

Good



Avon and Wiltshire Mental Health Partnership NHS
Trust

Community-based mental health services for older people

Quality Report

Avon and Wiltshire Mental Health Partnership NHS
Trust

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RVN3Q	Blackberry Hill Hospital	South Gloucestershire Later Life Community Mental Health Team South Gloucestershire Memory team South Gloucestershire Therapies – Later life South Gloucestershire Care home liaison	BS16 2EW BS16 2EW BS16 2EW BS16 2EW

Summary of findings

RVNCE	Victoria Centre	Swindon Complex intervention team Swindon Memory team Swindon Therapies Team	SN3 6BW SN3 6BW SN3 6BW
RVN1H	Trust Headquarters	North Somerset Later life psychology team North Somerset Memory Team North Somerset Later Life Community Mental Health Team Bath and North East Somerset (BANES) Therapy Team BANES Complex Intervention and Treatment team	BS21 6UJ BS21 6UJ BA1 3QE BA1 3QE BA3 2DP
RVN3N	Southmead AWP	psychiatric liaison service	BS10 5 NB

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

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

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

Summary of findings

Ratings

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

Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated community-based mental health services for older people as good because:

- Staff demonstrated an awareness of risk. The majority of care records contained an appropriate and up to date risk assessment. Staff had safe lone working arrangements. Staff had an understanding about how to report incidents. Staff felt confident in raising concerns and knew how to escalate them if necessary.
- The teams included a full range of specialist allied health professionals to provide effective assessment and treatment. The staff in the teams worked well with other local services and with the other older adult services provided by the trust in their locality.
- Patients and carers that we spoke with reported that the staff were kind and caring. They said they felt included in their care and we saw that this was clearly documented in almost all of the care records we reviewed.

- Staff reported that management within the locality were approachable. They said that morale was generally good and that things had improved in recent years.

However:

- Some teams (North Somerset later life therapies and Swindon memory service) were not meeting the trust's targets for assessment.
- In the North Somerset teams, although there were alarms available for staff to use, there was no record to show these had been routinely checked.
- While local management was approachable and involved, staff reported that the senior management team based at trust headquarters were not as visible.

Summary of findings

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

Are services safe?

We rated Safe as good because:

- Staff had access to alarms should an emergency arise, and there was access to appropriate medical assistance.
- Caseloads could be monitored and adjustments made to ensure they were manageable.
- Staff triaged referrals into the service and saw patients who were in urgent need more quickly.
- The majority of care records we reviewed contained up to date and appropriate risk assessments.
- There was a positive culture for reporting incidents.

However:

- In North Somerset there was no record of personal alarms being checked since March 2016 and so we could not be clear that they were regularly tested.

Good



Are services effective?

We rated Effective as good because:

- The majority of care plans we reviewed were holistic and up to date.
- There was a mix of professions available in all of the teams we inspected.
- We found evidence that in the majority of cases there was opportunity for specialist training.
- Staff reported good access to clinical supervision.
- Staff in the teams reported working well with other teams within the trust, and with external services.

However:

- Staff were only using clinical scales to measure individual patient progress, not the effectiveness of the service.

Good



Are services caring?

We rated Caring as good because:

- Carers and patients we spoke with said staff were kind and supportive.
- Staff included carers in decisions and assessments.

Good



Summary of findings

- We saw evidence that staff had involved the person using the service in decisions about their care in 49 out of 51 care records that we reviewed.

Are services responsive to people's needs?

We rated Responsive as Good because:

- There were clear criteria for referrals within the teams.
- Staff reported a good awareness of the complaints procedure and we saw evidence that staff discussed whether there were any complaints in a team meeting.

However:

- Targets for waiting times for assessment were not always being met. For example, the Swindon memory service only saw 19% of patients within four weeks of referral.

Good



Are services well-led?

We rated Well-led as Good because:

- Staff reported positive changes within the teams and had good contact with senior managers within their locality.
- The trust had implemented an electronic system that helped managers to track key performance indicators.
- Staff said they were confident in raising concerns and were aware of the whistleblowing policy.
- Most staff we spoke with said they could make a positive impact on service development within their locality.
- Staff employed by Avon and Wiltshire Partnership Trust in the psychiatric liaison service had been involved in a Cochrane collaboration review and had been published in a peer reviewed online journal.

However:

- Staff reported that senior management based at trust headquarters were not as visible as their locality senior management team.

Good



Summary of findings

Information about the service

Avon and Wiltshire Partnership trust provides community-based mental health services for older patients across a wide geographical area. The trust has organised these services into six localities. The localities relevant to this core service are Bath and North East Somerset, Bristol, North Somerset, South Gloucestershire, Swindon and Wiltshire. These localities have different teams within them, and in some of the localities the trust had integrated community mental health services so that they do not only provide care to patients in a specific age group (which they call 'ageless services'). These services are listed below.

Bath and North East Somerset (BANES):

- BANES therapies team. This team provides therapy to adults of working age, and older adults. This team operates 9am-5pm Monday to Friday.
- BANES complex intervention and treatment team. This team provides care co-ordination and care to older adults. This team operates 9am-5pm Monday to Friday.

Bristol:

- Psychiatric liaison service. This service is an ageless service providing liaison at Southmead Hospital. This team is split into two halves, the emergency zone team and the inpatient team. The emergency zone team operates between the hours of 7am and 9pm covering the emergency department, seven days a week. This is split in three shifts, early (7am-3pm), late (1pm-9pm) and long day (7:30am-9pm). The half of the team covering the inpatient wards (i.e. ones that were not for emergency medical care) at the hospital work Monday to Friday 9-5pm. They provided an age inclusive service (to patients of all ages), rather than purely being for older age adults.
- Liaison Psychiatry at Bristol Royal Infirmary. We did not inspect this ageless service. Liaison Psychiatry is not a core service.
- Bristol community mental health team (CMHT). This team provides care and care co-ordination to adults of

a working age as well as older patients. This service was inspected as part of this inspection; the findings are reported in the community based mental health services for adults of a working age report.

North Somerset:

- North Somerset memory service. This service provides assessment for patients experiencing cognitive decline. This team operates 9am-5pm Monday to Friday.
- North Somerset later life community mental health team. This team provides care and care co-ordination for older adults. This team operates 9am-5pm Monday to Friday.
- North Somerset later life psychology team. This team provides psychological therapies to older adults, 9am-5pm Monday to Friday.

