome Scale (HoNOS) was updated onto the computerised system. 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. However, it was noted that outcome measures were not routinely used to benchmark the outcomes for people using the service, for example, the use and benefit of the recovery star model.

We were informed that all people discharged from the ward would have a follow up review by the intensive support team within 48 hours. We did not see any audits or analysis to confirm that this practice and the service were provided within the 48-hour guidelines.

The service used the recovery star model. The recovery star model is used to support people to make and understand changes in their lives. The aim of the model is to help people build a picture of where they may need more support and how to do things differently. We did not see any evidence of outcomes regarding the use of the recovery star model.

Staff, equipment and facilities

The records and evidence seen showed us that the trust ensured that adequate staffing, equipment and facilities were available to promote the effective delivery of

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.

community care and treatment for the people who use the service. We observed a good working relationship with the doctor during handover who also confirmed staff attended daily ward rounds.

We reviewed the training matrix and noted the current percentage of identified staff trained was 87%. There was a comprehensive induction programme in place with staff being mentored for six weeks. The manager told us that staff had not been trained in the use of the recovery star. The services did not have a competency framework in place to assess staffs ability to carry out their role with people who use the service. We reviewed the clinical supervision audit on the trust's IQ system which identified that 90% of the staff had received their supervision and 95 % of staff had received their annual appraisal.

Multidisciplinary working
We saw the trust worked effectively with other providers and partners in the provision of the service. We observed detailed multidisciplinary discussions during handover to ensure people's care and treatment was co-ordinated in line with the expected outcome. Areas covered included referrals, admissions and transfers.

We observed arrangements in place to work with health and care providers to co-ordinate the care that met people's needs. Where applicable, we saw that their relatives had been involved in their care.

Mental Health Act (MHA) 1983
We did not review the Mental Health Act at this service.

BaNES intensive service
Assessment and delivery of care and treatment
All people who use the service underwent a care assessment of their needs. A pro forma was use to capture key information about the person, including their presenting condition, mental health history, personal and family history. Assessments were carried out by senior (band 6) nurses and every third visit to a patient was undertaken by a registered nurse. We spent only a short time visiting this service and did not have the opportunity to look at patients' records.

Outcomes for people using services
The service had participated in a research project (Crisis Resolution Teams Optimisation and Relapse Prevention Fidelity review) which aims to develop national best practice in crisis resolution teams. The team had achieved an overall score of 'fair'. They had achieved a 'good' or

excellent rating in some areas, whilst other areas were highlighted as areas for improvement. The service had recently been approached to share good practice in facilitating early discharge from hospital because they were one a few services that participated, which had achieved an excellent score in this area. The team's senior practitioner had been tasked with producing a case study to be shared with other services.

The service received no complaints from October 2013 to May 2014. Friends and family data for April and May 2014 was entirely positive, although the response rate was low.

Staff, equipment and facilities
Training records showed that not all staff were up-to-date with statutory and mandatory training. In particular, we noted that eight staff had not completed basic resuscitation training and six staff had not completed training in managing conflict. Team members had been supported to develop specialist skills such as cognitive behavioural therapy (CBT) and family work with people in crisis. Patients had access to a range of group therapy sessions including CBT, dialectal behavioural therapy (DBT) and mindfulness. Staff were regularly supervised and their performance appraised.

Multidisciplinary working
The team worked closely with a range of health and social care teams, both within and outside of the trust. These included recovery staff, inpatient services, primary care liaison service, psychology, housing department and GPs.

There were three handovers each day, where the whole team discussed the current caseload, including people requiring admission or transfer and those currently in hospital who may be approaching discharge. Bed availability was also discussed. A team member was allocated to liaise with Sycamore ward for the shift.

Mental Health Act (MHA) 1983
We did not review the Mental Health Act at this service.

Bristol intensive service
Assessment and delivery of care and treatment
The trust was able to demonstrate that people who use this service received effective care and treatment by competent staff. We saw that people received care based on a comprehensive assessment of individual need using the

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.

Health of the Nation Outcome Scale (HoNOS) assessment. The extent of support that people received was determined by the 'clustering' tool used by the trust to assess individual risk.

Care and treatment records reflected the assessed needs of people who use the service and how they were being met. We found that the information contained was person centred and had been reviewed and signed by people who use the service.

The records showed us that people's physical healthcare needs were assessed and addressed in partnership with the person's GP. People who used the service confirmed that they had access to emergency numbers to enable them to access advice and support when required.

Senior staff confirmed that trust wide monthly audits were carried out via the internal IQ system. We observed these findings were cascaded down and discussed at the fortnightly team meetings

Outcomes for people using services
The records and other evidence seen showed us that the trust was involved in the monitoring and measurements of quality and outcomes for people who use the service. For example, by the use of Patient Reported Experience Measures (PREMS) and Patient Reported Outcome Measures (PROMS). Evidence was seen that this service was accredited with the home treatment accreditation service run by the Royal College of Psychiatrists.

The service also used the recovery star model. The aim of the model was to help people build a picture of where they may need more support and how to do things differently.

Staff, equipment and facilities
The records and evidence seen showed us that the trust ensured that adequate staffing, equipment and facilities were available to promote the effective delivery of community crisis care and treatment for people who used the service.

Senior staff confirmed that discussions were taking place with the trust's complex interventions team with regards to the crisis support of older people with a diagnosis of an organic illness. Training records reviewed showed us that attendance at mandatory training was above 90%. Senior staff informed us that non-attendance was monitored through the trust's training department.

Staff told us that there was a comprehensive induction programme in place with new staff being mentored for six weeks. The supervision and appraisal records seen showed us that staff were receiving supervision monthly and these meetings were used to discuss caseload management and complex care delivery. Staff confirmed that they received annual appraisals and these were used to identify individual training needs and professional development opportunities.

