Avon and Wiltshire Mental Health Partnership NHS Trust

Services for older people

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)
Fountain Way	RVN9A	Amblescroft North and South Wards	SP27FD
Longfox Unit	RVN4B	Cove and Dune Wards	BS234TQ
Callington Road Hospital	RVNEQ	Laurel and Aspen Wards	BS45BJ
St Martins Hospital	RVN2B	Ward 4	BA2 5RP
Victoria Centre	RVNCE	Liddington and Hodson Wards	SN3 6BW
Fountain Way	RVN9A	Wiltshire South CIT (OPMH)	SP27FD
Trust Headquarters	RVN1H	Bath and North East Somerset CIT (OPMH)	BA13QE
Trust Headquarters	RVN1H	Swindon CIT (OPMH)	SN3 6BW
Trust Headquarters	RVN1H	Bristol CIT (OPMH)	BS45BJ

Summary of findings

Trust Headquarters	RVN1H	North Somerset CIT (OPMH)	BS23 4TQ
Trust Headquarters	RVN1H	Bristol and South Gloucestershire Later Life Mental Health Liaison Team	BS10 5NB

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.

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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Overall summary

Avon and Wiltshire Mental Health Partnership NHS Trust's older people's services provide support for people aged 65 and over with mental health needs or functional mental illnesses (such as depression). The service also provides both community and inpatient support for people of any age with a diagnosis of dementia. We also inspected the Bristol and South Gloucestershire later life liaison team.

Overall, we found that older people's community services were generally effective however older people's inpatient services required improvement. We were particularly concerned about how safe the care was for patients in some of the inpatient wards.

Staff understood their responsibilities about safeguarding, but we found that incidents at the inpatient units had not always been recognised, reported, investigated or learnt from. Although risks were usually assessed, it did not always lead to changes in practice.

There were ligature and environmental risks on some of the wards that had not been addressed. In addition, some wards were described as cold and institutional. There were also issues about mixed sex accommodation and protecting people's dignity.

Multidisciplinary staff worked well together and we found staff were compassionate and caring. However, on a number of units there were not enough staff, and there were issues with the environment, which may have had an impact on patient care and safety.

On the whole, people we spoke with were positive about the staff and felt they made a positive impact on their experience on the ward. However, some people were concerned that staff did not have enough time to spend with them.

The availability of beds appeared to be a trust-wide issue, with beds for older people always in demand. People were not always treated in their local area and were sometimes moved during their care, which had an impact on their recovery.

Staff knowledge about the trust's vision and values varied across services. In general, staff felt supported by their managers at a local level, but not all staff felt supported by senior trust management.

There are governance processes in place, as well as a trust-wide governance and information system called IQ, but this had not always led to positive changes in practice.

Summary of findings

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

Are services safe?

Community

Service meetings and assessments of people's care were undertaken regularly.

Staff received training, even though this was difficult to access because of where the trust is located. Staff were also aware of policies for keeping people safe and there were good systems in place for reporting incidents.

However, records showed that not all risk assessments were up-to-date and that there had been little feedback following two recent serious incidents.

Inpatient services

Some wards had assessments for environmental ligatures in place, but there were also issues of physical safety. For example, equipment not being maintained correctly, not enough fire extinguishers and, on two wards, concerns about managing medicines safely. Across the service, there was a high risk of falls and, in some places, there were not enough audits or resulting action to reduce this risk or learn from incidents.

A couple of wards were described as cold and institutional.

In general, the management of medicines was acceptable (except on two wards) and the requirements for covert medication (giving medicines in a disguised form) had been followed correctly.

We found at one unit the use of restraint that did not meet the guidance set out in the Mental Health Act 1983 Code of Practice.

We found that sleeping and bathroom arrangements at some wards that did not protect the dignity or safety of patients.

As we entered one service, we found patient-sensitive information was left unattended by the visitors' signing in book. We told the relevant manager who immediately referred the incident to the Caldecott Guardian for the trust.

Are services effective?

Community services

There was a system in place to monitor the quality and safety of the service. We found that there was a strong working relationship between the different professionals. There was also enough staff and an effective system for supervising staff and conducting staff appraisals.

Summary of findings

However, there was evidence that the service was not consistently gaining people's consent to care, and there was no system in place for measuring people's outcomes.

Although there was an appraisal system, we did not find a competency framework for judging staff's ability and or training for staff in the model of care being used.

Inpatient services

The inpatient service had good input from senior medical staff and consultants, and staff worked in close knit, supportive teams.

Mental health and mental capacity advocacy services were included in the ward processes and staff used them well.

Staff received supervision and, in most wards, the majority of staff were up-to-date with their mandatory training.

We did, however, have concerns about privacy and dignity. For example, we found doors missing curtains, people sharing rooms against their wishes and staff not addressing situations in a creative way so that people's dignity was protected.

Documents, for example daily notes, risk assessments and one-to-one sessions, were not completed consistently. People and staff also told us that there were not enough activities and that there was a lack of follow-up after being discharged.

Are services caring?

Community services

Staff were caring, compassionate and respectful, and relatives gave positive feedback.

People and their relatives were also given information about, and access to, the advocacy service. However, we noted that the information was not readily available in different languages.

Inpatient services

Relatives praised the staff as hard working, diligent and dedicated, and said that they were always made to feel welcome when they visited the wards. In the majority of cases, we observed staff interacting in a respectful and friendly manner.

One ward complained about the laundry because relatives were asked to remove and launder people's clothes if they could.

On another ward, we were very concerned to see that a piece of cake served to a person was placed directly onto the table without a napkin or plate. We were also concerned by an incident where a person's dignity was not protected by staff.

Summary of findings

Are services responsive to people's needs?

Community services

There was a detailed discharge process in place, and the teams communicated well with each other.

Staff we spoke with knew about the independent mental capacity advocacy (IMCA) service and patient advice and liaison service (PALS), and there was information available for people about these.

Although there was an effective complaints system in place, we did not see any evidence of feedback from this. In addition, staff seemed unaware of the policies relating to the service.

Access to beds was an ongoing problem. One of the community teams did not have an out-of-hours service. This meant that they had to use general medical services if someone needed support out-of-hours.

Inpatient services

We found that sleeping and bathroom arrangements at some wards that did not meet the guidance on single sex accommodation.

We were told about issues such as people being placed 'out of area', which made it hard for relatives to visit and be involved in their care. Another comment was that there was less support for older people with functional disorders as opposed to organic disorders.

In general, care plans were adequate, but they did not always include input from the person or their relatives. Also, risk assessments were not updated consistently to reflect learning from incidents.

We heard comments that the food was good and nutritious. However, on one ward, there were no arrangements in place if a person wanted their food kept for them.

The multidisciplinary team worked well together with strong links out to the community teams, but awareness of the advocacy service varied across the inpatient services.

We saw that staff had made applications under the Deprivation of Liberty Safeguards (DoLS). Except for one case, the paperwork appeared to have been completed correctly. However, details of applications were not recorded fully on the trust electronic recording system.

There was also a lack of consistency in people's care records. For example, names changing midway through care plans and inaccuracies on the 'do not resuscitate' forms.

Summary of findings

Are services well-led?

Community services

The trust's senior managers had visited some of the teams and this appeared to contribute to a shared vision throughout the service.

At a local level, staff were aware of their roles and understood the challenges they faced. However, this did not translate into the overall vision for the trust.

There were regular multidisciplinary meetings and audits at a local level to measure progress. Advocacy services were promoted and supported, and staff described managers as supportive, approachable and said that there was an open door policy.

At one site, there was no risk register. Across the services, we did not find any benchmark for standards in relation to national guidance such as from the National Institute for Health and Care Excellence. Also, information from complaints was not fed back consistently.

Inpatient services

Local managers appeared to be forward thinking, supportive and have a strong vision of the trust. Staff on one ward described a 'no blame' culture, which was supported by the high level of incident reporting. While we heard varying reports about the support from ward managers, these were mostly positive.

During our inspections, we highlighted several issues to ward managers, which were addressed quickly in most cases.

We were more concerned about the wider trust management. Many staff told us that there was a sense of detachment between local services and senior trust management. In addition some staff were unable to name the chief executive and many said they would not recognise any of the trust senior management team if they visited the ward.

Summary of findings

Background to the service

The older people's services are based on five hospital sites at Fountain Way (Salisbury), Callington Road (Bristol), St Martin's Hospital (Bath), The Longfox Unit (North Somerset) and the Victoria Centre (Swindon). They are purpose built facilities and provide inpatient mental health services for adults aged over 65 years.

There are community teams based across the trust area. Services include:

- Inpatient assessment and treatment services.
- Community mental health services.
- Complex intervention & treatment teams.
- Inpatient rehabilitation services.

These services provide community support for older people with mental health needs. These can be either older people with a diagnosis of dementia or other functional mental illnesses (such as depression).

The multidisciplinary team worked closely with the trust's memory service and inpatient wards. The team supported people and their carers through the use of support, advice, medicines and a range of therapeutic interventions. We saw evidence that the service worked well with GPs and other adult social care providers.

We also inspected the Bristol and South Gloucestershire later life liaison team who were based at the Southmead Hospital in Bristol. This service provided a specialist psychiatric liaison service for older people who were receiving physical health care in local acute NHS hospital trusts.

Our inspection team

Our inspection team was led by:

Chair: Professor Chris Thompson, Consultant Psychiatrist

Team Leaders: Julie Meikle, Head of Inspection and 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?

We carried out announced visits between 9 and 13 June 2014. Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. During the visits, we held focus groups with a range of staff including nurses, doctors, therapists and allied staff. We observed how people were being cared for and reviewed their care or treatment records. We also met with and talked to

Summary of findings

people who use services and their carers and/or family members, who shared their views and experiences of the core service. We carried out unannounced visits between 24 and 26 June 2014.

What people who use the provider's services say

In general, people were positive about the later life services provided by this trust. One person said that staff were very kind and supportive. Someone else told us that staff were very good and treated them with respect.