South Gloucestershire:

- South Gloucestershire later life community mental health team. This team provides care and care-co-ordination for older adults 9am-5pm Monday to Friday.
- South Gloucestershire care home liaison. This team provides support to older adults living in care homes, and provided advice, liaison and training to care home providers. This team operates 9am-5pm Monday to Friday.
- South Gloucestershire later life therapies team. This team provides a variety of different therapeutic input to older adults, including occupational therapy, physiotherapy and psychological therapies. This team operates 9am-5pm Monday to Friday.
- South Gloucestershire memory service. This team operates 9am-5pm Monday to Friday providing assessments for patients experiencing cognitive decline.

Swindon:

- Swindon complex intervention team. This team provides care and care co-ordination to older age adults 9am-5pm Monday to Friday.

Summary of findings

- Swindon memory service. This team provides assessment for patients experiencing cognitive decline. This team was only inspected as part of a specific medicines review during the current inspection the findings are reported here.
- Swindon therapies team. This team provides a variety of different therapeutic input to older adults, including occupational therapy and physiotherapy. This team operates 9am-5pm Monday to Friday.

Wiltshire:

- Sarum CMHT. This team provides care and care co-ordination to older adults and adults of working age. This service was inspected as part of this inspection; the findings are reported in the community based mental health services for adults of a working age report.
- Wiltshire CMHT. This team provides care and care co-ordination to older adults and adults of working age. This service was inspected as part of this inspection; the findings are reported in the community based mental health services for adults of a working age report.

- Wiltshire NEW Memory Service. This service was not inspected at this inspection.
- Wiltshire Sarum Memory Service. This service was not inspected at this inspection.
- Wiltshire WWYKD Memory Service. This service was not inspected at this inspection.

We last inspected community-based mental health services for older people in June 2014 (report published in September 2014). However, the Bristol community mental health team had been inspected following this as part of a responsive inspection in December 2015 following concerns that had been raised and we issued a section 29a warning notice as part of this responsive inspection. We returned to the service on 17 February 2016 and followed up on the immediate actions we had told the trust to take and found the trust had taken these. More detail on this can be found in the community-based mental health services for adults of working age published 25 February 2016.

Our inspection team

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

Head of Hospital inspection: Karen Bennett-Wilson

The team that inspected this core service comprised two inspectors, a specialist pharmacist inspector, one occupational therapist with experience working with older adults and three specialist nurse advisors

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited 14 of the 19 teams at six different sites and looked at the quality of the clinical areas and observed how staff were caring for patients

Summary of findings

- spoke with eight patients and eight carers
- spoke with the managers or acting managers for each of the teams
- spoke with 63 other staff members; including psychiatrists, nurses and psychologists
- held a staff focus group at one of the locations
- spoke with two managers of local care homes
- interviewed the divisional director with responsibility for these services
- attended and observed a multi-disciplinary meeting, a complex case review and two home visits
- looked at 51 treatment records of patients
- reviewed 16 staff supervision records
- carried out a specific check of the medicines management at one team
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Patients told us that the staff were patient, kind, and good at listening to their needs. They felt informed about their care and felt supported by the teams.

Good practice

The Bath and North East Somerset (BANES) therapies team employed an ex service user to implement a project called Fresh Art at Work. This art project was provided at community locations and on in-patient wards. The trust funded the project and the Clinical Commissioning Group supported the project. The project, which was based on national studies and looked at five ways to well-being, provided supportive engagement with service users through art work and helped bridge the gap from ward discharge to community and independent living. The service had been recognised nationally and locally and a celebration occurred at the mayor's parlour for the success achieved.

Psychological therapy services in BANES undertook an extensive audit of quality improvement in the service. This took into account the trust's values and CQCs five key questions. There were a number of improvements that had been made as a consequence of this evaluation. For example, a recently published recovery book which supported patients to take control of their own recovery and which was available to all teams; and experience-based design. This is where patients who use services work in partnership with clinicians to improve service provision.

Areas for improvement

Action the provider **SHOULD** take to improve

- The trust should ensure that personal alarms used by staff are regularly tested and that this is documented.
- Systems that the trust had in place to monitor compliance with waiting and response times showed

that teams were not meeting the assessment targets agreed by the trust. The trust should review each team's capacity to undertake urgent and routine assessments within the agreed time frames and ensure action is taken where teams are consistently not able to meet the assessment target.

Avon and Wiltshire Mental Health Partnership NHS Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
South Gloucestershire later life community mental health team South Gloucestershire Memory team South Gloucestershire Therapies – Later life South Gloucestershire Care home liaison	Blackberry Hill Hospital - RVN3Q
Swindon Complex intervention team Swindon Memory team	Victoria Centre - RVNCE
North Somerset Later life psychology team North Somerset Later Life Community Mental Health Team North Somerset Memory Team Bath and North East Somerset (BANES) Therapy Team BANES Complex Intervention and Treatment team	Trust Headquarters - RVN1H
Psychiatric liaison service	Southmead AWP - RVN3N

Detailed findings

Mental Health Act responsibilities

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

All staff we spoke to were aware of and had received training in Mental Health Act responsibilities. Information about adherence to training was available on the trust's intranet and managers and supervisors were made aware if staff were not up to date with this. There was good support provided by the local authority and teams received good support from Approved Mental Health Practitioners (AMHPs). Staff we spoke to told us they had attended the local authority training on the Mental Health Act and had received annual updates through the e-learning system provided by the trust. Staff in the Mental Health Act office were good at sending reminders to staff about upcoming reviews and independently scrutinized every completed

paper work. Legal advice was available from the trust, if needed. Staff told us the AMHP office was very helpful and knowledgeable and would often challenge decisions made. Staff would seek consent to share information.

Independent mental health advocacy was readily available and staff demonstrated good knowledge and understanding of when to use this service with good examples provided.

At the time of the inspection, there were no patients subject to a Community Treatment Order (CTO) (the provision of supervised treatment following a stay in hospital). Staff showed knowledge in this area as they had supported patients in the past on a CTO.