Multidisciplinary working
We saw that the trust worked effectively with other providers and partners to provide the service. We observed detailed multidisciplinary discussions during handover to ensure people's care and treatment was effectively co-ordinated. We found that the team worked well with other specialities and therapy services to provide good multidisciplinary care.

We observed arrangements in place to work with the person's general practitioner to co-ordinate the care that met people's needs. 'Out-of-hours' psychiatric medical care was provided by trust employed psychiatrists who also covered the acute admission wards and other services in Bristol.

Mental Health Act (MHA) 1983
Staff told us they had good knowledge of the MHA and the MHA Code of Practice. The training records seen confirmed that staff had received training on this Act. Senior staff told us that they assessed individual competency with the legislative and other requirements of this Act during supervision.

North Somerset intensive service
Assessment and delivery of care and treatment
We saw that people received care based on a comprehensive assessment of individual need using the Health of the Nation Outcome Scale (HoNOS) assessment. The extent of support that people received was determined by the 'clustering' tool used by the trust to assess individual risk.

Individual care and treatment records reflected the assessed needs of people who use the service and how they were being met. The records showed us that people's physical healthcare needs were assessed and addressed in

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.

partnership with the person's GP. People who used the service confirmed that they had access to emergency numbers to enable them to access advice and support when required.

Outcomes for people using services

The records and other evidence seen showed us that the trust was involved in the monitoring and measurements of quality and outcomes for people who use the service. For example, by the use of Patient Reported Experience Measures (PREMS) and Patient Reported Outcome Measures (PROMS).

Senior staff confirmed that trust wide monthly audits were carried out via the internal IQ system. We observed these findings were cascaded down and discussed at the fortnightly team meetings

Staff, equipment and facilities

The records and evidence seen showed us that the trust ensured that adequate staffing, equipment and facilities were available during the day time to promote the effective delivery of community crisis care and treatment for people who used the service. Senior staff confirmed that discussions were taking place with the trust's complex interventions teams with regards to the crisis support of older people with a diagnosis of an organic illness.

Those training records reviewed showed us that attendance at mandatory training was above 90%. Senior staff informed us that non-attendance was monitored through the trust's training department.

Staff told us that there was a comprehensive induction programme in place with new staff being mentored for six weeks. The supervision and appraisal records seen showed us that staff were receiving supervision monthly and these meetings were used to discuss caseload management and complex care delivery. Staff confirmed that they received annual appraisals. Some staff told us that there were limited opportunities for nurses to develop extended roles, for example, nurse prescribing.

Multidisciplinary working

We saw the trust worked effectively with other providers and partners in the provision of the service. We observed detailed multidisciplinary discussions during handover to ensure people's care and treatment was effectively co-ordinated.

We observed arrangements in place to work with the person's general practitioner to co-ordinate the care that met people's needs. Psychiatric medical care was being provided by two part time psychiatrists and there was no 'out-of-hours' psychiatric medical cover for this service. This was discussed with senior staff and the trust during our inspection.

Mental Health Act (MHA) 1983

Staff told us they had good knowledge of the MHA and the MHA Code of Practice. The training records seen confirmed that staff had received training on this Act. Senior staff told us that they assessed competency with the legislative and other requirements of this Act during individual supervision.

Are services caring?

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

Summary of findings

Most people using services told us that they were treated with kindness, dignity and respect, and did not raise any concerns about how staff treated them. However, there were mixed views of the Swindon intensive team. While some said they had a good experience of using their services, others reported an inconsistent, and sometimes unhelpful and uncaring, response when they contacted the team.

Overall, we found that staff assessed and planned care in line with individuals' needs. We also found that they were good at involving people, family and friends in their care; although some carers told us that they did not always feel listened to.

Our findings

South Gloucestershire intensive service
Kindness, dignity and respect
People who use the service and their representatives were asked for their views about their care and treatment. We were told that surveys were sent out to all people that use the service when they were discharged from the team caseload. Although there was not a good level of return from these surveys, most we saw reported positive, caring interactions with staff. We observed staff discussing people in a caring and respectful manner.

People using services involvement
When a service user first accessed the service, the consent to share form stating their preferences was uploaded onto the electronic note system (RiO) and the team handover spreadsheet. This was then checked regularly and any changes in the service user's preferences were documented. The team had a keyworker system which ensured that people had a consistent point of contact.

People who use the service were routinely offered a copy of their care plan. We looked at three care records, two of these contained clear and comprehensive information, including risk assessments and care plans. Service user feedback forms were generally positive that they received the support they needed.

Emotional support for care and treatment
The team had comprehensive information packs which were given to people who use the service and carers. The team operated an 'open dialogue' model, and attempted to involve carers throughout the care pathway. Some team members had trained in a specialist area, for example, cognitive behavioural therapy (CBT) for psychosis, dialectical behavioural therapy (DBT) or mindfulness. Staff from the psychotherapy department conducted team supervision regularly.

Swindon intensive service
Kindness, dignity and respect
We spoke with people who had used the service and received feedback from a local service user network, who had undertaken some work to capture people's experiences. There were mixed reviews about the care and treatment people received. While some people reported that they had good experiences of working with the team, others reported an inconsistent and unhelpful response when they contacted the team.

People who use the service and their representatives were asked for their views about their care and treatment by the trust. We were told that surveys were sent out to all people who use the service when they were discharged from the team caseload, although there was not a good level of response. The manager had been looking at the surveys returned for themes raised to identify areas of concern.

People using services involvement
Service user feedback reflected variation in people`s views about their involvement in their care. Some people reported that plans were changed without their involvement. Care records we looked at reflected that assessment and initial planning involved the individual. In most of the notes we looked at, consent had been recorded, although it was not always clearly documented who the person agreed to sharing information with.