People were informed about the care and treatment they received and told us that staff were good at explaining things to them. People received a copy of their care plan and a list of emergency contact numbers if needed.

We observed staff following good practice and interacting well people and their carers. Carers also told us that they felt well supported by the service and found that staff were responsive and kind.

A number of carers told us that while the Bath and North East Somerset (BaNES) Complex intervention & treatment team was very good, the service their loved one had received was stopped suddenly and alternative arrangements had not been put in place.

Good practice

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

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must make sure that ligature and environmental risks are addressed.
- The trust must make sure that the privacy and dignity of people using the service is fully protected and that all older people's wards meet guidance on mixed sex accommodation.
- The trust must make sure that emergency lifesaving equipment is readily available and fit for purpose.
- The trust must make sure that there are clear procedures for managing fire safety and that equipment is readily available.
- The trust must make sure that manual handling and other safety equipment is serviced and fit for purpose.
- The trust must make sure that there are enough staff on duty to meet patient's needs.
- The trust must make sure that individual patient risk assessments are reviewed and updated following changes in people's needs and risks.
- The trust must make sure that care and care planning is person-centred.
- The trust must make sure that discharge arrangements are clear and effective.
- The trust must make sure that the arrangements for managing medicines and administration procedures are safe and effective and that checks are undertaken to ensure the integrity of medicines.
- the trust must work with the commissioners of their service to make sure that there are enough beds in the required location so that people receive the right treatment at the right time
- The trust must make sure that local governance arrangements lead to positive changes in practice.
- The trust should make sure that restraint is recognised and managed within the safeguards set out in the Mental Health Act (MHA) 1983 Code of Practice.

Summary of findings

- The trust should make sure that there is no restrictive practice leading to a deprivation of liberty.
- The trust must make sure that all staff have completed relevant mandatory training including safeguarding, management of aggression and life support.

Action the provider SHOULD take to improve

- The trust should make sure that information about the MHA and the service is available in alternative languages and formats.

Avon and Wiltshire Mental Health Partnership NHS Trust

Services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Wiltshire South Complex Intervention & Treatment Team	Fountain Way
South Gloucestershire Complex Intervention & Treatment Team	Victoria Centre
Swindon Complex Intervention & Treatment Team	Victoria Centre
BaNES Complex Intervention & Treatment Team	Trust HQ
Bristol Complex Intervention & Treatment Team	Callington Road Hospital
North Somerset Complex Intervention & Treatment Team	Longfox Unit
Bristol and South Gloucestershire later life mental health liaison team	Callington Road Hospital
Laurel Ward Aspen Ward	Callington Road Hospital
Amblescroft North Amblescroft South	Fountain Way
Liddington and Hodson Wards	Victoria Centre
Ward 4	St Martins Hospital
Cove Ward Dune Ward	Longfox Unit

Detailed findings

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 reviewed the application of the MHA and the MHA Code of Practice at all of the older people's wards we visited. We found that legal paperwork was in place and fully completed.

Staff confirmed that they had received training in the MHA and had access to advice where required.

In the patient records we reviewed, assessments of a patients capacity to consent to treatment was carried out at regular intervals and to a satisfactory standard. All treatment appeared to have been given under an appropriate legal authority.

There was evidence that patients were regularly presented and re-presented with their rights under the MHA. This included their right to an independent mental health advocate (IMHA). There was generally a good advocacy presence on the wards.

A standardised system was in place for authorising and recording section 17 leave of absence. At Fountain Way, we found a local process in place for managing the leave of informal patients which may lead to a restriction on a person's liberty.

We found a number of areas of practice that did not meet the MHA Code of Practice, relating to separate gender accommodation and around the use of restraint. These are detailed within the body of the report.

Mental Capacity Act and Deprivation of Liberty Safeguards

Community teams:
We found that all requirements were followed as required. Staff said they were aware of the Mental Capacity Act 2005 and the implications this had for their clinical and professional practice. Staff had received training on this Act. There was evidence that capacity assessments were being completed appropriately and reviewed as required.

Inpatient services:
We found inconsistency in assessment processes and inaccuracies in the documentation. Not all relevant information was fully recorded on the electronic record. We did however find that Deprivation of Liberty Safeguards (DoLS) applications were made appropriately.

Are services safe?

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

Summary of findings

Community

Service meetings and assessments of people's care were undertaken regularly.

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However, records showed that not all risk assessments were up-to-date and that there had been little feedback following two recent serious incidents.

Inpatient services

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As we entered one service, we found patient-sensitive information was left unattended by the visitors' signing in book. We told the relevant manager who immediately referred the incident to the Caldecott Guardian for the trust.

Our findings

Wiltshire South Complex Intervention & Treatment Team (OPMH)

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 manager confirmed clinical and other incidents were reviewed and monitored monthly and discussed by the management team and shared with staff. The report outlined the impact to the service, the underlying cause as well as the risk and governance team's comments. We observed the service did not have a risk register. The manager informed us they were aware of the shortfall and were working on developing this within the service utilising the red, amber, green (RAG) system.

Learning from incidents and improving safety standards

Both the staff and managers confirmed 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'. People who use the service told us they were able to voice their concerns to staff although they had not had to do so.

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

We reviewed an investigation report on a recent incident which resulted in a full liaison team being set up. This showed the trust had identified and analysed the risk and

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

Are services safe?

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

had taken the necessary steps to feedback to staff of lessons learnt. The evidence seen showed us that the trust had effective systems in place to learn from untoward incidents.

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

The trust had a head of safeguarding who predominantly covered children as well as a safeguarding adult lead. Staff were aware of the trust's safeguarding policy which was available on the trust's internal computer system. The records seen showed staff had received their mandatory safeguarding children's and adults safeguarding training.

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 was clean and well maintained with up-to-date environmental risk assessments in place which included for example; slips, trips and falls. Medicines management within the services was conducted by the pharmacy who reviewed the system regularly.

Assessing and monitoring safety and risk

Records identified that sickness levels were high but procedures were in place for all staff returning to work which included a return to work interview as well as access to the occupational health service. We reviewed the staffing rotas which the staffing levels were adequate and any shortfalls were covered by the trust's own bank staff.

The junior doctors interviewed said they enjoyed being part of the team and everyone got on very well. They also said they found the consultants to be very approachable. They told us they could refuse to do any additional shifts they were unhappy to do and did not feel coerced to doing additional shifts.

Understanding and management of foreseeable risks

Staff told us they were aware of the lone working policy and the guidance contained therein. The services had a record of staffs whereabouts and a coded message system to identify support needs when visiting people in the community.

BaNES Complex Intervention & Treatment Team

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). Staff told us they knew how to report incidents and were encouraged to do so.

Learning from incidents and improving safety standards

Incident reporting was a standing agenda item at regular business meetings, although we saw no discussion of incidents recorded. We saw two recent internal safety alerts which had been marked 'team meeting basket' but saw no evidence that these had been signed or discussed with staff. Some staff told us they had not received any feedback following the two recent deaths at Hillview Lodge. One staff member told us that they had received an email which emphasised the importance of inpatients being allocated a care coordinator. The email was subsequently located for us. However, we saw no reference to this at team meetings.

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

Staff we spoke with confirmed they were aware of their responsibilities to safeguard children and adults and to report any concerns. Health and safety issues, safeguarding and high risk, complex patients were, regularly discussed at business meetings.

South Gloucestershire Complex Intervention & Treatment Team

Track record on safety

The manager told us that they used the trust IQ dashboard and risk register to identify and monitor risks. The trust held data on a wide range of safety processes. Trust policies and procedures were accessible on the trusts own intranet site and there were adapted local variations where appropriate.

Are services safe?

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

Learning from incidents and improving safety standards

Staff had access to the trust safety alerts and resources on the intranet. Staff understood how incidents were recorded and reported on. Staff were given feedback following incidents so that lessons could be learnt as to how incidents might be prevented in the future. According to trust data the team had a low level of incident reporting.

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

There were systems in place to monitor quality and safety. Staff knew about safeguarding adults and children and what to do in the event of a safeguarding concern. The majority of staff had received safeguarding training, although they had raised concern that there was currently a wait to access this safeguarding training. Safeguarding guidance was available to staff.

Staff were aware of the lone working policy and we observed that they recorded their whereabouts in line with this. The team were participating in an out-of-hours pilot, in order to manage the risk of lone working staff based themselves with the intensive team during this time.

Staff demonstrated a good understanding of confidentiality and information governance issues. The trust used a secure electronic records system, RIO.

Assessing and monitoring safety and risk

There were procedures in place to identify and manage risks to people who used the service. The teams operated a caseload weighting system to clearly identify risk levels on their caseload. There was a weekly multidisciplinary team meeting to discuss any concerns. Staff also had regular caseload management supervision. Staff reported that their caseloads were manageable and they felt supported by their medical colleagues and manager.

People's needs and risks were assessed and clearly documented. However, not all risk assessments we looked at were up-to-date. One risk assessment had not been updated since August 2012 and we saw a letter to the individual outlining that the team were planning their discharge in the next few weeks. It was not clear that the risk assessment reflected current individual risks or how the forthcoming change in care plan may impact on their risk.

Understanding and management of foreseeable risks

The team did not operate a duty system; this is a system where an allocated clinician would be responsible for managing any urgent contacts to the team. The manager told us that they were usually available to oversee urgent contacts to the team or delegate to another team member. Changes to staffing due to annual leave or staff sickness was managed from within the team.

We saw the South Gloucestershire community action plan, which set out current and potential issues that may affect the service and how the trust planned to address these. This included areas such as staffing and increase in demand for services.

Swindon Complex Intervention & Treatment Team

Track record on safety

The manager told us that they used the trust IQ dashboard system and risk register to identify and monitor risks. The trust held data on a wide range of safety processes. Staff were confident that they could use these processes and action would be taken to ensure that people who used the service were safe. Trust policies and procedures were accessible on the trusts own intranet site.