No audits of compliance with the Act had been undertaken within the teams.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust reported that 94% of staff in the older adults team had received training in the Mental Capacity Act in February 2016. Staff had a good understanding of their role in ensuring mental capacity was assessed and that, where patients lacked capacity, best interest meetings were held with relatives and carers. Staff told us that paper work was completed; then they uploaded it on the electronic record system (RIO) and printed off for the person using services and their carers. We saw evidence of capacity decisions

being made in the care records we reviewed. The local authority had provided case law training. Mental Capacity Act information was available on the intranet called Our Space and staff could access this whilst in the office.

Staff spoke knowledgeably about deprivation of liberty safeguards and we were told about joint training that had been provided by the local authority that staff had attended.

There was no evidence that there were arrangements in place to monitor adherence to the Mental Capacity Act within the teams.

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

Our findings

Safe and clean environment

- The trust had installed alarm systems or put other systems in place to ensure that staff could trigger an alarm if there was an emergency in the clinic rooms. Staff in the Bath and North East Somerset, South Gloucestershire, and North Somerset teams had personal alarms. Staff in South Gloucestershire checked the alarms when they signed the alarms out and documented this as routine. However, staff did not always log this in the North Somerset base. In one of the clinic rooms at the Victoria Centre, access to the alarm was difficult because there was a filing cabinet in front of it. However, we brought this to the attention of staff and they moved the filing cabinet to allow access to the alarm. Staff had not reported any incidents where they needed to use the alarm.
- All of the clinic rooms we inspected across the teams had the necessary equipment to carry out physical observations. These machines included blood pressure monitors. Where the teams were not based on a general hospital grounds, we saw that staff had access to appropriate emergency first aid kits.
- Most of the clinical areas were well furnished, clean and comfortable. We noted that the consulting room that was used by the psychiatric liaison service had worn furniture and a table that could pose a risk as it was not designed for a psychiatric setting. However, staff had arranged for new furniture to be ordered and it was due within four weeks of the inspection.
- Staff were aware of infection control principles. We saw that there were posters on handwashing and access to hand sanitiser where appropriate.
- At the Swindon memory service we found that prescription paper were being stored in an open desk draw (staff said that it was locked out of office hours and when there was not a member of staff in the room) and that there were not sufficient measures in place to maintain an audit trail of prescriptions. We raised this with the trust, and they immediately put in procedures to ensure access to the prescription paper was restricted.

Safe staffing

- Staffing levels varied across the teams serving different areas. Staff had liaised with the local care commissioning groups to establish staffing levels based on the demand for the services. All managers spoke of good working relationships with the clinical commissioning groups and business cases were supported when more staff were needed and this was often based on waiting times, numbers of patients waiting and the length of time it took to allocate cases. Staff we spoke with mostly said they felt the teams had enough staff. All of the staffing figures were provided by the trust for the time between 1 November 2015 and 31 January 2016.
- For the teams covering South Gloucestershire, there were seven whole time equivalent (WTE) staff in the care home liaison team, 19 WTE in the community mental health team for older adults, 11 WTE in the therapies team and 11 WTE in the memory service. Of all of the older adult community teams, vacancy rates were highest in these teams, with 44% vacancy rate in the care home liaison team (at the time of inspection, there were two WTE vacancies in this team, 29%), 12% in the therapies team and 7% in the later life community mental health team. There were no vacancies in the memory service. Staff sickness (percentage of staff off work sick over the previous year) and turnover rates (number of WTE staff leaving) were proportionally low. In the care home liaison team, 0.5 WTE staff had left and the average sickness rate was 2%, in the community mental health team for older patients 1.8 WTE staff had left and the sickness rate was 3%. The therapies team had 0.8 WTE staff leave, and a sickness rate of 2%, and the memory team had 1.1 WTE staff leave and the lowest sickness rate of the south Gloucestershire teams of 1%.
- For the North Somerset teams, there were 22 WTE staff in the later life community mental health team, 6 WTE in the later life psychology team and 8 WTE in the memory team. There were vacancies in the later life community mental health team (4.8% of staffing levels) and memory team (6.5% of staffing levels, staff told us it was for a consultant psychiatrist) but no vacancies in the later life therapies team. Staff retention was relatively good in the

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later life community mental health team, two WTE staff had left, but was proportionally higher in the memory team at three WTE staff leaving. No staff had left the later life psychology team. Sickness rates were the highest in the community older adult teams for the later life therapies team (8%) and memory service (7%).

However, sickness rates were more in line with the other older adult community mental health services provided by Avon and Wiltshire Partnership trust in the North Somerset later life community mental health team at 3%.

- In the teams covering Swindon, the complex intervention team had 16 WTE staff and the later life therapies team had 12 WTE staff. There were no vacancies in the complex interventions team and 4.7% vacancies in the later life therapies team. At the time of inspection, the vacancy had been filled and the staff member was due to start at the beginning of June. There had been three WTE staff leave the complex intervention service and four WTE leave the later life therapies team. Staff sickness was in line with the other older adult community teams, and lower than the national average at 3% in the complex intervention team and 2% in the later life therapies team.
- For the team covering Bath and North East Somerset (BANES), there were 17 WTE staff employed and the trust reported no vacancies (although at the time of inspection the team were recruiting a part time post to cover maternity leave. There had been two WTE staff leave the team and the sickness rate was 4%.
- The psychiatric liaison service had four WTE staff employed by Avon and Wiltshire Partnership trust. Trust had reported a 56% vacancy rate. One WTE staff left and the trust reported 4% sickness. The minimum staffing set was two qualified members of staff in the emergency zone team, and the inpatient zone team was to be decided based on patient need.
- Staff told us that their caseloads were manageable across the localities and mostly averaged 20 per whole time equivalent in the Swindon and BANES teams. We were told that social worker caseloads were limited to 23 patients per social worker in the North Somerset teams and that on average nurses had a caseload of 30. Managers monitored caseload size through management supervision using a caseload management tool to aid them in doing this. We requested the average caseload of people for the teams from the trust. Data provided by the trust showed the

average caseloads for most of the teams between June 2015 and June 2016. There was a lot of difference between the team caseloads, with an average of 99 in the South Gloucestershire memory service and an average of 301 in the North Somerset CIT. The ageless teams had much higher caseloads (potentially due to the expanded age range of patients they saw), for example 603 in the Wiltshire community mental health team based in Warminster.