Some people who use the service also told us that appointments were not always kept and sometimes people were not informed of changes. We observed discussion in a team meeting about trialling an appointment system in order to allow people choice of when to be seen and reduce numerous appointments being booked at the same time, which was currently leading to changes for some service users.

Are services caring?

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

Emotional support for care and treatment

Some people who use the service and their carers, told us that they found staff communication and response was inconsistent and not always caring. The team and manager were aware of concerns raised and we saw that there were action plans address these.

People who use the service did not have a direct contact number for the team after 5pm or at weekends. Some people expressed concern about not being able to speak with someone in a timely manner and felt that this was unsafe and had a negative impact on their mental health.

Wiltshire North intensive service (Green Lane)

Kindness, dignity and respect

We spoke with three people and three carers via the telephone and found the feedback to be good. People said they were positive about the service provided, One person said that staff who had visited them had been "fantastic" and another said that they would recommend the service to family and friends. We observed staff speaking about people in a respectful manner during their handover meeting.

People using services involvement

We saw examples of individual involvement in the records reviewed and of active participation by people in their treatment plans. People were given information regarding the advocacy service available. The trust used the recovery star model but we found no evidence that staff had received training in its delivery. We were informed they were considering using other assessment tools to gauge recovery but observed this was not in place and there was no audit or benchmarking in place to monitor recovery.

Emotional support for care and treatment

Staff told us they supported people to cope emotionally with their care and treatment and the support was available when they needed it. The records showed that people were supported to manage their own health and care needs to maintain their independence. People told us they found it difficult when they were admitted out of the area, as they had limited access to family and friends.

Wiltshire South intensive service (Fountain Way)

Kindness, dignity and respect

We observed the interaction between a person who used the service and a carer by telephone and found the

feedback to be good. One person said that everyone was very helpful and another said that they had been fully involved in their care and treatment. Staff discussed people in a caring and respectful manner.

People using services involvement

We saw examples of individual involvement in the records reviewed and of active participation by people in their treatment plans. People said they understood their care plans and were able to ask questions. We reviewed four care plans and found that the information contained enabled staff to provide the support and care that met people's needs. All care plans looked at had been regularly reviewed and signed by people. We saw guidance regarding the early discharge pathway, which identified the gate-keeping process. The guidance identified the criteria to be met which included consultation with carers, named nurses and the community mental health team.

The trust used the recovery star model but we found no evidence that staff had received training in its delivery. We were informed they were considering using other assessment tools to gauge recovery but observed this was not in place and there was no audit or benchmarking in place to monitor recovery.

Emotional support for care and treatment

Staff told us they supported people to cope emotionally with their care and treatment and the support was available when they needed it. People we spoke with confirmed this. The records showed that people were supported to manage their own health and care needs to maintain their independence. Staff assessed people's social needs which included accommodation, work, finance and activities of daily living (ADL).

BaNES intensive service

Kindness, dignity and respect

We spoke with three carers and two people who use the service over the telephone. They told us that staff were caring, kind and reassuring. We looked at responses to friends and family test questionnaires in April and May 2014. Comments included: "The members of the team came to my house and were very comforting. They listened without comment and were responsive and kind. They gave me a sense of security, knowing that if the mental illness occurs, I have support." and "very supportive….. were quick to understand, listened to me and my situation and I am so grateful for the support getting through my difficult stage."

Are services caring?

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

People using services involvement

People were given information so that they were informed about their illness and their treatment. They were given an information pack which described the service and how to contact it. There was also information about how to make a complaint and how to contact the patient advice and liaison service (PALS) and other support groups. Information leaflets about medicines were made available to patients on request and advice could be sought from the trust's pharmacy department.

Emotional support for care and treatment

People`s spiritual needs were taken into consideration. An assessment tool (HOPE) was used by staff to assess people's needs and inform their care plans. A carer's lead and champion had been appointed in the team to lead initiatives to ensure that carers were supported and involved in their family members/friend's care and treatment.

Three carers we spoke with expressed concerns about a lack of support and communication with them in relation to their relative's care. They told us that they felt the service did not work in partnership with carers who had many years of experience of their family member's illness. One person told us "they never seem to take any history into account so every time there is a new incident with my (relative) we have to start again. They never talk to the carer so they don't get the full picture. Then when you can get hold of someone to find out what is going on, they won't tell you because of confidentiality. This is so ridiculous because it is the family who have to pick up the pieces". Another relative told us that they wanted carers to be listened to and involved in their relative's care, "They were very kind but they were not hearing that I was dealing with a life threatening situation."

Bristol intensive service
Kindness, dignity and respect

We found that the people who use the service were being treated with kindness, dignity, respect, compassion and empathy. We observed staff were respectful when they were discussing people during their handover meetings. Staff demonstrated confidentiality when discussing the care and treatment needs of individual people who used the service.

We spoke with five people on the telephone and received positive feedback about the service being provided. People told us that they received a good service. One person said that staff who had visited them had treated them with respect and been very supportive Another person said that they would recommend the service to family and friends.

Evidence was seen of positive feedback from carers regarding the role of the 'carers' champion'. They told us that staff had involved them in the care and treatment of their relative. They also felt that they were involved in how wider community services were being delivered by the trust.

People using services involvement

The evidence reviewed during the inspection showed us that people were involved as far as possible in their own care and treatments. People said they understood their care plans and were able to ask questions. We reviewed three care plans and found that the information contained enabled staff to provide the support and care that met people's needs. All the care plans reviewed had been regularly reviewed and signed by people.

People were given information regarding the advocacy service available. The service had access to an interpreting service, if required, but we noted there was no provision for written information to be accessible in a different language or format.