Learning from incidents and improving standards

Staff had access to the trust safety alerts and resources on the intranet. Staff understood how incidents were recorded and reported on. Learning from incidents was shared within the team meetings and in individual management supervision.

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

Most staff had received their mandatory safeguarding training and knew about the relevant trust wide policies relating to safeguarding. Safeguarding guidance was available to staff from the identified safeguarding lead, who also kept a spreadsheet of team safeguarding concerns and referrals in order to monitor them. We observed comprehensive discussion regarding safeguarding concerns during the team meeting. Staff were confident in safely managing safeguarding concerns.

Are services safe?

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

Staff were aware of the lone working policy and we observed that they recorded their whereabouts in line with this. Staff demonstrated good understanding of confidentiality and information governance issues. The trust used a secure electronic patient records system, RIO.

Assessing and monitoring safety and risk

There were procedures in place to identify and manage risks to people who used the service. We observed comprehensive discussion within the weekly multidisciplinary team meeting. Staff also had regular caseload management supervision. Staff reported that their caseloads were manageable and they felt supported by their medical colleagues and manager.

We looked at care records and saw that people's needs and risks were assessed and clearly documented. People also had a clear crisis management plan in their care plan, so they would know who to contact if needed.

Understanding and management of foreseeable risk

The team operated a duty system, the clinician allocated on duty had protected time from caseload work to ensure they were free to respond effectively. Annual leave and sickness was managed within the team.

Bristol Complex Intervention & Treatment Team

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 the trust was reporting concerns through the National Reporting and Learning System (NRLS).

Senior staff confirmed clinical and other incidents were reviewed and monitored monthly and discussed by the management team and shared with front line staff. The report outlined the impact to the service, the underlying cause as well as the risk and governance team's comments.

The service had a local risk register and senior staff were able to identify the current risks to the service provided.

Learning from incidents and improving safety standards

Front line staff and managers confirmed 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'. People who use the service told us that they were able to voice their concerns to staff. Staff confirmed they had received mandatory safety training and felt supported by their manager following any incidents or near misses. They told us the trust encouraged openness and transparency and provided clear guidance on incident reporting. All staff could describe their role in the reporting process.

An example was provided of how the team had addressed a recent incident within this service. This showed that the trust had identified and analysed the risk and had taken the necessary steps to feedback regarding the lessons learnt. The evidence seen showed us that the trust had effective systems in place to learn from untoward incidents.

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

The trust had a safeguarding adult lead. Staff were aware of the trust's safeguarding policy which was available on the trust's intranet. The records seen showed us staff had received their mandatory safeguarding training. The records within the electronic system identified any potential safeguarding concerns. Staff we spoke with confirmed they were aware of their responsibilities to safeguard adults and where applicable children. They were aware of how to report any concerns to the relevant local authority. Staff were aware of the trust's whistleblowing policy and confirmed they felt able to raise concerns with their manager.

The community base we visited was clean and well maintained with an up-to-date environmental risk assessment in place. Medicines management within the service was monitored by the trust's pharmacy department.

Assessing and monitoring safety and risk

Systems were in place for assessing and monitoring safety and risk within the service. This included detailed records about people who were assessed as requiring support. We saw the team was quick to provide support and guidance to each other. This showed us staff were able to meet the individual needs of the people who use the service.

Are services safe?

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

We reviewed the staffing rotas which showed us the staffing levels were adequate and any shortfalls were covered by the trust's own bank staff. Caseloads seen varied between the locality teams and those senior staff spoken to had a good understanding of the reasons for this local variation.

We noted each staff member had an average caseload of between 15 and 25. Senior staff confirmed work was taking place with individual team members regarding proactive caseload management. Staff told us 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 joint visits and other precautions were taken by staff where appropriate and these were supported by clear risk assessments. The services had a record of staff's visit locations and clear systems for highlighting possible risks to their safety. Clear trust-wide and local contingency plans were in place and staff were aware of these. A local risk register was in place and this identified the current risks to the service.

North Somerset Complex Intervention & Treatment Team

Track record on safety

The trust-wide evidence provided showed us that the trust was reporting concerns appropriately through the National Reporting and Learning System (NRLS). We saw the local risk register was updated and regularly reviewed. Staff also received feedback on local and trust-wide incidents at their weekly team meeting.

We saw 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 community based visit we carried out with the permission of the person who used this service and their main carer.

Learning from incidents and improving safety standards

Staff confirmed 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 staff had received incident training and that incidents were discussed at their regular supervision. People who used the service, and their carers, told us that they were able to raise any concerns about their care with staff.

Staff confirmed they had received mandatory safety training and felt supported by their managers following any incidents or near misses. For example, we saw post incident management plans in place. The trust provided clear guidance on incident reporting. Staff described their role in the reporting process. The evidence seen showed us the trust had effective systems in place to learn from untoward incidents and 'near misses'

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

Staff confirmed they had received their mandatory safeguarding training and were aware of the trust's safeguarding policy. We found that care and treatment records identified any potential safeguarding concerns. These included areas such as capacity, mobility and power of attorney issues. Staff were aware of their responsibilities to report any concerns to the relevant statutory authorities.

Staff were aware of the trust's whistleblowing policy and confirmed they felt able to raise concerns with their manager. During a home visit with trust 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 some errors in the reconciliation of medicines being ordered and dispensed. This was brought to the attention of senior staff during our inspection.

Assessing and monitoring safety and risk

We carried out a home visit with the permission of the person who used the service and their main carer. We noted that staff proactively assessed and managed the safety and risk to the person and their carer. For example, by discussing any recent concerns or increased confusion in some areas.

Are services safe?

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

Staff reported that team meetings and individual supervisions were used to discuss complex cases where necessary. We found that there were adequate staff to meet the needs of the service. We noted that each staff member had an average caseload of between 19 and 25. Senior staff confirmed that trust employed bank staff would be used if there was any prolonged increase in caseloads or long term staff absence.

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 staff's whereabouts and clear systems for highlighting possible risks to the safety of staff.

Clear trust-wide and local contingency plans were in place and staff were aware of these. Staff confirmed that they were aware of the arrangements in place to maintain service continuity. A local risk register was in place and this identified the current risks to the service. This meant that the trust had effectively anticipated and managed any potential or foreseeable risk to the service.

Later life mental health liaison team

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).

Senior staff confirmed that clinical and other incidents were reviewed and monitored monthly and discussed at the weekly team meetings with front line staff. The report outlined the impact to the service, the underlying cause as well as the risk and governance team's comments.

The service had a local risk register and links were in place with the acute NHS hospital's risk register. This ensured that a joint approach to risk management took place. Senior staff were able to identify the current risks to the service provided.

Learning from incidents and improving safety standards

Senior 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.

Effective joint working on reporting incidents and 'near misses' was seen with the local acute NHS hospitals where this service worked. Staff confirmed that they had received mandatory safety training and that they felt supported by their manager following any incidents or near misses. They told us that the trust encouraged openness and transparency and provided clear guidance on incident reporting. All staff could describe their role in the reporting process.

An example was provided of how the team had addressed a recent incident within this service. This showed us that the service had worked proactively and collaboratively with the acute hospital involved to identify joint learning and future actions to embed this learning. The evidence seen showed us that the service had effective collaborative systems in place to learn from untoward incidents.

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

Staff confirmed that they had received their mandatory safeguarding training and were aware of the trusts and the relevant acute hospital's safeguarding policy. We found that referrals and intervention records identified any potential safeguarding concerns. Staff were aware of their responsibilities to work collaboratively with the referrer and report any concerns to the relevant statutory authorities.

Staff were aware of the trust's whistleblowing policy and confirmed they felt able to raise concerns with their manager.

Assessing and monitoring safety and risk

The evidence seen showed us that staff proactively assessed and managed the safety and risk to the person who had been referred to the service. For example, by discussing any recent concerns with the ward based staff within the acute hospital service. Staff were aware of the trust's lone worker policy.

Staff reported that weekly team meetings and individual supervisions were used to discuss complex cases were necessary. We found that there were adequate staff to meet the needs of the service. We noted that the service had an average caseload of between 40 and 60 and adopted a team approach to all new referrals. This ensured a prompt response to those referrals received. Short-term absences were covered from within the team. Senior staff reported plans to recruit a team of specialist bank nurses.

Are services safe?

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

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. These had been drawn up in collaboration with the relevant acute NHS hospital trust.

The services had a record of staffs whereabouts and clear systems for highlighting possible risks to the safety of staff. Clear local contingency plans were in place and staff were aware of these. A local risk register was in place and this identified the current risks to the service. This meant that the trust had effectively anticipated and managed any potential or foreseeable risk to the service.

Fountain Way - Amblescroft North and South

Track record on safety

The unit had policies in place relating to safeguarding and whistleblowing procedures. The trust policies and procedures were accessible via the trust's intranet site. Approximately half the staff had undertaken training in safeguarding vulnerable adults and not all had done Mental Capacity Act 2005 training. This meant that staff were not sufficiently well trained and knowledgeable in the potential causes and signs of abuse.

Patients told us that they felt safe on the ward most of the time. The occasions when they did not feel safe on the ward were due to the lack of visible staffing and staff being overloaded with paperwork. They did however praise the staff for managing some very difficult situations. Staff told us they did not feel they had enough staff to keep people safe citing the example of needing multiple staff to care for a patient leaving the other patients unsupervised and at risk of falls or other harm.

The medication management was of concern. The room temperature of the clinic room was excessively high. The manager acknowledged this was an issue but nothing had been done to remedy or monitor this situation prior to our inspection. On out return visit, the manager had some taken action but the room remained very hot. Monitoring had begun.

We noted there was no recording system for the receipt or management of stock medicines. Waste medicines were not stored securely and open bottles of medicine were not dated. Patients were not being protected from the risks associated with unsafe management of medicines.