- Staff in the North Somerset memory service had filled 23 shifts with bank staff, and the Swindon memory service had filled four shifts with bank or agency staff. No other teams had used bank or agency staff between 1 November 2015 and 31 January 2016.
- Each service we inspected had psychiatrists allocated to their teams and staff told us they could access a psychiatrist within a couple of hours, when required. Each consultant participated in an on-call rota.
- At the time of inspection in May, the staff we spoke with told us they were up to date with their mandatory training. Overall, the CIT team with the highest average completion rate (percentage of training staff had completed) was the North Somerset CIT team (94%), and the lowest overall completion rate in the CIT teams was 87% in the BANES team. The only training topics that had completion rates less than 75% were; basic resuscitation, which was 69% (in the BANES team only), managing conflict which was 65% (in the BANES team) and 73% in the South Gloucestershire team.
- In the Memory teams, staff in the North Somerset and South Gloucestershire teams were all up to date with their training; the lowest completion rate across trainings was 76% in the Wiltshire NEW memory service. The training rate was 75% or below in three teams in basic resuscitation. It was 75% in the Swindon memory team, 63% in the Wiltshire NEW team and 67% in the Wiltshire WWYKD team. The training rate was also below 75% in the Wiltshire WWYKD team for fire training (67%) and deprivation of liberty safeguards training (57%). Training rates were also below 75% in a number of trainings in the Wiltshire NEW team. It was 63% in the Care act, 57% in the deprivation of liberty safeguard training and medicines management, 63 % in safeguarding children level 2, and 43% in the Mental Health Act.
- In the therapies teams the team with the highest completion rate was the North Somerset team (99%) and lowest average completion rate was South

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Gloucestershire later life therapies team (who had an average of 92%). The only team that had below 75% in a single topic of training was the North Somerset team, which had 71% of its staff trained in basic resuscitation.

- The Wiltshire care home liaison team had an overall training completion rate of 94%, and the South Gloucestershire team had an overall completion rate of 99%. Neither of the teams had a completion rate of less than 75% for the individual training.

Assessing and managing risk to patients and staff

- Staff triaged referrals based on the risk that the person referred presented to themselves or others. The assessment involved deciding the priority of the referral, and whether two members of staff were needed to visit the person together. In the psychiatric liaison service, referrals were screened by the administration staff, and then triaged by the shift co-ordinator according to a traffic light system. Patients who had more risk factors identified by the triaging staff were prioritised for assessment. Out of hours, green and amber risk rated patients were monitored by physical health staff, red rated patients would be seen by their local crisis team and an on call doctor.
- Arrangements for ongoing assessment of risk varied between team and locality. For example, staff in the complex intervention team in Swindon would assess a person's risk every time they visited the person using the service, the same team in Swindon would also have a formal risk assessment every six months or when an incident occurred. In the vast majority of care records we reviewed (44 out of 51) we saw robust and good quality risk assessments and plans for managing those risks. In the seven records we did not see this; in two of the records we looked at had identified risks but did not list any actions or interventions. Three of these had not been reviewed or updated regularly, one of which had not been updated in two years. One had identified self-neglect as a potential risk but there was no mention of staff raising a safeguarding alert. We saw another care record that was initially rated as high risk, but three weeks later was revised to low risk without any evidence of a clinical change.
- Staff told us they identified crisis plans at appropriate times and that they gave these to patients and their carers as part of the care plan. We observed a complex case review meeting and there was good understanding and identification of the risk factors including taking into

account historical risks. Historical risks had been identified as a gap when reviewing a serious incident and this was now included as part of the risk assessment process.

- There was generally a good understanding and application of safeguarding systems. Staff told us this was part of their daily work and that they thought the system worked well. Staff were trained to level 3 adult safeguarding and received annual update training via the trust's e-learning process. Since the introduction of the Care Act 2014, safeguarding was now the responsibility of the local authority. Some staff told us they did not always receive feedback when a safeguarding alert was raised.
- There was a comprehensive lone working policy and staff were aware of this and put it into practice. Staff were required to phone in at the end of the day to inform the duty worker or manager that they had finished for the day. Staff had telephones so they could be contacted if they had forgotten to dial in. There were easily visible and up to date signing in and out boards in the staff offices. There was a code word in operation in the event of an emergency.

Track record on safety

- There had been two serious incidents reported in the last 12 months for older people community mental health teams. The incidents had been shared within team meetings and learning had been identified within the minutes. Staff confirmed they were aware of these incidents and the learning that had occurred.

Reporting incidents and learning from when things go wrong

- Staff had an understanding about how to report incidents. Staff felt confident in raising concerns and knew how to escalate them if necessary.
- All staff were able to describe the process involved in reporting incidents and they told us that lessons learned were discussed at team and business meetings. We observed one team meeting where incidents from across the trust were discussed. Staff also told us that incidents were discussed as part of the supervision process. Managers told us that incidents from across the trust were sent to the senior locality managers and

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these were cascaded on three levels; email to service managers and team managers; as an agenda item on team meetings; and to the individual that raised by the incident.

- Alerts for medicines errors were recorded as incidents if a domiciliary care agency informed the CIT team of an

error. If there were more than two incidents reported for the same domiciliary care agency, this would be raised as a safeguarding alert and the team would work with the agency to help prevent this occurring again.

- Staff were aware of their responsibility regarding duty of candour to be open and honest when explaining an incident to someone who was using the service, or the relevant person.

Are services effective?

Good 

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

Our findings

Assessment of needs and planning of care

- The teams received most of their referrals from the primary care liaison service (provided by the trust). The teams completed a social history, psychological history, risk assessment, capacity to make or contribute to decisions, and a medicines review. Carers were also offered a carers assessment. The person's general practitioner undertook physical health checks and staff told us in most teams there were good working relationships between the older people community mental health teams and local general practitioners.
- Staff were expected to complete care plans within 28 days of the initial assessment and were required to record details around the person's care onto the electronic patient system. Of the 51 care records that we looked at, all had a care plan and we saw evidence that the majority of these (49 out of 51) plans were holistic, and up to date. When we reviewed care records, we found them to be succinct, relevant and evidence based. Progress notes were well documented and timely.
- Records in the teams were held on an electronic record system used throughout the trust. The psychiatric liaison service also had access to the hospital's systems and ensured that they entered clinical information on both electronic record systems though some staff told us that this was a time consuming process.