Emotional support for care and treatment

People that we spoke with told us that staff supported people to cope emotionally with their care and treatment and the support was available when they needed it. The trust used the recovery star model and other outcome measures that were clearly documented in those care and treatment records reviewed.

We also noted that access to inpatient care close to home was not always possible with people being treated out of the area. People told us they found it difficult when this happened as they had limited access to family and friends.

North Somerset intensive service
Kindness, dignity and respect

We found that the people who use the service were being treated with kindness, dignity, respect, compassion and empathy. This was reflected in records we looked at and observations of staff discussions.

We spoke with three people on the telephone and visited two people with their permission and accompanied by trust staff. We received positive feedback about the service

Are services caring?

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

being provided. People told us that they received a good service. One person said that staff who had visited them had treated them with dignity and respect. Another person said that staff were kind and supportive.

People using services involvement

We saw examples of individual involvement in the records reviewed and of active participation by people in their treatment plans. Evidence was seen of positive feedback from carers regarding the service being provided. They told us that staff had involved them in the care and treatment of their relative. People were given information regarding the advocacy service available.

People said they understood their care plans and were able to ask questions. We reviewed three care plans and found

that the information contained enabled staff to provide the support and care that met people's needs. All the care plans reviewed had been regularly reviewed and signed by people. Evidence was seen of appropriate outcome measures being used by the service.

Emotional support for care and treatment

Staff told us they supported people to cope emotionally with their care and treatment and the support was available when they needed it. This was supported by those people that we spoke with. The records seen showed us that people were supported to manage their own health and care needs wherever possible.

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 teams had the systems in place and the capacity to respond effectively to routine and urgent referrals. Urgent assessments could be arranged within four hours. Quality assurance information also showed that the teams were generally keeping within this target.

Some people said they had raised concerns about not being able to access help quickly enough outside of office hours. They were particularly concerned about how long it sometimes took for teams to make contact with people after they had left messages at the call centre. In addition, not all teams provided 24-hour access to the intensive support services. For example, Bristol operated their own crisis telephone service, while calls to the South Gloucestershire team were diverted to an inpatient ward at night.

While staff knew how to manage complaints, feedback about local complaints varied between the teams. The trust were aware of a number of complaints relating to the Swindon intensive service.

Staff told us that it was very difficult to find a bed locally if a person needed to be admitted to hospital, particularly to a psychiatric intensive care unit (PICU). Staff said that they could spend a significant part of their shift trying to locate a bed. This meant that people sometimes had to be admitted to a hospital that was not close to their home or family.

The trust had recently established a number of forums to improve engagement with staff, people and their representatives. These included holding open listening events to hear the views of people who use the services and the wider community. There was a service user involvement co-ordinator for each area, whose role it was to promote people's involvement. Some people told us that they had the opportunity to get involved in a number of projects that contribute to shaping services.

Our findings

South Gloucestershire intensive service
Planning and delivering services

The 'standard operating procedure for intensive services' was a trust wide policy produced in June 2014, with local service appendices that were still being drafted. The intention was that these would reflect the needs of the local population.

Staffing arrangements meant that the standard of care provided was not consistent 24 hours a day, seven days a week. An on-call service was provided between 10pm and 8am. We were given a copy of the Quality Impact Assessment which was undertaken to review the night time staffing arrangements for the South Gloucestershire intensive support team. It was not clear whether service users and carers had been part of this process. If required, an on-call staff member could attend the local A&E department to undertake an urgent assessment. The service did not collate information relating to the number and outcome of contacts overnight or how often on-call staff attended assessments overnight. There was no plan to review the night time arrangements.

Staff reported it was very difficult to find a local bed if a person needed to be admitted to hospital, particularly a psychiatric intensive care unit (PICU). There was no current access to day service or crisis bed facilities, which would enable the team to support people who may need a more supportive environment and allow respite for their carers.

Right care at the right time

The team had access to a comprehensive directory of local services. Information on other services was included in the pack given to every service user. One staff member was undertaking their nurse prescriber training. People who use the service did not have a direct contact number for the team. Outside of office hours calls were triaged through a call centre and passed on to the team. After 9.30pm the service operated an on-call service at night, with telephone advice and support from the inpatient ward.

Care pathway

There was an acute care pathway that had been locally developed and agreed. The team was responsible for gatekeeping the local working age adult inpatient beds at

Are services responsive to people's needs?

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

Southmead Hospital, which meant all potential admissions were assessed by the team. Staff told us that there was a significant challenge in finding appropriate beds for people.

Referrals to the intensive service were accepted from health professionals and other agencies where appropriate. Where necessary, urgent assessments could be arranged within four hours. Quality assurance information reflected that they were generally keeping within this target. 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 ward and attended weekly ward reviews. The team supported referrals to other services where indicated.

Learning from concerns and complaints
People who use the service were given information about how to make a complaint in the information pack they received. We were told that there was a low level of complaints and there were no current complaints being addressed. However, there may have been a lack of knowledge of local complaints as we were informed of a current complaint that had been investigated by the trust and the person had referred it to patient advice and liaison service (PALS).

Swindon intensive service
Planning and delivering services
The 'standard operating procedure for intensive services' was a trust-wide policy produced in June 2014, with local service appendices that were still being drafted. The intention was that these would reflect the needs of the local population.

There was no current access to day service facilities or an acute occupational therapy pathway. The team accessed a wellbeing and respite house run by Mind, although this was usually used as 'step-down' from inpatient admission rather than an alternative to admission.

Right care at the right time
The service was staffed 24 hours a day, seven days a week. People who use the service and their carers did not always understand the role of the intensive Service or when they could contact them.