While in the medicine room, we noted some of the lifesaving equipment had not been serviced or checked in six months. This had been resolved on our return visit.

Some of the manual handling equipment in the functional disorder unit had not been serviced since 2012 and had been broken since February 2013. We highlighted this to the management during our inspection and they appeared unaware of this. This had not been resolved on our return visit so the equipment was taken out of service.

Of grave concern, we found that restraint was being used at the unit without being recognised as such and recorded within the safeguards set out in the MHA Code of Practice. The manager spoke with us about the circumstances in which this was used, calling it "safe holds" and demonstrated how they were going about it. They had undertaken a risk assessment on the ward and it was used only as a last resort. However, there was no paperwork and no follow-up reviews as required under the Mental Health Act Code of Practice. This meant that the patients were not safeguard as required against the wrongful use of restraint. On our return visit, this issue was being addressed and staff training was to begin the following week. A new system was being put into place.

Learning from incidents and improving safety standards

Incidents were investigated and referrals made to relevant services including physiotherapy. However, there rate of falls remained very high meaning that the actions taken were not sufficient. This practice meant that patients were not consistently safeguarded from potential harm caused by risks not being addressed.

Some staff told us they had reported their concerns around safe staffing levels to management who escalated it to trust level. They felt that their management were not assertive enough around these issues.

When we looked at the incident forms we noticed that a number of patients had been restrained using "safe holds". While there was some limited recording of what happened when the patient was restrained, the requirements of the code of practice where not followed as there was not a clear account of what had occurred. On our return visit, a system had been arranged to ensure this happened in future.

Are services safe?

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

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

We observed the ward managing some very complex situations while remaining calm and positive. The staff told us they were proud of how they manage complex conditions and how interesting but challenging that made their work.

Staff had access to the online reporting system used to report and record incidents. To ensure security of patient's records, the system was accessed using personalised access cards. We saw that care plans were detailed and reviewed regularly. However, the full information was not being transferred effectively on the electronic record system meaning that staff potentially didn't have access to complete information.

The training records were chaotic and difficult to understand. Significant numbers of staff were out of date with training including safeguarding, managing aggression and basic resuscitation. On our return visit, the management had instigated a system to monitor training of each member of staff. Information was being added and training courses had been booked to meet immediate needs.

As we entered the service, we found patient sensitive information unattended by the visitor's signing in book. This was highlighted to the manager concerned who immediately referred the incident to the Caldecott Guardian for the trust.

Assessing and monitoring safety and risk

Some staff felt the ward was not safe when very busy, at night or when staff were off sick with no replacements. Staff told us they felt they did not have enough staff to keep people safe on a day to day basis. One senior member of staff told us "the trust are looking at numbers not people's needs".

There were comprehensive handover sessions between shifts where every person was discussed briefly and current risks were identified. Communication was good, the language respectful and the level to detail was sufficient to provide a basis for providing care.

We saw evidence of a wide range of audits covering various aspects of care that were up-to-date. However, there were no measures on important topics including temperatures of the medication room, medication fridge, training of staff and maintenance of the equipment (including repairs and servicing).

Understanding and management of foreseeable risks

We found incidents were being investigated and care plans being altered to reflect any changes in most cases. However, information about incidents was sometimes not recorded in full on the electronic record system leaving potential for miscommunication and misunderstanding.

We witnessed staff completing incident forms and submitting them online for investigation by the unit manager. This information went verbally into handover to be shared with the staff team.

Of concern was the lack of review after restraint as required under the Mental Health Act code of practice. We found this was being addressed by the management on our return visit.

Victoria Centre - Liddington and Hodson Wards

Track record on safety

The service had a clear system for the reporting of incidents and staff were able to describe their role in the reporting process. Information on safety was being collected from a range of sources to monitor performance and we saw evidence that safety and performance information was regularly reported and discussed at all levels within the trust.

Learning from incidents and improving safety standards

Systems were in place to make sure that the managers and staff learnt from events such as accidents and incidents, complaints, concerns, whistleblowing and investigations. This reduced the risks to people and helped the service to continually improve. Staff told us they were clear about their roles and responsibilities. And were passionate about what they did. We were advised that the managers have an open door policy and that the staff felt valued and supported.

We noted that staff were able to access all policies and procedures on the trust's intranet system to ensure they had the appropriate guidance to care for people safely.

Are services safe?

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

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

There were systems in place for keeping people safe and safeguarded from abuse. We saw evidence that all staff had completed training in the safeguarding of vulnerable adults and children. Staff we spoke with were able to describe different types of abuse and their responsibilities around safeguarding and knew what action to take if they suspected abuse had occurred. We saw evidence of safeguarding referrals.

Assessing and monitoring safety and risk

People told us they felt safe. We saw evidence that staff identified emerging risks and displayed good response's to challenging behaviours. We were shown that every bedroom had a PIR system to detect if patients get out of bed at night. This enabled the staff to be more aware of any potential risks and enabled them to offer prompt assistance where required.

We were told that staffing levels have improved recently. Guidance had been put in place to support this and the management were actively recruiting to fill vacant posts. The ward manager told us she now sets the staff rotas and she feels able to take people's care needs into account when making decisions about numbers, qualifications, skills and experience required. This helped to ensure that people's care needs were always met.

St Martins Hospital - Ward 4

Track record on safety

A patient death had occurred on the ward in March 2014 which had been subject to a full investigation. While this death had not involved a ligature the investigation had identified that the use of anti-ligature collapsible curtain rails, as recommended by the National Patient Safety Agency (NPSA) should be reviewed trust-wide. It was also recommended that the ward make more effective use of devices, such as pressure mats to monitor movement of patients. There were no risks recorded on the locality risk register which related to this ward, despite this incident.

Learning from incidents and improving safety standards

Staff knew how to report adverse events and were encouraged to do so. The ward had been a high reporter of incidents but it was felt that there was insufficient feedback for incidents reported. The outcome of this investigation had been shared with some, but not all staff. The trust was actively sourcing more suitable curtain rails but there was some anxiety among ward staff that the risk still remained on the ward. There was, however, an understanding of the risk posed by anti- ligature rails and the need to be vigilant in relation to mobile patients who were at risk of falls.

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

There were systems in place for safeguarding people from abuse. We saw evidence that staff had completed training in the safeguarding of vulnerable adults and children. Staff we spoke with were able to describe different types of abuse and their responsibilities around safeguarding and knew what action to take if they suspected abuse had occurred.

We noted that staff were able to access all policies and procedures on the trust's intranet system to ensure they had the appropriate guidance to care for people safely.

Risk assessments were completed on admission and care plans were developed to manage those risks. Risks were discussed and updated at each handover.

The ward did not provide an acceptable environment which was conducive to maintaining patients' privacy and dignity. Bedroom accommodation was provided in male and female dormitories, with bed spaces separated by curtains. There was a separate lounge for women only. Staff made efforts to ensure this separation was maintained but they told us they were not always successful. They told us that there had been two recent occasions when the female lounge was used as a male bedroom. This meant that male patients had to walk through communal areas of the ward to access male bathrooms and toilets. This does not meet the Department of Health single sex accommodation requirements or the Mental Health Act Code of Practice. This states 'all sleeping areas (bedrooms and bays) must be segregated, and members of one sex should not have to walk through an area occupied by the other sex to reach toilets or bathrooms.' It also meant that women did not have separate lounge area.

Assessing and monitoring safety and risk

A health and safety risk assessment of the ward environment had taken place on 18 March 2014, shortly after the death had occurred. This identified a number of areas of risk and controls to mitigate these risks.

Are services safe?

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

Understanding and management of foreseeable risks

Staff demonstrated an understanding of both individual and more general environmental risks on the ward. This included the risk of falls. The observation policy was used to ensure that those at high risk of harm were observed frequently.

Callington Road - Laurel and Aspen wards

Track record on safety

The trust had in place a system for the reporting of incidents and staff on the unit were able to describe their role in the reporting process. Adverse incidents were documented and all completed forms seen had been reviewed by the manager and completed to a satisfactory standard. However, we found occasions where there was no apparent learning or action taken as a result of incidents involving falls.

Learning from incidents and improving safety standards

Laurel ward has been identified as reporting a high number of patient falls, some of which have resulted in fractures. We were told that when a patient falls, they are referred to the physiotherapist for a falls risk assessment and possible remedial work. The fall is analysed and environmental factors taken into consideration. Observation levels would be increased if considered necessary. The physiotherapist told us that for people who fall frequently, a monthly analysis is carried out of all the factors pertaining to that individual. We were told that an audit of falls is carried out annually by staff at trust headquarters, but no audit had been carried out at the ward level across all falls to identify trends and learning outcomes. When we asked staff about this, they all said that the flooring in the ward is very slippery and is possibly contributing to the number of falls. We found that although some patients on Aspen ward experience falls, the number of falls is less than those on Laurel. We saw that the flooring on Aspen ward was of a non-slip material.

We were told that some patients return from the local acute hospital with pressure ulcers. The pharmacist had expressed concerns about poly pharmacy used to manage challenging behaviours and the possible link to falls risk. This was being looked at by the trust's falls group.

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

There were systems in place for safeguarding people from abuse. We saw evidence that staff had completed training in the safeguarding of vulnerable adults and children. Staff we spoke with were able to describe different types of abuse and their responsibilities around safeguarding and knew what action to take if they suspected abuse had occurred.

However, we have concerns regarding processes for assessing people in regard to resuscitation decisions. We noted that most patients had a note against their name on the white board in the office at Aspen ward indicating that they were not for resuscitation (DNAR). When we looked at patients care records, we were concerned to note that the forms documenting these decisions did not always list the names of those involved in the decision making, or demonstrate why the decision was made. Where the patient had no relative, there was no evidence that an advocate had been involved in the decision made.