Best practice in treatment and care

- Guidelines from the National Institute for Health and Care Excellence (NICE) were sent to consultants and disseminated as appropriate. Pharmacists also received weekly updates and passed these on where necessary.
- Patients had access to psychological therapies recommended by NICE. However, staff in the North Somerset team told us they did not have access to cognitive stimulation therapy.
- In response to NICE guidelines the Swindon complex intervention and treatment team (CIT) team had worked with the therapies team to develop a functional illness community group run at the 'forget me not' day centre which was service user led. In Bath and North East Somerset (BANES) there was a medicines optimisation group that considered new information about medicine.

There was good liaison between GPs and consultant psychiatrists in developing shared care arrangements for monitoring use of lithium, antipsychotics and anti-dementia medicine. Staff in the North Somerset memory service told us that as part of their assessment they screened patients for physical health concerns, including low vitamin B12, Parkinson's symptoms, and uncontrolled diabetes. We saw evidence of physical health checks being done in the care records we reviewed.

- Clinical audits were undertaken by the psychiatry and psychology teams in all the localities and this had resulted in improved care. For example, the BANES psychology service had involved patients in an evaluation of the services offered. This led to staff producing a psychological therapies information video, which gave patients who were newly referred to the team information about what to expect from the service.
- Staff used evidence based clinical scales to measure the wellbeing of patients. For example, the Addenbrooks Cognitive Evaluation 3, and the clinical outcomes in routine evaluation (CORE) assessment. However, staff did not use these to measure how well the service was performing. The staff were, instead, using positive feedback as a measure of their effectiveness. Specifically, they were using the friends and family test and the trust reported very positive results with the lowest score in the memory services in March 2016 being 94% recommending the service in the Wiltshire Sarum team (though this had dropped to 86% in April) and 79% recommending the South Gloucestershire later life community mental health team in April 2016. Data was missing for some of the teams in the April 2016 data provided by the trust. Whilst on site we saw five compliments displayed in the staff office at the South Gloucestershire team's base.

Skilled staff to deliver care

- There was a wide range of skilled and experienced staff across each of the teams we visited and managers were knowledgeable about the skill mix and abilities of each team member. Psychological therapies, occupational therapy, speech and language therapy and physiotherapy were available to all patients where and when required. Local arrangements in the teams also allowed patient's access to social workers; this was

Are services effective?

Good 

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.

either via the local authority, or by the social worker being seconded by the trust. Staff in the psychiatric liaison service had access to nurses, social workers and a substance misuse specialist nurse as well as psychiatrists.

- Each team we visited had at least one senior practitioner who provided clinical supervision to the band five and six nurses. The only nurse prescribers were in the psychiatric liaison service and the South Gloucestershire teams out of the teams we inspected. Where vacancies had come up, managers ensured the needs of the service were met by thinking about the role of the post and the ability to recruit. In Swindon band four staff were care co-ordinators. There wasn't a competency sign off process (where staff would be checked they had the relevant competencies for the role) for this role but staff completed an induction, shadowed qualified staff and participated in joint working prior to taking on a caseload. There were clear roles and responsibilities identified in the person specification and this indicated that no comprehensive health assessments would be undertaken, they would not administer medicines nor offer advice about this. Mental capacity assessments were part of the role and the staff we spoke to were knowledgeable about the Mental Capacity Act and Deprivation of Liberty Safeguards.
- We spoke to two staff who felt career progression was limited and were concerned that skills may be lost due to the joint working and sharing of roles within the team (between social workers and nursing staff). Managers were aware of this and tried to ensure skills were maintained. In Swindon, team managers told us that functional illness cases were usually allocated to the community psychiatric nurse and organic illness cases would be allocated to the social workers as staff felt this better fitted their skills.
- Supervision was undertaken monthly and this included all staff groups. Administrative staff told us they felt supported by this process. Staff also had access to weekly complex case meetings where they could obtain peer supervision routinely. Staff confirmed that they could seek supervision when required from senior members of the team. We reviewed a sample of 16 supervision records, which demonstrated staff were supported to discuss a range of clinical issues and concerns.
- Trust records indicated that teams were mostly up to date with appraisals. The lowest rate in the CIT teams was 80% in the Swindon CIT. In the memory teams we inspected, only the Swindon memory team had staff without an appraisal (it was 90% of the 16 members of staff). Of the three memory teams we did not inspect, appraisal rates varied. No staff in the WWYKD team had received an appraisal within the year before the inspection, 75% had received appraisals in the Wiltshire NEW team and 82% had in the Wiltshire Sarum memory team. In the Therapies teams, the North Somerset team and the South Gloucestershire teams had all of their staff up to date with appraisals, in BANES 92% of staff had appraisals. In the care home liaison teams, 83% of the staff in the South Gloucestershire team had an up to date appraisal and 88% had one in the Wiltshire team. We saw that in the psychiatric liaison team at Southmead hospital, only one member of staff had not received a recent appraisal, and this was due to them being off sick.
- Appraisals were linked to the trust values. Continuing professional development was identified as part of this process. A small number of staff we spoke with told us that it was difficult to get funding to attend conferences or other external courses. Others told us they had been funded to attend conferences. Managers and staff considered how best to use the limited funds available. Staff told us they had received internal courses in dementia, frailty and were arranging for training in dialectical behavioural therapy. In the South Gloucestershire team, a member of staff was supported to take a specialist dementia course at a local university and staff had received training on the Newcastle model of managing challenging behaviour. Consultant psychiatrists felt well supported and there were a number of opportunities to participate in continuing professional development. We were told medical leadership was good and supported opportunities to learn and develop including, for example, regular professional meetings and attending monthly journal clubs.

Are services effective?

Good 

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 limited examples of poor staff performance. However, where we did, the staff members had continued in the role and with support, their performance had improved.