People who use the service did not have a direct contact number for the team after 5pm. Calls to the team were

initially answered by a call centre, who took a message and passed it on to the team. Some people who use the service told us that there could be a long delay between making a call and a clinician contacting them and that this could negatively affect how they coped with their distress. We saw minutes from the Swindon quality and safety meeting in April 2014 that this had been acknowledged and the locality management team were aware of this issue.

Care pathway
Referrals to the intensive service were accepted from a variety of health and social care professionals, as well as service users and carers. Feedback from the Great Western Hospital reflected that assessments were not always being undertaken in a timely fashion. However, quality assurance information reflected that the team were generally keeping within the required four hours response time target.

The team were responsible for `gatekeeping` the local working age adult inpatient beds at Sandalwood Court, which meant all potential admissions, were assessed by the team. Staff told us that there was a significant challenge in finding appropriate beds for people.

The team had an identified facilitated early discharge (FED) lead, who attended the ward to enable timely discharge from the inpatient unit. Where people had been admitted to an out of area bed, the Intensive Service monitored when they could be transferred to a local bed or taken onto the team caseload.

There were weekly care pathway meetings. This was an opportunity build on collaborative working with other teams and a forum within which they could discuss particular concerns around a person`s access to the correct care pathway.

Learning from concerns and complaints
Staff were aware of the process for managing complaints and we observed the team being given feedback relating to a local complaint. The trust were aware of a number of complaints about service user experiences with the Swindon intensive service. Some people had made complaints locally and others through the patient advice and liaison service (PALS). There had also been articles in the local newspaper relating to negative experiences that service users and carers had experienced.

Are services responsive to people's needs?

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

The manager was able to demonstrate that, within the time they had been in post, they had responded appropriately to complaints and also used outcomes in supporting the team to learn from these.

Wiltshire North intensive service (Green Lane)

Planning and delivering services

Evidence was seen that showed us that the trust understood the different needs of the people who use the service and acts on those plans to design and deliver the service. The trust actively engaged with local authorities, GP's to provide a co-ordinated and integrated pathway to meet people's needs.

Bed management was a major concern within the service. The manager informed us that staff could spend all day looking for a bed to accommodate a person. We also noted that access to care close to home was not always possible with people being admitted out of area, away from family and friends.

Avon and Wiltshire partnership had a LIFT psychology service in place. People were able to access the service as a step down discharge to primary care. LIFT psychology was a talking therapy accessible through GP surgeries to support people through periods of difficulty in their lives.

Right care at the right time

People told us that they knew what to do, 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. People said they had utilised the service and had no issues or concerns. A 24 hour service was provided by the intensive support team. All calls out-of-hours 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. 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 within the allocated time of 15 minutes at a local level.

We noted there was an effective approach to managing referrals and assessments and there were plans in place to tackle any identified problems. Service provided in the community was flexible to fit in with people's lives where possible for example, work and family commitments.

Care pathway

We noted good care pathways in place which were designed to be flexible whilst ensuring that different services worked together to meet the person's changing needs. The care and treatment records reviewed showed us that the services took into account people's needs and wishes whenever possible and when care and treatment was being planned and delivered. Care records showed us that people and their families were involved in multidisciplinary reviews.

Learning from concerns and complaints

People were given a copy of the patient advice liaison service (PALS) leaflet which outlined the complaints procedure together with information about the service. PALS supported people to discuss their concerns and problems as well as helping to resolve situations. People told us they knew of the complaints procedure but did not have any issues or concerns. Staff told us they were aware of the complaints process and would re-direct people to the PALS service if they felt they were unable to deal with their query. Staff were not aware of outcomes from complaints being shared with them.

Wiltshire South intensive service (Fountain Way)

Planning and delivering services

Evidence was seen that showed us that the trust understood the different needs of the people who use the service and acts on those plans to design and deliver the service. The trust actively engaged with local authorities and GP's to provide a co-ordinated and integrated pathway to meet people's needs.

Bed management was a concern within the service with staff spending a large percentage of their time "chasing" beds within the trust. We also noted that access to care close to home was not always possible with people being situated out of the area. People told us they found it difficult when they were out of the area as they had limited access to family and friends.

Avon and Wiltshire Partnership had a LIFT psychology service in place. People were able to access the service as a step down discharge to primary care. LIFT psychology was a talking therapy accessible through GP surgeries to support people through periods of difficulty in their lives.

Are services responsive to people's needs?

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

Right care at the right time
We noted there was an effective approach to managing referrals and assessments and there were plans in place to tackle any identified problems. Service provided in the community was flexible to fit in with people's lives where possible for example, work and family commitments.

People told us that they 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. People said they had utilised the service and had no issues or concerns. All calls out of office hours went to a call centre that filtered the calls trust-wide and then gave messages to the appropriate team.

Care pathway
Care records showed us that people and their families were involved in multidisciplinary reviews and that the services took into account people's needs and wishes whenever possible. We noted good care pathways in place which were designed to be flexible whilst ensuring that different services worked together to meet the person's changing needs. This meant that the trust had processes in place to ensure that discharge or transition arrangements met the needs of vulnerable people.

Learning from concerns and complaints
People were given a copy of the patient advice and liaison service (PALS) leaflet which outlined the complaints procedure together with information about the service. PALS supported people to discuss their concerns and problems as well as helping to resolve situations. People told us they knew of the complaints procedure but did not have any issues or concerns.

Staff told us they were aware of the complaints process and would re-direct people to the PALS service if they felt they were unable to deal with their query. Staff told us they had not received feedback in relation to complaints raised.

BaNES intensive service
Planning and delivering services
Staff told us that they tried to allocate patients to the most appropriate team members, taking into account gender, previous contact with the service and specialist skills of practitioners.

Right care at the right time
The service measured its performance against a range of national and local performance indicators. One of the key performance indicators was completing an assessment within four hours of a person contacting the service. The BaNES intensive team was consistently achieving 100% compliance with this target.