Deprivation of Liberty applications had been made for several patients and we were told that an audit trail was kept of contact with the local authority. We could not find that this was documented in the patient's records. The Mental Capacity Act says that an independent mental capacity advocate (IMCA) must be instructed by the responsible body in situations where certain decisions are being made on behalf of a person who lacks capacity. There was limited evidence that IMCAs were involved in decision making for Deprivation of Liberty applications.

We noted that staff were able to access all policies and procedures on the trust's intranet system to ensure they had the appropriate guidance to care for people safely.

Assessing and monitoring safety and risk

There was a local ligature risk assessment of the unit, which was scheduled to be completed annually. The last date this was done was 21 March 2014. Taking into account existing controls, all the identified risks had been rated as no greater than a medium risk. An environmental risk assessment has also been completed.

On Aspen ward we found that there was one female patient being accommodate in a male bedroom area. Prior to us pointing it out, the ward manager did not seem to be aware of the situation.

Are services safe?

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

Longfox Unit – Cove and Dune wards

Track record on safety

The trust had in place a system for the reporting of incidents and staff on the unit were able to describe their role in the reporting process. Adverse incidents were documented and all completed forms seen had been reviewed by the manager and completed to a satisfactory standard.

Learning from incidents and improving safety standards

Staff told us they were clear about their roles and responsibilities.

While a system was in place to learn from events such as accidents and incidents, complaints, concerns, whistleblowing and investigations we found there have been two instances over the last two months where patients have fallen and fractured their wrists. We did not find any evidence that this was responded to as a concern and there was no evidence of any broader learning identified or local trend analysis.

We noted that staff were able to access all policies and procedures on the trust's intranet system to ensure they had the appropriate guidance to care for people safely.

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

We saw evidence that staff had completed training in the safeguarding of vulnerable adults and children. Staff we spoke with were able to describe different types of abuse and their responsibilities around safeguarding and knew what action to take if they suspected abuse had occurred.

However, while there were systems in place to safeguard people from abuse we found concerns regarding the management of gender separation within both wards, and an incident were staff had not protected a patients' dignity on Cove ward that had not been addressed.

We noted that staff were able to access all policies and procedures on the trust's intranet system to ensure they had the appropriate guidance to care for people safely.

Assessing and monitoring safety and risk

There was a local ligature risk assessment of the unit, which was scheduled to be completed annually. The last date this was done was 31 March 2014. Taking into account existing controls, all the identified risks had been rated as no greater than a medium risk. An environmental risk assessment has also been completed.

We were concerned to find that there were no fire extinguishers on the walls throughout the ward. We were told this was because they had previously been used as weapons and they were now stored in the ward office. However, there was no signage indicating where people finding a fire could access the fire extinguishers. We raised this immediately with the ward manager. The ward manager told us that the team had been considering for some time how the fire extinguishers could be made safe.

The fire extinguishers directly the Snoezelum had been removed.

A clinical pharmacist visits daily for medicines reconciliation and medicines supply. However we had concerns that the temperature of the clinic room felt very warm and the temperature was not being recorded. This could mean that the efficacy of medications is reduced. Staff told us that the process for obtaining medication when the pharmacist was not visiting was onerous, time consuming and resulted in delays since the pharmacy service moved from the Weston Hospital to Callington Road Hospital.

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

Community services

There was a system in place to monitor the quality and safety of the service. We found that there was a strong working relationship between the different professionals. There was also enough staff and an effective system for supervising staff and conducting staff appraisals.

However, there was evidence that the service was not consistently gaining people's consent to care, and there was no system in place for measuring people's outcomes.

Although there was an appraisal system, we did not find a competency framework for judging staff's ability and or training for staff in the model of care being used.

Inpatient services

The inpatient service had good input from senior medical staff and consultants, and staff worked in close knit, supportive teams.

Mental health and mental capacity advocacy services were included in the ward processes and staff used them well.

Staff received supervision and, in most wards, the majority of staff were up-to-date with their mandatory training.

We did, however, have concerns about privacy and dignity. For example, we found doors missing curtains, people sharing rooms against their wishes and staff not addressing situations in a creative way so that people's dignity was protected. Two wards were also described as cold and institutional.

Documents, for example daily notes, risk assessments and one-to-one sessions, were not completed consistently. People and staff also told us that there were not enough activities and that there was a lack of follow-up after being discharged.

Our findings

Wiltshire South Complex Intervention & Treatment Team

Assessment and delivery of care and treatment

The crisis intervention team used a variety of guidelines to enable staff to ensure that people who use the services 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 reviewed three care plan records and found that the information contained were person centred. For example, we found the content of the care plans provided guidance to staff on how to support people. We observed that all three care plans had been reviewed and signed by people who use the service.

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 did not observe any national strategies and programmes in place, for example National Institute of Health and Care Excellence (NICE) quality standards and guidelines.

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 was updated onto the computerised system and there were clear pathways in place for admission, review and discharge. However, it was noted that outcome measures were not used to benchmark the outcomes for people using the service.

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. The manager told us that staff had not been trained in the use of the recovery star. 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

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.

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, locum doctor and staff during our visit.

Staff said they were aware of the trusts 'Everybody's Business' document which outlined the need for staff to skill-up and pass on their expertise. The manager told us staff were allocated their caseloads in line with their individual skills.

We reviewed the training matrix and noted staff had completed their mandatory training. There was a comprehensive induction programme in place with staff being mentored for six weeks. The services did not have a competency framework in place to assess staff's ability to carry out their role with people who use the service. We reviewed the clinical supervision audit on the trust's IQ system. Supervision was currently at 79% due to staff sickness but we saw arrangements in place to capture outstanding supervision for return to work staff. Annual appraisals were up-to-date with due dates identified.

Multidisciplinary working

We saw the trust worked effectively with other providers and partners in the provision of the service. Staff told us they felt integrated and part of a team. Medical and nursing teams worked well with other specialities and therapy services to provide good multidisciplinary care.

We observed arrangements in place to work with health and care providers to co-ordinate care to meet people's needs. The records reviewed showed us that people, and where applicable, their relatives had been involved in their care. We saw good examples of individual involvement in the drawing up of community treatment plans.

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

Staff told us they had good knowledge of the Mental Health Act (MHA) 1983 and Code of Practice. The managers told us that they reviewed staffs' ability during supervision to ensure they were competent to deliver assessments, care and treatment which were compliant with the MHA for example, protection of people's rights.

BaNES Complex Intervention & Treatment Team

Assessment and delivery of care and treatment

We found that staff assessed and planned care in line with the needs of the individual. Service users were offered a copy of their care plan, people we spoke with confirmed this and that they had been involved in their reviews. Physical health needs were documented but were largely managed by primary care services.

Outcomes for people using services

Staff had access to the trust's electronic IQ system that allowed them to look at their performance as a team and compare that to other areas of the trust.

The service received few complaints. Three complaints were received in the period January to May 2014. They all related to poor communication and delayed assessment and treatment. Complaints were discussed at risk and safety meetings. Reports detailed the nature of complaints and a summary of actions taken in response. However, we saw no evidence that there was learning at team level following complaints. Staff we spoke with did not demonstrate any awareness of the themes relating to complaints received about their team or other community based services within the trust.

The service also used the friends and family test to capture patient feedback. Thirty-one responses were received between December 2013 and May 2014, all of which were positive. The main themes were supportive and caring staff.

Compliments from patients, carers and other health and social care professionals were logged and displayed on the team notice board. Five letters of praise were received from patients or carers between January and May 2014. In addition, there were four letters from nursing home/care agencies thanking staff for their support.

Staff, equipment and facilities

Staff reported that there were two current vacancies in the team. Some staff felt that caseloads were increasing and that there was an increase in waiting times for people to be assessed following referral to the service.

Multidisciplinary working

The team was an integrated mental health and social care team. There was also a separately commissioned memory service and good access to a range of therapy services, including occupational and physiotherapy. There were regular multidisciplinary handovers to ensure continuity of care.

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.

Mental Health Act (MHA) 1983

We did not look at records that related to people subject to elements of the Mental Health Act.

South Gloucestershire Complex Intervention & Treatment Team

Assessment and delivery of care and treatment

We found that staff assessed and planned care in line with the needs of the individual. Service users were offered a copy of their care plan, people we spoke with confirmed this and that they had been involved in their reviews. Physical health needs were documented but were largely managed by primary care services.

Outcomes for people using services

The trust had a range of audit systems in place which monitored team performance. These systems had highlighted that the CIT had not performed well in relation to obtaining and recording patient's consent to care and treatment. The manager acknowledged that this needed to be addressed, although there was not a clear plan in place to show how this would be actioned or reviewed. Quality and performance was also monitored through regular individual supervision and we saw examples of this.

The team worked closely with both the memory and psychological services to provide comprehensive assessment and psychological interventions. The manager was undertaking a skills mapping exercise of the staff to identify where there were service skills strengths and deficits.

Staff, equipment and facilities

Opportunities for training and professional development other than core mandatory training had been reduced trust-wide. The issue of staff having to wait to access safeguarding training had been raised and noted in the minutes of the 'quality and standards' meeting in May 2014. The manager had an overview of mandatory training requirements for the team.

Staff confirmed that they received regular clinical and management supervision and we saw some supervision records. The team had a weekly clinical meeting for case discussion, which we were told also included governance and information sharing; however, there was no reflection of this in the team meeting minutes we looked at.

Multidisciplinary working

People's health, safety and welfare were protected when more than one provider was involved in their care and treatment. The multidisciplinary team discussed all referrals and agreed a treatment plan with the individual. Staff told us that they worked collaboratively with other professionals, for example, the wards and other community mental health teams, using the care programme approach process.

A good relationship was reported between the CIT team, in-patient and other local community teams. The CIT team had also developed a 'care home liaison' link to work with care homes and primary care services, to identify people requiring support as early as possible to prevent potential crisis admissions.

Mental Health Act (MHA) 1983

Staff told us that they had access to social workers to provide guidance on the Mental Health Act. We did not look at records that related to people subject to elements of the Mental Health Act. Staff had not needed to access out of hours Mental Health Act assessments.