Multi-disciplinary and inter-agency team work

- We observed, and staff told us, there was good multidisciplinary and multiagency working in each of the localities. Teams across the localities had weekly meetings in which they could discuss cases, and the complex intervention and treatment teams had weekly allocation meetings. In Swindon, therapy teams were invited to the weekly meetings but did not always attend. Therapy teams in Swindon and BANES attended their own monthly team meetings and in BANES there was a monthly team meeting and a monthly link meeting with the inpatient ward. The psychiatric liaison service had allocation meetings in the morning and further handovers later in the day that ensured that patients who had been referred had been allocated and seen as appropriate. These allocations and handovers were split so that the emergency zone team and the inpatient team had different meetings.
- Staff told us that having the other older adult community mental health teams for their locality at the same location was particularly useful and it meant they could access all staff groups easily. The Swindon office was considered a hub and district nurses were also located on the same site, ensuring good communication with primary care nursing.
- There was good liaison with other teams and in particular the primary care liaison service. Staff said that consultants described a good working relationship with inpatient colleagues although handover from and to inpatient services was not always robust. In BANES one of the trainee Doctors was looking at how this could be improved.
- Staff in the teams we inspected told us there was a good working relationship with the local authority and there was joint training between the local authority and the trust in the BANES team. Staff told us the support they received from the AMHP office was excellent.
- Staff said that the working relationship with care homes was also good. We spoke with two care home managers who told us the services they received were excellent and they felt supported in carrying out joint risk

assessments and care planning. Occupational therapy had provided training for care homes and domiciliary care agencies in understanding different aspects of mental health.

- Staff in most localities also described a good working relationship with local general practitioners.

Adherence to the MHA and the MHA Code of Practice

- The trust reported that in February 2016, the overall percentage of staff that had received training in the Mental Health Act was 96% in older adult community mental health teams. However, all staff we spoke with were aware of and had received training in Mental Health Act responsibilities. Information about whether staff had been trained in the Mental Health Act was on the trust intranet, managers and supervisors were made aware if staff were not up to date with this. There was good support provided by the local authority and teams received good support from Approved Mental Health Practitioners (AMHPs). Staff we spoke to told us they had attended the local authority training on the Mental Health Act and had received annual updates through the e-learning system provided by the trust.
- Staff in the Mental Health Act office sent reminders to staff about upcoming reviews and independently scrutinized completed paper work. Legal advice was available from the trust, if needed. Staff told us the AMHP office was very helpful and knowledgeable and would often challenge decisions made. Staff would seek consent to share information.
- Independent mental health advocacy was readily available and staff demonstrated good knowledge and understanding of when to use this service with good examples provided.
- At the time of the inspection there were no patients subject to a Community Treatment Order (CTO) (the provision of supervised treatment following a stay in hospital). Staff showed knowledge in this area as they had supported patients in the past who had been subject to a CTO.
- No audits of compliance with the Act had been undertaken within the teams

Good practice in applying the MCA

Are services effective?

Good 

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.

- The overall percentage of staff in older adult community mental health teams that had received training in the Mental Capacity Act was reported as 94% in February 2016. This ranged from 67% (although this was for a team of three) in the Wiltshire care home liaison team to 100% in the Swindon, South Gloucestershire and North Somerset memory teams.
- Staff had a good understanding of their role in ensuring mental capacity was assessed and that, where patients lacked capacity, best interest meetings were held with relatives and carers. Staff told us that paper work was completed; it was uploaded on the electronic record system and printed off for the person using services and their carers. We saw capacity assessments and evidence of best interest meetings where appropriate in the care records we reviewed. The local authority had provided case law training. Mental Capacity Act information was available on the intranet called Our Space and staff could access this whilst in the office.
- Staff spoke knowledgeably about deprivation of liberty safeguards and we were told about joint training that had been provided by the local authority that staff had attended.
- There was no evidence that there were arrangements in place to monitor adherence to the Mental Capacity Act within the teams.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Patients and carers described staff as polite, respectful, and said they involved carers and service users in decisions about their care. Risk assessments and care planning was considered to be part of a joint assessment and care homes felt supported to implement these. Staff were available and would respond in a timely manner to both to calls from patients and their carers, and to local care homes.
- Carers of patients were, overall, very complimentary about the service they received and all carers thought staff were friendly, caring and responsive. They thought staff had a good team rapport and ensured all questions were answered fully and all calls responded to quickly.
- Information was readily available and relevant. Carers told us this had supported them in making decisions about aspects of the care needed. Staff also provided information about the availability of local support services such as the 'Forget Me Not' day service and befriending services, which some patients had found useful.
- Carers felt that the teams were aware of, and took into account, their views and that they were integral to care

that staff delivered. Some carers had been offered an assessment to help them care for their loved one and told us that their quality of life had improved with the support that was provided.

The involvement of people in the care they receive

- The vast majority of records showed that patients had been involved in decisions about their care. Carers of patients told us they were involved in the care planning approach process and they felt their opinions were valued when determining the appropriate course of treatment. However, not all carers and patients had received a copy of their care plan.
- Staff in the North Somerset and South Gloucestershire teams told us about a post dementia diagnosis group that they ran. This group provided support to carers as well as patients with dementia.
- Patients and their carers were given the opportunity to feed back on their care through the friends and family test, and we saw examples of compliments that the teams had received. We saw evidence in the Swindon teams that they had developed a service user charter that was due to be launched on 26 May 2016. Staff in the North Somerset teams told us that they had a locality involvement worker. Staff in the Swindon complex intervention team had involved a patient in recruiting staff.

Are services responsive to people's needs?