All calls to the intensive service out-of-hours were handled by a central call centre, which was staffed by non-clinical staff. Staff told us that the service was universally unpopular with staff, people who use the service and carers. The service had been in place for approximately two years. We asked how effective it was. There was no information with regard to its effectiveness or responsiveness held at a local level. Staff were not aware whether there were any targets in terms of how promptly the service answered the phone and how quickly information was passed to the team. This had been raised with the trust at previous inspection visits but the information was still not available.

The two carers we spoke with both expressed concerns about the lack of responsiveness of the service. One carer said "sometimes it is difficult to get people to respond urgently." The second carer told us that one day they had phoned the crisis team five times and left messages. They said "by 4pm I was so desperate so I took (relative) to A&E where they were assessed".

The first carer told us that on two occasions their relative had been discharged without either them or their relative being informed. They said "The last time my (relative) phoned in desperation they were told they couldn't come out to them because they were discharged. They were absolutely distraught at this information."

Care pathway
The intensive service and inpatient services worked closely together. The intensive service provided a gatekeeping and assessment role for all inpatient admissions, attended ward reviews and worked with ward staff to facilitate safe and appropriate discharge. There was a weekly care pathway meeting held on the adult acute ward, Sycamore which was attended by the intensive service manager or representative. The consultants in the intensive service met weekly with the consultant on Sycamore Ward.

Are services responsive to people's needs?

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

Learning from concerns and complaints

People who use the service were informed of the trust's complaints procedure and how to contact PALS. Complaints were reported to and discussed at the locality risk and safety meeting. The intensive service had received no complaints from October 2013 to May 2014.

Bristol intensive service

Planning and delivering services

Evidence was seen that showed us that the trust understood the different needs of the people who used the service. The trust actively engaged with the local authority and general practitioners to provide a co-ordinated and integrated pathway to meet people's needs.

We found evidence that that demonstrated that this service trust was reaching out to 'hard to reach' groups. For example two members of staff had a special interest in black minority ethnic (BME) work. Clear links were seen with a BME support group.

Staff reported a shortage of local inpatient acute admission beds throughout the trust. This meant that some people were being accommodated in hospital beds that were some distance from their home.

The trust had a LIFT psychology service in place. People were able to access this service as a step down discharge to primary care.

Right care at the right time

People spoken with 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. Bristol Intensive service does not use the trust wide call centre. In response to concerns raised by commissioners and stakeholders in Bristol, over accessibility to the intensive service, a project was set up to implement changes. There was a crisis line staffed by clinicians who provide mental health crisis telephone support and signpost people to the most appropriate service. We saw evidence that this project was being evaluated and was subject to ongoing developments as a result of feedback.

We noted there was an effective approach to managing referrals and assessments and there were plans in place to tackle any identified problems. Examples were seen of flexible appointments being offered to people.

Care pathway

Records demonstrated that people and their families were involved in how their care was planned and delivered, they were also involved in multidisciplinary reviews. This was supported by those people spoken with.

We noted multidisciplinary care pathways in place which ensured that different services worked together to meet the person's changing needs. This meant that the trust had processes in place to ensure that discharge or transition arrangements met the needs of people.

Learning from concerns and complaints

People who used the service were given a copy of the patient advice and liaison service (PALS) leaflet which outlined the trust's complaints procedure together with information about the service. People told us they knew of the service's complaints procedure. Staff told us they were aware of the complaints process and the role of PALs. We found evidence that complaints received about the service were reviewed and investigated appropriately. A response had been sent to the complainant in a timely manner.

North Somerset intensive service

Planning and delivering services

Evidence was seen that showed us that the trust understood the different needs of the people who used the service. The trust actively engaged with the local authority and general practitioners to provide a co-ordinated and integrated pathway to meet people's needs.

Staff reported a shortage of local inpatient acute admission beds throughout the trust. This meant that some people were being accommodated in hospital beds that were some distance from their home.

The trust had a psychology service in place provided by Positive Step. People were able to access this service as a step down discharge to primary care.

Right care at the right time

There was an effective approach to managing referrals and assessments. People spoken with 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. We noted that all calls during working hours were managed by 'phone practitioners' and 'out-of-hours' calls went to a trust-wide call centre that took calls and passed messages to the relevant team. Examples were seen of flexible treatment appointments being offered to people.

Are services responsive to people's needs?

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

Care pathway

We saw guidance regarding the early discharge pathway which identified the gate-keeping process. The guidance identified the criteria to be met which included consultation with carers, named nurses and the relevant recovery team.

Those care and treatment records reviewed showed us that the service took into account people's needs and wishes when care and treatment was being planned and delivered.

We noted multidisciplinary care pathways in place which ensured that different services worked together to meet the person's changing needs. We saw good examples of innovative practice to ensure that discharge or transition arrangements met the needs of people.

Learning from concerns and complaints

People who used the service were given a copy of the patient advice and liaison service (PALS) leaflet which outlined the trust's complaints procedure together with information about the service. People told us they knew of the service's complaints procedure. Staff demonstrated awareness of the complaints process. People also had access to a local independent advocacy service and information about this service was given to people on initial assessment.

Are services well-led?

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

Summary of findings

We saw that service developments were being made with consideration for local needs and were monitored for risks. In the services we visited, we saw good examples of local leadership. Staff also told us that they felt well supported by local managers and that there were clear lines of accountability. Most of the teams had good staff morale.

The trust had developed a local management team for each area as part of the restructuring of the senior management team. Each local management team consisted of a managing director, a clinical director and a head of profession and practice. How supported and listened to staff felt by senior management teams, however, varied between areas.