Swindon Complex Intervention & Treatment Team

Assessment and delivery of care and treatment

We found that staff assessed and planned care in line with the needs of the individual. We saw that care plans reflected the individual's needs and choices as far as possible. Service users were offered a copy of their care plan, people we spoke with confirmed this and that they had been involved in their reviews. Records showed that risks to physical health were identified and managed. Physical health issues were largely managed by primary care services.

Outcomes for people using services

The trust had a range of audit systems and performance targets in place, which monitored team performance. The team worked closely with both the memory and psychological services to provide comprehensive assessment and psychological interventions.

Staff, equipment and facilities

The manager had an overview of mandatory training requirements for the team and most staff were up-to-date. Some staff told us that opportunities for training and professional development other than core mandatory training had been reduced trust-wide.

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.

Staff confirmed that they received regular clinical and management supervision and we saw some supervision records. The team had a weekly team meeting, where we observed comprehensive discussions around caseloads, risk issues, governance and information sharing.

Staff told us that they had reported difficulties that they experienced with the computer system crashing but it was still a frequent issue.

Multidisciplinary working

There was evidence of effective multidisciplinary team working. People's health, safety and welfare were protected when more than one provider was involved in their care and treatment. The multidisciplinary team discussed all referrals and agreed a treatment plan with the individual.

Staff told us that they worked collaboratively with other professionals, for example, the wards and other community mental health teams, using the care programme approach process. A good relationship was reported between the CIT team, Great Western Hospital and other health and social services.

Mental Health Act (MHA)

Staff told us that they had access to social workers to provide guidance on the Mental Health Act. We did not look at records that related to people subject to elements of the Mental Health Act.

Bristol Complex Intervention & Treatment Team

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

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 care and treatment records and found that the information contained was person centred. For example, we found the content of the care plans provided guidance to staff on how to support people and their carer. We observed that these had been reviewed and signed by people who used the service or their carer if required.

We found that people's physical healthcare needs were assessed and addressed in partnership with the person's general practitioner. People who used the service and their carers 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. We observed that during the referral process information was assessed and entered into the correct records. There were clear care and treatment pathways in place.

We saw the service used outcome measures. These included the Care Programme Approach (CPA) audits and the friends and family test.

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 complex intervention treatment for people who used the service.

Senior staff confirmed that discussions were taking place with the crisis interventions team 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 and these were used to identify individual training needs and professional development opportunities.

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.

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 found detailed multidisciplinary recording of care and treatment provided in those records reviewed. Staff told us that they discussed their caseloads and the complexities of some individual's assessed needs with their line managers as part of their monthly supervision. We found that the team worked well with other specialities and the 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 of physical health needs. The records reviewed showed us that people, and where applicable, their relatives had been involved in their care. We saw good examples of individual involvement in the drawing up of individual care plans.

Mental Health Act (MHA) 1983

Staff told us they had good knowledge of the Mental Health Act (MHA) and 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 Complex Intervention & Treatment Team

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

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 care and treatment records and found that the information contained was person centred. For example, we found the content of the care plans provided guidance to staff on how to support people and their carer. We observed that these had been reviewed and signed by people who used the service or their carer if required.

We observed an initial assessment of a person who used the service with their permission. The assessment was comprehensive and person centred. We found that time was set aside to answer any questions that the person might have.

We found that people's physical healthcare needs were assessed and addressed in partnership with the person's general practitioner. People who used the service and their carers 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 weekly 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. We observed that during the initial admission process information was assessed and recorded accurately. We found clear care pathways in place.

We saw the service used outcome measures. These included Care Programme Approach (CPA) audits and the friends and family test.

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 complex intervention treatment for people who used the service.

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 and these were used to identify individual training needs and professional development opportunities.

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.

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 found detailed multidisciplinary recording of care and treatment provided in those records reviewed. Staff told us that they discussed their caseloads and the complexities of some individual's assessed needs with their line managers as part of regular team meeting and during their monthly supervision. 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 of physical health needs. The records reviewed showed us that people, and where applicable, their relatives had been involved in their care. We saw good examples of individual involvement in the drawing up of individual care plans.

Mental Health Act (MHA) 1983

Staff told us they had good knowledge of the Mental Health Act (MHA) and 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.

Later life mental health liaison team

Assessment and delivery of care and treatment

The trust was able to demonstrate that people who were referred to this service received an effective service from the trust. The extent of support that people received was determined by the referral and discussions with the acute NHS trust.

We saw that individual care and treatment records reflected the assessed needs of people who had been referred. We reviewed care and treatment records and found that the information contained was designed to provide acute nursing staff with guidance and support.

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 later life mental health liaison service used the RAID (Rapid Assessment Interface Discharge) model. Some outcome measures were benchmarked against the referrer's criteria. We found some outstanding examples of collaborative partnership working within this service.

We saw the service used outcome measures. These included feedback from people and their families and from the referrers to the service. This feedback was reviewed and noted to be very positive about the support and care provided by this service.

Staff, equipment and facilities

The records and evidence seen showed us that the trust ensured that adequate skilled and committed staff were available to meet the specialised needs of those people who were referred by the local acute hospitals.

Senior staff confirmed that regular discussions took place with the trust's general psychiatric liaison service.

Training records reviewed showed us that attendance at mandatory training was above 90%. Staff told us that team meetings were held weekly and used to discuss referrals to the team. The supervision and appraisal records seen showed us that staff were receiving supervision monthly. Staff confirmed that they received annual appraisals and these were used to identify individual training needs and professional development opportunities.

Multidisciplinary working

We saw the trust worked effectively with other providers and partners in the provision of this service. Staff told us they felt a part of a team with good leadership. We found detailed multidisciplinary recording of support and treatment provided in those records reviewed. Staff told us that they discussed their caseloads and the complexities of some individual's assessed needs with their line managers as part of the weekly team meeting. We found that the team worked well with the acute hospital trusts to provide good multidisciplinary care. We saw good examples of individual involvement in the drawing up of individual care plans.

Mental Health Act (MHA) 1983

Staff told us they had good knowledge of the Mental Health Act (MHA) and Code of Practice. The training records seen confirmed that staff had received training on this Act.

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.

Fountain Way - Amblescroft North and South

Assessment and delivery of care and treatment

Patients were reviewed regularly by the consultant and we saw documentation of this. We saw that close observation records were being kept for some patients and the ones we sampled were completed fully.

Documentation we looked at showed care plans were detailed and reflected the care we witnessed. Staff expressed frustration about how long paperwork took to complete saying they should spend that time with the patients. We received varying reports with regards to relatives being involved in care planning and reviews. Some relatives described the service as excellent and they were kept informed. Others told us they were very disappointed with the ward for the lack of communication about care. One comment we heard many times was about the staff being too busy to spend any quality time with the patients. The staff agreed with this adding it impacted on the activities available for patients.

Outcomes for people using services

The ward had a detailed system in place for measuring the outcomes for each patient.

Both patients and staff told us of the lack of activities on the ward. Staff said they often didn't have time to engage as much as they wanted with patients. We raised this with the management and we saw increased activities on our return visit. They had a member of staff allocated to do activities in addition to the occupational therapist.

Staff, equipment and facilities

Every staff member we spoke with on the ward said they really enjoyed working on the ward and with the patient group. Lack of staffing was identified as a concern both by patients and staff, and by the manager. Staff told us they did not have enough time to complete paperwork, engage effectively with patients on a one to one basis or take patients on escorted leave. Staff told us staff sickness was not always covered, leaving the ward unsafe and increasing the pressure on the remaining staff.

Staff told us it was a regular occurrence they did not get any breaks during the day. This was being addressed through supervision on our return visit.

Patients told us that staff were well trained and knowledgeable. We found significant concerns with the organisation and level of training in the service. On our return visit these issues were being addressed and a new system was in place. Additional training had been booked for immediate concerns.

Staff told us they wanted to access more training in addition to their mandatory training. Issues of travel and time were cited as barriers to accessing some training which occurred on other sites in the trust. Several staff told us all training had been cancelled in January 2014 due to lack of funds.

The staff described a weekly meeting with the psychologist during which they felt was very supportive and valuable to them in managing the stress levels.

Multidisciplinary working

The consultant and medical staff were a regular presence on the ward and patients told us they were excellent.

The managers told us of problems with delayed discharges. The issues cited were a lack of funding for placements and a lack of suitable placements in the locality. This was exacerbated by the number of 'out of area' patients who were on the ward. Managers told us priority was given to people in their localities and so patients who were out of area missed out on beds. This was confirmed by senior staff in the focus groups we held.

There were regular team meetings on the ward to discuss issues arising and monitor care provision. Ward rounds happened weekly and involved all relevant professionals.

We noted the advocacy service visited the ward regularly and information about the service was available in the reception area.

Mental Health Act (MHA) 1983

We looked at the legal documentation for a number of detained patients and we found that the paperwork was in good order and appeared lawful. Effective scrutiny arrangements were in place and errors in the documentation were identified and dealt with.

With one application, the approved mental health act professional had not included their name when making the application. It is regrettable that this significant error was not picked by the nurse who received the paperwork on the ward.

From the patient records that we examined, with one exception, consent and capacity issues were addressed at

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the start of the patient's treatment, regularly reviewed and documented. The one exception was patient who had been admitted to a unit elsewhere in the trust where capacity and consent had not been considered prior to the start of treatment.

Victoria Centre - Liddington and Hodson wards

Assessment and delivery of care and treatment

Care was delivered accordance with individual patients presenting needs. Patients mental and physical healthcare needs were assessed and discussed with them wherever possible. Patients were involved in writing their plans of care which reflected their current needs. Specialist dietary, mobility and equipment needs had been identified in care plans where required. Patients said they had been involved in writing their care plans.

We saw evidence of Mental Capacity Act (MCA) 2005 considerations in the progress notes. Use of MCA evidence of assessments and good working practices between professional groups.