Good 

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

Our findings

Access and discharge

- The trust had set a target of having 95% of patients assessed by the service within four weeks of their referral and that they had received treatment within 18 weeks. After the inspection, the trust provided us with data on its waiting lists and performance against its targets. Across all teams, the number of people waiting was generally low with two people waiting in the Bath and North East Somerset (BANES) complex interventions and treatment team and the highest waiting times were 40 people who had been waiting up to four weeks in the memory teams in Swindon and North Somerset.
- In April 2016, the trust reported that 86% of patients referred to the complex intervention teams were assessed within four weeks. This was below the trust's target; the lowest was in the Swindon complex intervention team where they saw 33% of patients within four weeks, 80% of patients were seen within four weeks in the BANES team, 88% by the North Somerset team, and all referrals were seen within four weeks by the South Gloucestershire team. The overall percentage of patients who received treatment within 18 weeks of being referred to complex intervention and treatment teams was 97% in April 2016. The team with the lowest percentage meeting that target was the Swindon complex intervention and treatment team, which had seen 81% of patients for treatment within 18 weeks of them being referred. The rest of the teams had reached above the trust's target, with North Somerset and South Gloucestershire later life community mental health teams seeing all patients for treatment within the 18 weeks, and the BANES complex intervention and treatment team seeing 98% of patients within 18 weeks of them being referred.
- There was vacancy for a psychology post in the BANES team due to maternity leave and this meant that 11 patients were waiting to be seen. The longest wait was over 18 months but this was the patients' choice, as they only wanted to access services provided by a female member of staff. The team was recruiting at the time of inspection to cover the maternity leave. Staff told us that there was also a wait in South Gloucestershire for the therapies team of six weeks, there were six patients waiting at the time of inspection. The trust only provided information about therapy teams meeting the targets for the North Somerset team, which had seen 66% of people within four weeks for assessment and 100% within 18 weeks for treatment.
- The four-week target between assessment and referral was also in place for the memory services. In April 2016, overall was 64% of patients referred being seen within four weeks. While all of the teams were below the trust's target, the performance varied by team, with the North Somerset memory service seeing 91% of patients within four weeks of referral and the Swindon memory service seeing 19% of patients within four weeks of referral. From data available from trust the majority of teams waiting times were acceptable.
- Patients could not self-refer into the services, and so would be monitored by the referring clinician (general practitioner, care home, primary care liaison service) until they could have an appointment with the older adult community services. Referrals were triaged by the senior practitioner and or manager and if urgent would be allocated straight away. There was always at least one duty worker available each day to take on urgent cases. All other referrals were allocated at the weekly allocation meeting. Patients had contact numbers for out of hour's services.
- Staff in the South Gloucestershire team said that as there was no out of hours dementia specific contact service, patients had to contact the crisis team and those with organic dementia had to wait until the following working day. This was the same in the Swindon teams. They had run a pilot service in order to try to justify funding from the commissioners, but this had not demonstrated the full need for the service. In BANES, the intensive team (an ageless team providing support to people in a crisis) covered accident and emergency services out of hours for patients with functional illnesses. There was an out of hour's specialist dementia service in North Somerset.
- The trust's older adult beds were distributed across the whole geographical area it covered, and so it could not be guaranteed that a person would be admitted to a ward near their home if they needed inpatient services. Staff told us that the trust had no respite beds (beds that could be used to provide temporary care to someone who used the service) for older adults. Staff said that in South Gloucestershire, the access to respite beds was limited and because of this, staff may have admitted patients to an older adult inpatient ward

Are services responsive to people's needs?

Good 

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

instead. Respite beds provide time limited care to help stabilise patients provide a break for caregivers. Patients on an inpatient wards may have more acute care needs. It also reduced the availability of beds for people who needed an acute inpatient bed.

- There were clear criteria for the four types of older adult community mental health service. Memory services would see anyone with cognitive changes in their memory; if the person had identified risks then they would refer them to the primary care liaison service. The other older adult community mental health services would refer within themselves depending on the persons need, if they were presenting with risky behaviour then the complex intervention and treatment team would care-co-ordinate them. If they required psychological, occupational or physiotherapies, then they would be referred to the later life therapies team. Care home liaison would see patients living in care homes when their specialist input was needed to help manage a patient's distress or decline in functioning. There were also criteria for the level of risk a patient presented with and the period within they would be seen in the psychiatric liaison service, with urgent referrals being seen within the hour, the next level was four hours and finally six hours for the emergency zone. Psychiatric liaison patients in the inpatient wards had a target of being seen within 24 hours.
- Staff said that they did not have a policy for limiting the number of attempts made to contact patients after they missed an appointment, but that they would continue, or arrange for the referrer or other clinician to contact the person. They also said they would attempt to alert carers, if they had been identified and consent had been given.
- Most appointments were held between 9am – 5pm, Monday to Friday. However, staff in the services could arrange for an out of hours appointment on a case by case basis. Patients, carers, and other professionals, we spoke with, confirmed that calls were returned in a timely manner. Staff confirmed that they had capacity to respond effectively if they needed to make additional visits or contacts.
- Access to a consultant psychiatrist was good. All staff we spoke to told us they could access a psychiatrist within a couple of hours. Carers and patients also thought that psychiatrists were accessible and many spoke of regular,

joint visits with the nurse. All staff we spoke with thought that being co-located with the psychiatrist helped communication but also ensured good accessibility and speedy responses.

The facilities promote recovery, comfort, dignity and confidentiality

- Memory services were provided in clinics, either on site, or in local healthcare sites such as general practitioners surgeries or other hospital sights. Later life therapy services and complex intervention teams could use therapy rooms to see patients, or could arrange home visits.
- There were no confidentiality issues with the clinic rooms. We spoke to reception staff that were very aware of confidentiality and Caldicott principles about sharing information.
- Waiting rooms had noticeboards and leaflets containing useful information for patients and their carers, such as local service, the complaints procedure, advocacy groups, and information for carers.

Meeting the needs of all people who use the service

- Staff tried to make sure that the place where they saw patients fitted their needs. The clinical areas we inspected had access for patients with differing mobility. All patients we spoke with and their carers told us that staff saw them at home, which they appreciated. At the psychiatric liaison service, patients were either seen in a private area of the ward (the hospital had single occupancy rooms) or in a designated consulting room that was in a less busy part of the hospital.
- Staff provided an information pack to patients and a separate information pack was available for carers. This included information about how to access the team and out of hour's services as part of the care plan of the person using the service.
- Staff told us they could access interpreters if needed but this had not happened in the last 12 months.

Listening to and learning from concerns and complaints

- There had been three complaints between February 2015 and January 2016. One of these was upheld against the Wiltshire care home liaison and the learning from the complaint was to ensure that relatives were included in the assessment process. The other two

Are services responsive to people's needs?

Good 

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complaints were not upheld by the trust. The trust did not report whether the complaints about older adult mental health services had been referred to the ombudsman.

- Managers reported a good process for managing complaints across the trust and felt supported when a complaint was raised. Informal complaints were dealt with locally and these were not reported centrally.
- Staff told us they were aware of the complaints procedure and were able to describe the process. They told us complaints were discussed at team meetings

and we observed a team meeting where it was noted no complaints had been made and there was no learning to share from complaints across the trust. Some staff told us the information leaflet "how to complain" was given out during the initial assessment. Of the 14 service users and carers we spoke to, three told us they did not know how to complain and all others stated they would contact the care co-ordinator in the first instance. All patients we spoke to said they did not feel the need to make a complaint.