Our findings

South Gloucestershire intensive service
Vision and strategy
Staff we spoke with said they were aware of the trust's vision and values and strategic objectives. Staff were aware of the trust's triumvirate structure and how to contact those within it. There were regular trust updates via the trust's intranet and other bulletins.

Responsible governance
The manager reported that the trust IQ governance system allowed them monitor quality and assurance at a local level. Governance issues were discussed in the team meeting and the locality quality and safety meeting. We saw minutes of these meetings.

Leadership and culture
We found that the South Gloucestershire intensive service was well led and there was evidence of clear leadership. Staff told us that they felt well supported and morale within the team was good. We were told that the senior management team, South Gloucestershire triumvirate, were accessible and approachable. Staff felt listened to and that concerns were acted on.

Engagement
There were regular interface meetings between the intensive team, the community team and the inpatient ward. The team were part of the crisis concordant which worked with police and commissioners. The trust was establishing a number of forums to improve engagement with staff, service users and carers. The locality service user involvement co-ordinator would also work with the team when indicated.

Performance improvement
We saw that there were regular team audits undertaken to monitor quality. Team meeting minutes reflected that team audits and performance were discussed. Staff told us that they had opportunity to reflect on any performance or learning outcomes in management and team supervision.

Swindon intensive service
Vision and strategy
Most staff we spoke were aware of the trust's vision and values and strategic objectives. Staff were aware of the trust's triumvirate structure and how to contact those within it. There were regular trust updates via the trust's intranet and other bulletins.

Responsible governance
The trust had a comprehensive governance system, which the manager used to monitor and support the service. Team meetings were held on a weekly basis and were used for sharing relevant information. Staff received regular management supervision.

Leadership and culture
We found that the Swindon intensive service was well-led and there was evidence of clear leadership. The manager had been in post for five weeks at the point of our inspection however, they had worked within the trust for some time and were aware of some of the historical difficulties with the service, in terms of performance and staff morale. The manager demonstrated determination to support the team, listen to service users, introduce change and monitor performance.

Staff generally felt able to raise concerns. The manager told us that they felt senior managers in the trust listened to concerns that they raised and acted on them. There was positive feedback about the service manager and Swindon triumvirate, being accessible and approachable.

Engagement
The trust was developing a number of forums to improve engagement with staff, service users and carers. These were still in the process of being established during the time of inspection however, the intensive service ensured representation where possible.

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.

The manager had introduced an 'open session' on the ward to get feedback from people and incorporate this into making improvements to team practice. We saw meeting minutes which showed that the trust senior management team had met with people who use the service to discuss their concerns about the Swindon intensive service and how they could work together to resolve these.

Performance improvement

Staff told us that there had been a number of managers for the team over a short period of time and that this had led to frequent changes and inconsistent managerial support. The staff we spoke with identified that morale and team performance had been negatively affected. Most staff we spoke with felt hopeful about positive changes and having clear direction taking place within the team.

The manager had introduced a number of changes to support the delivery of safe, effective care. For example, a comprehensive notes audit and in-house training plan had been established, in response to recommendations from an investigation and internal observations from the manager. The manager had clear action plans to monitor and review this.

Wiltshire North intensive service (Green Lane)

Vision and strategy

Some staff we spoke with said they were unaware of the trust's vision and values and strategic objectives. We found some evidence of the vision and values on display within the service provided. Staff reported they were unaware of the trust's triumvirate management structure.

Responsible governance

We saw clear clinical governance arrangements were in place at a local level. We saw the trust's record management and quality review of the service for May 2014. Staff were aware of their particular lead roles and duties and the manager attended regular performance meetings and informed us they passed the information to their teams via team meetings. The manager said they felt valued and listened to and had a good working relationship with their line manager.

Leadership and culture

We observed staff morale within the staff teams to be good and this was confirmed with staff. We observed staff working together with good communication between the multidisciplinary teams and people who use the service.

We observed there were effective intervention procedures in place to deal with behaviour and performance inconsistencies. Staff said that the managers had an open door policy and they were able to address any issues or concerns they may have with them.

Engagement

People had access to the advocacy service and were supported to make complaints through the PALS service. We found that feedback was not shared across the teams with regard to concern and complaints.

Staff were aware of the whistleblowing policy and informed us they knew the processes to follow should they have any concerns.

We found no evidence of feedback from people who use the service, although the friends and family graph that we saw showed that people were happy with the service provided and would recommend the service.

Where relevant people were given access to the independent mental health advocate (IMHA) whose role would be to support people within the mental health act framework. IMHA's supported people with their rights under the MHA and helped them to understand the particular part of the Act which applied to them.

Performance improvement

Staff told us they were aware of their professional objectives and these were reviewed regularly at supervision and appraisals.

The trust had an IQ system in place to monitor and audit the care management records and the quality records in line with the outcomes set out by the Care Quality Commission.

Wiltshire South intensive service (Fountain Way)

Vision and strategy

Some staff we spoke with said they were unaware of the trust's vision and values and strategic objectives. We found some evidence of the vision and values on display within the service provided. Staff reported they were unaware of the trust's triumvirate management structure and that they felt there was a "real disconnect" between the trust and staff.

Responsible governance

We saw clear clinical governance arrangements were in place at a local level. We saw the trust's record management and quality review of the service for May

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2014. The manager attended regular performance meetings and informed us they passed the information to their teams via supervision and team meetings. The manager said they felt valued and listened to and had a good working relationship with their senior managers. We noted there was a risk register in place which identified specific risks. However, we found no benchmarking of national audits to assess the performance of the service.

Leadership and culture

We observed staff morale within the team to be good and this was confirmed with staff. We observed staff working together with good communication between the multidisciplinary teams and people who use the service.

We observed there were effective intervention procedures in place to deal with behaviour and performance inconsistencies. Staff said that the manager had an open door policy and they were able to address any issues or concerns they may have with them.