Outcomes for people using services

There was a comprehensive activities programme up and running and activities were in progress on Liddington ward. A full time activities co-ordinator post had been advertised. At the time of the inspection the centre were using their own bank staff that were well known to the patients to facilitate activities.

In the therapy room we saw 'rummage boxes' male and female versions, containing items such as sand paper and tools for men and sewing items for women to help jog memories of the past and to instigate conversation.

One patient spoken to said "there are much more activities going on than when I was here before".

Staff, equipment and facilities

Recruitment practice was safe and thorough. No staff had been subject to a disciplinary action. Policies and procedures were in place to make sure that unsafe practice was identified and people were protected.

All staff had been up-to-date with mandatory training in emergency response, infection control, information governance, and the Mental Health Act (MHA) 1983. All other training was seen as booked for the year.

We observed patients enjoying a range of activities. There was a women's only quiet lounge available and the 'reflection' room which was a quiet place to go for multi-cultural or non-denominational worship or prayer.

There were lots of outdoor spaces and a garden with raised flower beds and good wheelchair access that could be used by the patients. Both wards were bright and airy with plenty of windows that looked out over the garden and outdoor spaces. Some members of staff said it was difficult to keep the ward cool in summer but they offered patients more drinks to maintain hydration and fans had been provided.

The unit had single en-suite rooms for every patient with vistamatic panels set on open for observation, however, the patients could close these for privacy from the inside.

Multidisciplinary working

We saw good evidence of multidisciplinary team working with appropriately trained and inducted staff.

Mental Health Act (MHA) 1983

The unit was fully compliant with Mental Health Act. Staff understood their statutory roles and worked cohesively as a team. All medications were prescribed in line with section 58 of the MHA. Evidence was seen of "least restrictive options". Patients were detained sometimes under the Mental Health Act (MHA) other times informal. Some patients had Deprivation of Liberty Safeguards (DOLS). The unit had correct policies and procedures in relation to the Mental Capacity Act. Deprivation of Liberty and Safeguards were in place where required and relevant staff had been trained to understand when an application should be made and how to submit one. This meant that people were safeguarded as required.

St Martins Hospital - Ward 4

Assessment and delivery of care and treatment

Patients' needs were assessed in a holistic way, taking into account their life history, lifestyle preferences and physical health. The ward used a profile developed by the Alzheimer's Society and the Royal College of Nursing called "This is me". This was completed in consultation with people who were close to the patient to ensure that people's needs were understood.

Dementia mapping was used to evaluate care.

Staff received specialist training to observe patients in the care setting to help them understand what life might be

Are services effective?

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like for a person with dementia. Data gathered was used to review and update care plans. Care plans were developed within 72 hours of admission and there was evidence that physical heath checks took place. Mental capacity assessments were undertaken for all patients and were comprehensive and thorough.

Outcomes for people using services

The ward used the friends and family test (FFT) to capture patient feedback. Feedback was largely positive during 2013-14. Two negative comments related to the environment stating "ward noisy - need calmer environment" and "my relative found the unit like a prison". In-patient services had achieved scores of 13, 42 and nil for March, April and May 2014 respectively (the range of possible scores is -100 to +100, where the more positive score the better).

Most of the national and local KPIs were met, with the exception of the seven day follow-up to discharge, which was rated 'red'.

Discharge planning was well documented and regularly discussed within the multidisciplinary team The average length of stay on Ward 4 was two months, although staff reported that a lack of specialist placements in the community for people with dementia, meant that some discharges were delayed.

Staff, equipment and facilities

The ward had two staff vacancies at the time of our visit but no problems were reported with regard to maintaining appropriate staffing levels and skill mix.

Overall, the ward environment was not suitable. Dormitories were sparsely furnished and felt institutional. There was, however, a spacious and comfortable lounge and dining area and a secure garden where patients could get fresh air under supervision.

Multidisciplinary working

Twice weekly reviews of care took place with input from a multidisciplinary team. The ward manager spoke positively about the range and variety of therapies that were available to patients. Handovers took place at the start of every nursing shift and included a discussion about risks in relation to each patient.

Mental Health Act (MHA) 1983

We scrutinised four records of detained patients and found MHA documentation was in order.

Callington Road - Laurel and Aspen wards

Assessment and delivery of care and treatment

We spent time observing the handover between morning and afternoon shifts and heard that individuals are discussed including their risks, leave plans and history. The meeting was well attended but was frequently interrupted.

The records of one to one observations carried out by staff with patients requiring constant supervision were found to be not well completed. Staff had not recorded the content of any interaction they may have had with the patient while carrying out this duty. We were told that it was mainly healthcare assistants or bank staff who carried out this role, thus removing an opportunity for named nurses to spend time with their patients.

In the sample of patient records we reviewed, care plans were up-to-date and there was evidence of a multidisciplinary approach to assessment and care.

Outcomes for people using services

On Aspen we saw that not many activities were scheduled and the ward had a rather institutionalised feel. In the lounge area all the chairs were pushed back against the wall and patients were seen to be dozing in front of the television. We pointed put our observations to the ward manager about this and she said she had recently rearranged the chairs into smaller groups, but that patients had put them back into their original position.

During our visit, the ward manager was managing a potential new admission and to do this was using the bed of a person who was on leave who was due back in the morning. We were concerned that the pressure on beds was great. We were told that a number of patients on the ward are not from the local area but from other areas some distance away such as Bristol. On Laurel ward we were made aware that a whole ward safeguarding referral has recently been made because of increased levels of aggression on the ward, linked to the current patient profile and delays in finding suitable accommodation for people to move on to. We were provided with copies of the most recent meeting minutes and also the action plan, which demonstrate that staff are engaging fully in the process to improve outcomes for people. Staff gave an example of one patient who was not suitable to be placed in a nursing home due to his behaviour, and they hoped this person would be moving to a private provider soon.

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.

Staff, equipment and facilities

On Aspen we reviewed a sample of staff training records and personal development plans. We found that staff were up-to-date with mandatory training although some staff told us it was sometimes difficult to get time off the ward to attend training. We were told that the activity coordinator is off work at the present time and this role is being carried out by a healthcare assistant.

At Laurel we found that all staff were up-to-date with mandatory training which was monitored on a clear training matrix. Staff received regular supervision and appraisals and had personal development plans. They were given dedicated time to access on line learning modules. The duty rota had been completed in advance. The clinical psychologist runs a staff support group to facilitate reflective practice.

On Laurel ward the environment was well maintained, clean and tidy. People using the service have access to a well maintained garden area. Bedrooms are all en suite and spacious. Male and female bedroom areas were segregated. Bedroom doors were fitted with viewing panels with an integral blind. These were controllable from inside the bedroom and by staff on the outside using a key. We found that the windows in one bedroom had no curtains and were told that this was because they were frequently pulled down by the patient. This could compromise the patient's privacy and dignity because the ward was on the ground floor. After the concern was discussed with the ward manager she raised it with the housekeeping supervisor who made immediate arrangements to purchase obscuring film locally. We were told this had been applied to the bedroom windows before we left the ward.

We found that Aspen ward was well maintained and clean. There were separate lounge areas, a dining area and an activity room. The activity room was equipped with easy chairs making it appear more like another lounge than a room that was actively used for therapeutic engagement.

On Laurel ward patients were offered a choice of meals, which was served at the correct temperature, included fresh vegetables, looked nutritious and was well presented. Patients used a variety of aids to help them eat their meals including plate guards. Staff assisted patients as necessary and were seen encouraging people to eat at their own pace and in an unhurried way. Sandwiches were offered if the hot meal was declined. We observed that there was very little food waste at the end of lunch. The cook was seen asking patients about their meal.

On Aspen we saw that there was a timetable for when meals would be served, with very specific times such as 12.10 for lunch. We asked staff what would happen if a patient decided they did not want their meal at that particular time and were told that it would be kept hot for them for a short time as decided by the cook. After this it was thrown away. This seemed to be a regimented inflexible approach that did not reflect individual preference and choice.

Multidisciplinary working

A multidisciplinary staff team is in place and there was a good staffing ratio. There was one member of staff who works flexible hours including weekends, specifically employed to carry out activities with patients. The staff we spoke with said they were a close knit group who enjoyed working with each other. Two members of staff are trained in dementia mapping and provide advice to team members. There was also a lead nurse identified to conduct carer's assessments. Staff told us that the consultant is 'hands on' and readily accessible. We also saw there was good communication with care coordinators.

Mental Health Act (MHA)

We found that overall Mental Health Act documentation was in order and well completed. The documents were uploaded to the electronic record in a timely manner and the secondary paper files were well ordered and systematic. The ward is visited by an independent mental health advocate, who calls in regularly and will also visit if requested. However, there were no records documenting the statutory consultations for patients' treatment nor was there evidence of patients being informed of the outcome of a second opinion appointed doctor (SOAD) visit or a record made of why this was considered inappropriate.

There was evidence that patients were explained their rights under section 132, however, this was not available in an easy read format.

However, we have concerns regarding processes for assessing people in regard to resuscitation decisions. We noted that most patients had a note against their name on the white board in the office at Aspen ward indicating that they were not for resuscitation (DNAR). When we looked at

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patients care records, we were concerned to note that the forms documenting these decisions did not always list the names of those involved in the decision making, or demonstrate why the decision was made. Where the patient had no relative, there was no evidence that an advocate had been involved in the decision made.

Deprivation of Liberty applications had been made for several patients and we were told that an audit trail was kept of contact with the local authority. We could not find that this was documented in the patient's records. The Mental Capacity Act says that an independent mental capacity advocate (IMCA) must be instructed by the responsible body in situations where certain decisions are being made on behalf of a person who lacks capacity. There was limited evidence that IMCAs were involved in decision making for Deprivation of Liberty applications.