Are services well-led?

Good 

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

Our findings

Vision and values

- All staff we spoke with were aware of the trust's values and visions. We saw that this was an integral part of the appraisal process.
- Staff reported that the changes that had occurred within the leadership of the trust over the last two years were very positive and felt that the locality focus was working well. There was a real sense of vision for their locality and staff felt that locality managers protected them from some of the more corporate issues. Some staff felt that they had lost some sharing of information about their speciality across the trust but also recognised the benefits of integrating with other services within the locality.
- Staff were more aware of their locality senior managers, and said that they had regular contact with them. They reported having less contact with the senior team based at trust headquarters.

Good governance

- All staff we spoke to told us they were up to date with mandatory training at the time of inspection and that the trust was supportive in ensuring this was completed. The trust's 'Information for Quality' (IQ) system produced a monthly report, which was traffic light rated (green meaning on target, amber meaning it was close to being due and red meaning it was overdue) so that managers could see if staff were not up to date. Most of the training was through e-learning and staff commented that this was not always the best medium to use, particularly for safeguarding.
- The IQ system also monitored supervision and appraisal rates. All staff groups that we spoke with told us they were up to date with annual appraisal (although the rates varied by team from 0% in the Wiltshire WWYKD memory team to all staff in the North Somerset later life psychology team) and received monthly supervision. When we reviewed staff supervision records, we found that in the South Gloucestershire therapies team paper records of the content of supervision were not always available. IQ only monitors the date that 1:1 supervision was logged and what type of supervision (clinical,

managerial) the supervision was and which two staff attended. This means that should there be an incident or complaint, the decision making process may not have been documented.

- We saw evidence that IQ not only tracked supervision and appraisal rates, but also tracked other key performance indicators including referral to assessment rates, friends and family test results, sickness rates and recorded audits being used to provide a quality monitoring report for commissioners.
- Safeguarding, MHA and MCA procedures were embedded in staff assessments. In most of the records we reviewed, we saw appropriate recording of capacity, although in one record we saw that staff had incorrectly completed one of the sections of the form but the concluding decision was correctly completed.
- There was an ongoing care record audit across all of the teams. Five care records were randomly selected each month and an audit of their compliance was completed by the manager or senior practitioner. Where issues were identified, managers discussed this with the relevant individual. We observed a quality report for March 2016 and this identified that 43 out of 50 records had achieved 100% compliance. All 50 had completed CPA reviews.
- There was a good incident reporting process and culture within the trust and managers had been encouraged to report low risk incidents as this had been under reported across the teams. Information was shared with senior managers and learning from incidents discussed at the monthly governance meetings. This was then shared with teams and staff were aware of learning from incidents across the organisation.
- In the standard operating procedures for Swindon there was a target of 13 week target from assessment to treatment. Managers were not aware of any other targets and there were no commissioning for quality and innovation (CQUIN) targets for the Swindon complex intervention team or the Swindon therapies team. The BANES manager was waiting for the most current CQUINs and stated there had been no CQUINs for the complex intervention team last year. However, there were CQUINs for other teams and the manager was knowledgeable about these. The team had implemented alcohol screening in dementia for the last year even though there was no requirement to do this.
- There were local risk registers in place, which contributed to the trust's risk register. In BANES the

Are services well-led?

Good 

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manager was able to describe all five risks on the register and the mitigating actions in place. Staff in the other teams were able to say how they would raise concerns about service risks within the trust other than by raising it with their manager.

Leadership, morale and staff engagement

- Staff told us they were supported by their managers and they were accessible and approachable. Staff felt their opinions and views were respected and that managers listened to their concerns and suggestions. Senior management in the locality were also approachable and staff told us they shared relevant information.
- We were made aware of two incidents of bullying and harassment and it was not clear how this would be resolved. Generally, staff felt that there had been a shift from a punitive management style to an open and sharing leadership style. Performance management was undertaken as and when needed.
- Staff said they would feel confident to use the whistle blowing procedure although no one had used this in the last 12 months.
- Staff were able to access mindfulness sessions and this was particularly evident in the therapies team at BANES.
- Some senior staff reported that they felt pressured to undertake investigations when an incident in another team had occurred. They felt that they were not best placed to undertake them and that it took time from their day-to-day work. The staff reported that the trust had made training available but that not all relevant staff had received it.
- We saw that staff morale was very good and we heard from the majority of staff that they worked with a supportive and good team. Managers operated an open door policy and were clearly knowledgeable about the staff in their team and aware of their capabilities. Caseloads were manageable and staff reported how much they enjoyed their job. Senior staff reported that they had received management and leadership training in the past supported by the trust.
- The teams we inspected reported capable administrative support, and found it valuable. However, there was an upcoming administrative vacancy, as well

as a current vacancy in the South Gloucestershire teams that staff had raised with us as a concern. They felt that this would effect the workload of clinical staff. The post was out to advert and interviews had been arranged.

- Most staff we spoke with said they felt they could contribute to service development and we heard from the managers of the services that they had liaised with local commissioners in order to establish funding for staff posts and for service development. A minority of staff felt they were not able to raise suggestions, and when they had, they had not been listened to.

Commitment to quality improvement and innovation

- The therapies team in Bath and North East Somerset (BANES) employed an ex service user to implement a project called Fresh Art at Work. This was an art project provided at community locations and on in-patient wards. It was funded by the trust and supported by the clinical commissioning group. The project was based on national studies. It looked at five ways to well-being, provides supportive engagement with service users through art work and helps bridge the gap from ward discharge to community and independent living. The service had been recognised nationally and locally.
- Psychological therapy services in BANES undertook an extensive audit of quality improvement in the service. This took into account the trust's values and Care Quality Commissions five key questions. There were a number of improvements that had been made as a consequence of this evaluation and patients worked in partnership with clinicians to improve service provision.
- The BANES later life therapies team had developed an activities group looking at how to encourage activities within the home.
- The BANES complex interventions and treatment team manager, and the local authority had undertaken a presentation on the Care Act to help raise awareness for carer's statutory assessments and other support they could access.
- The psychiatric liaison service had begun self-assessing against the Royal College of Psychiatrists' Psychiatric Liaison Accreditation Network. They had not yet begun the application process at the time of inspection. They had also participated in a Cochrane collaboration review and had been published in a peer reviewed online journal.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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