Engagement

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Performance improvement

Staff told us they were aware of their professional objectives and these were reviewed regularly at supervision and appraisals.

The trust had an IQ system in place to monitor and audit the care management records and the quality records in line with the outcomes set out by the Care Quality Commission.

BaNES intensive service
Vision and strategy

The trust had developed objectives, a motto and new values, which were published on the intranet and reproduced in the team's standard operating procedure. Staff were familiar with the motto "you matter, we care."

Responsible governance

The team had completed a self-assessment of their compliance with CQC's essential standards and had compiled a folder of evidence for us. Regular team meetings were held where a range of information was shared and discussed and decisions were recorded. An intensive service good practice network had been established trust-wide to share national policy developments, address local priorities and share good practice.

Leadership and culture

Staff told us they felt very well supported by local management and there were clear lines of accountability. The team leader, senior practitioner, service manager and the locality senior management triumvirate were visible and accessible to staff. There were two consultant psychiatrists who worked for the intensive and recovery teams. Staff told us they had good access to advice from consultants.

Engagement

The locality had appointed a service user involvement lead who facilitated a number of forums to capture feedback and facilitate involvement. Service User feedback from BANES Peoples Group, Acute Care Forum and Carers' Forum was a standing agenda item at the monthly quality and safety group.

Performance improvement

Individual staff members and the team had clear objectives focused on improvement and learning and these were regularly reviewed through supervision and team meetings.

Bristol intensive service
Vision and strategy

Staff we spoke with said they were aware of the trust's vision and values and strategic objectives, some evidence of this strategy and vision on display within the service. Staff knew of the trust's triumvirate structure and confirmed that they received regular trust updates via the trust's intranet and other bulletins and trust updates.

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.

Responsible governance

We saw clear clinical governance arrangements in place at a local level. We saw that a quality improvement visit took place for this service in November 2013. Staff told us they knew their specific roles and responsibilities. The managers attended monthly integrated governance meetings and informed us they cascaded information to their teams via supervision and team meetings. Staff said they felt valued and listened to and had a good working relationship with their line managers.

Leadership and culture

We noted that the manager of this service was in an 'interim' role. Staff told us that morale within the team was good. We saw that staff worked together effectively. This led to good communication between this service and those people who used the service.

We found effective clinical and managerial supervision in place to manage any concerns about individual practice. Staff confirmed that managers had an 'open door' policy and they felt able to approach them with any concerns.

Some staff expressed their concern that there was a lack of visibility of the trust executive management team within the community setting. Other staff expressed concerns about future trust changes linked to the recent NHS tendering process.

Engagement

People had access to the independent advocacy service and were supported to make complaints through the PALS service. Staff were aware of the whistleblowing policy and informed us they knew the processes to follow should they have any concerns. We found that medical staff informed us that there was no Bristol medical advisory group. This meant that they did not feel engaged with by the trust.

We saw evidence of feedback from people who used the service and their carers. Evidence was seen of effective liaison with carer through the carers' champion.

Performance improvement

Staff told us they were aware of their professional objectives and these were reviewed regularly at monthly supervision and annual appraisals.

The trust had an information quality (IQ) system in place, which reviewed the quality and record management of the service regularly with the findings being disseminated to the team. We saw that this was being effectively used by senior managers

North Somerset intensive service

Vision and strategy

Staff we spoke with said they were aware of the trust's vision and values and strategic objectives. We found some evidence of this strategy and vision on display within the service. Staff knew of the trust's triumvirate structure and confirmed that they received regular trust updates via the trust's intranet and other bulletins and trust updates.

Responsible governance

We saw clear clinical governance arrangements in place at a local level. Staff told us they knew their specific roles and responsibilities.

The managers attended monthly integrated governance meetings and monthly community forum meetings. They informed us they cascaded information to their teams via supervision and team meetings. Staff said they felt valued and listened to and had a good working relationship with their line managers.

We noted there was a local risk register in place which identified specific risks. The training records reviewed showed us that mandatory training was up to date and that specific training needs had been addressed.

Leadership and culture

We noted that the manager of this service was in an 'interim' role. We found that staff morale within the team to be good which was confirmed with staff. We saw that staff worked together effectively. We found effective clinical and managerial supervision in place to manage any concerns about individual practice. Staff confirmed that they felt able to approach managers with any concerns.

Some staff expressed their concern that there was a lack of visibility of the trust executive management team within this service. Other staff expressed concerns about future trust changes linked to the recent NHS tendering process.

Engagement

People had access to the independent advocacy service and were supported to make complaints through the PALS service.

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.

Staff were aware of the whistleblowing policy and informed us they knew the processes to follow should they have any concerns.

We saw evidence of feedback from people who used the service and their carers.

Performance improvement

Staff told us they were aware of their professional objectives and these were reviewed regularly at monthly supervision and annual appraisals.

The trust had an information quality (IQ) system in place, which reviewed the quality and record management of the service regularly with the findings being disseminated to the team. We saw that this was being effectively used by senior managers in the service.

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
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: • The South Wiltshire intensive service did not have clear procedures in place to protect people who use the service against the risks associated with the unsafe use and management of medicines. • Swindon and South Gloucestershire intensive services did not have appropriate facilities in place to monitor, store and dispose of medication. There were not lockable storage facilities for unwanted medications and we saw sealed pharmacy buckets on the shelf, containing medications. These could be easily removed. • North Somerset intensive service staff reported delays in obtaining some medication and some dispensing errors since the introduction of a centralised pharmacy service. Regulation 13
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 teams were experiencing staff shortages which may have impacted on people's care and safety

Compliance actions

- Arrangements for medical cover were not always sufficient

Regulation 22