Longfox Unit - Cove Ward and Dune Ward

Assessment and delivery of care and treatment

When we spoke to the unit manager we were told that both Cove and Dune wards are frequently asked to admit patients from beyond the local area, sometimes from as far away as Bristol. This can cause considerable difficulty for people visiting if they do not have ready access to transport.

We reviewed the care records and medication charts for patients receiving covert medication. We found that this was being managed safely, with a care plan in place, and details of discussions held at best interest meetings.

Outcomes for people using services

On Dune ward we saw that an activity programme was in place and there was good interaction between staff and patients.

On Cove ward there was little evidence of therapeutic activity. Staff were seen to be interacting with patients but not involved in activity that might promote independence and recovery.

People gave us mixed feedback about their involvement in their care and care planning. Some said they felt very involved in the process, whereas others said they were not. In the care records we reviewed, care plans and risk assessments were in place, were in date and regularly reviewed. We noted that not all care plans included people's involvement. We saw evidence that best interest meetings were held.

Staff, equipment and facilities

Staff training records were found to be up-to-date.

The ward environments were well maintained and clean and tidy. Brightly coloured furniture was in place so that people could easily distinguish the furniture. In both Cove and Dune wards we found that sleeping accommodation did not promote patients privacy and safety.

Multidisciplinary working

We found multidisciplinary recording of care and treatment provided in those records reviewed. Staff told us that they discussed their caseloads and the complexities of some individual's assessed needs with their line managers as part of regular team meeting and during their monthly supervision. We found that the team worked well with other specialities and therapy services to provide good multidisciplinary care.

Mental Health Act (MHA) 1983

We found that overall Mental Health Act documentation was in order and well completed. The documents were uploaded to the electronic record in a timely manner and the secondary paper files were well ordered and systematic. The ward is visited by an independent mental health advocate, who calls in regularly and will also visit if requested.

Are services caring?

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

Summary of findings

Community services

Staff were caring, compassionate and respectful, and relatives gave positive feedback.

People and their relatives were also given information about, and access to, the advocacy service. However, we noted that the information was not readily available in different languages.

Inpatient services

Relatives praised the staff as hard working, diligent and dedicated, and said that they were always made to feel welcome when they visited the wards. In the majority of cases, we observed staff interacting in a respectful and friendly manner.

One ward complained about the laundry because relatives were asked to remove and launder people's clothes if they could.

On another ward, we were very concerned to see that a piece of cake served to a person was placed directly onto the table without a napkin or plate. We were also concerned by an incident where a person's dignity was not protected by staff.

Our findings

Wiltshire South Complex Intervention & Treatment Team

Kindness, dignity and respect

The trust provided good evidence to demonstrate to us that the people who use the service were being treated with kindness, dignity, respect, compassion and empathy. We observed clear evidence of respect and dignity when staff were speaking with and about people.

We spoke with four people via the telephone and found the feedback to be good. People said they were happy with the service provided. One person said that staff were extremely helpful and another said they had received first class service.

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. 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 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.

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 care plans reviewed had been regularly reviewed and signed by people.

The trust used the recovery star model but we found no evidence that staff had received training in its delivery and we observed 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.

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.

BaNES Complex Intervention & Treatment Team

Kindness, dignity and respect

We spoke with seven carers of people who had used the service. We also looked at compliments and complaints which had been received by the service and feedback captured by the friends and family test (FFT). Many people told us that staff were sympathetic, caring and supportive. One patient who had recently written to the service said, "I wanted to write to thank you and your team for the help, encouragement and support you all gave me over the past five long, difficult months. Without your help, I'm not sure where I would be now, for I was in a very dark place."

People using services involvement

Patients and carers were provided with an information booklet which explained the functions of the team and how to contact the service. A welcome pack also included information about the trust's patient advice and liaison service and local support groups and services.

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

Carers told us that staff in the team had been very supportive towards them. The team offered advice and support when people were struggling to cope in their caring role. One carer who had recently written to the service said, "You have made a very difficult situation bearable and I have been so lucky to have you to contact if I have any worries at all." Another carer wrote, "… I was no longer able to cope and felt very isolated and alone. Enter (staff member). From their very first visit to I was impressed by their gentle way, fantastic listening skills and their totally professional, gentle but firm means of persuasion…So from a position of total frustration and hopelessness, we are now seeing a completely different scenario…"

South Gloucestershire Complex Intervention & Treatment Team

Kindness, dignity and respect

People using services told us they were treated with dignity and respect and did not raise concerns about how staff treated them. We observed staff discussing people in a caring and respectful manner.

People using services involvement

Information packs were given to service users and carers. These contained contact details for advocacy services and the patient advice and liaison service (PALS). There was evidence that carer's were involved in people`s assessment and care where possible. The team undertook carer's assessment. 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 that use the service. Although there was not a good level of response from these surveys, feedback they had received was largely positive.

Emotional support for care and treatment

Service users we spoke with were generally positive that they received the support they needed. Staff told us that people's carers were involved in their assessment and care planning. Carers we spoke with confirmed this. The team ran a range of carers and education groups, which have received positive feedback from people who attended. Staff told us that there was less support available for people with a functional mental health difficulty. The service provided people with accessible information about the service available to them and the range of needs the service supported.

Swindon Complex Intervention & Treatment Team

Kindness, dignity and respect

People using services told us they were treated with dignity and respect and did not raise concerns about how staff treated them. We observed staff discussing people in a caring and respectful manner. The team were committed to their work and passionate about providing good care experiences.

People using services involvement

Service users we spoke with were positive that they received the support they needed. Staff told us that people's carers were involved in their assessment and care. Carers we spoke with confirmed this. People who use the service were sent a letter clearly outlining the outcome of assessment and their agreed plan of care.

The service provides people with accessible information about the service available to them and the range of needs the service supports. The team ran a range of carers and education groups, which had received positive feedback from people who had attended.

Emotional support for care and treatment

Detailed information packs were given to service users and carers. We saw a range of information available in the waiting area. There was evidence that carer's were involved where possible. The team undertook carer's assessments and carers we spoke with confirmed that they received excellent care and support from the team. The team also worked closely with the memory clinic and day service to support this work. The service offered a counselling service to carers.

Bristol Complex Intervention & Treatment Team

Kindness, dignity and respect

The trust provided good evidence to demonstrate to us that the people who use the service were being treated with kindness, dignity, respect, compassion and empathy. We observed clear evidence of respect and dignity when staff were speaking with and about people.

We spoke with five people and two carers via the telephone and found the feedback to be good. People said they were happy with the service provided. One person said that staff were extremely helpful and another said they had received excellent care and support.

People using services involvement

The evidence reviewed during the inspection showed us that people were involved as far as possible in their own

Are services caring?

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

care and treatments. We saw examples of individual involvement in the care and treatment records reviewed and of active participation by people and their carers in their treatment plans.

People said they understood their care plans and were able to ask questions. We reviewed individual care plans and found that the information contained enabled staff to provide the support and care that met people's needs. All care plans we looked at had been regularly reviewed and signed by people or their carer.

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 and their carers were supported to manage their own health and care needs wherever possible.

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

North Somerset Complex Intervention & Treatment Team

Kindness, dignity and respect

The trust provided good evidence to demonstrate to us that the people who use the service were being treated with kindness. We observed clear evidence of respect and dignity when staff were speaking with and about people.

We spoke with three people and two carers via the telephone, carried out one home visit and observed an initial admission assessment. We found that people were generally happy with the service provided. One person said that staff were kind and helpful. Another person said nothing was too much trouble for staff.

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. We saw examples of individual involvement in the care and treatment records reviewed and of active participation by people and their carers in their treatment plans.

People told us that they were able to ask questions. We reviewed individual care plans and found that the information contained enabled staff to provide the support and care that met people's needs. All care plans reviewed had been regularly reviewed and signed by people or their carer.

Emotional support for care and treatment

We saw that staff supported people to cope emotionally with their care and treatment and that additional support was available when they needed it. The records showed that people and their carers were supported to manage their own health and care needs wherever possible.

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

Later life mental health liaison team

Kindness, dignity and respect

The trust provided good evidence to demonstrate to us that the people who had been referred to the service were being treated with compassion and empathy. We observed clear evidence of respect and dignity when staff were speaking with and about people.

We reviewed the feedback received from people who used the service, their families and referrers and found the feedback to be good. People said they were very satisfied with the care and treatment received.

People using services involvement

The evidence reviewed during the inspection showed us that people were involved as far as possible in their own mental health care planning. We saw examples of individual involvement in the three care and treatment records reviewed and of active participation by the referrers and where possible the person people and their carers in their own care and treatment.

We saw that people who used this service and their families were able to ask questions. We reviewed individual care plans and found that the information contained enabled staff to provide the support and treatment that met people's needs.

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

We found that the team worked well with the acute hospital trusts to provide good multidisciplinary care and support for people. We saw good examples of individual involvement in the drawing up of individual support and treatment plans.

Fountain Way - Amblescroft North and South

Kindness, dignity and respect

Staff we spoke with showed they were caring towards patients. They showed the desire to provide high quality care despite the challenges of staffing levels and sometimes very difficult situations on the wards.

Patients told us the staff always tried to be helpful and two people told us the staff worked hard to preserve their dignity and respect their values. We observed staff behaving in a supportive manner towards patients during our inspection.

People using services involvement

Where patients were able to, we found they were involved in the initial care planning. In cases where the patient's capacity was reduced, the relatives were involved and the required assessments of the person's capacity had taken place. Relatives told us it was particularly difficult for relatives of patients who were from out of the locality due to the geography of the trust.

Emotional support for care and treatment

We saw patient's families were able to visit and a separate room was available to allow children to visit safely. We noted a comment that it often took a long time to gain access to the ward. We experienced this during our inspection.

Patients told us staff do listen to them on the ward. The patients we spoke with felt supported by their named nurse and the carers. They did say they felt that the staff appeared stressed and needed to be supported more by the senior management. Relatives said the staff always appeared stressed and they felt this impacted on the quality of care provided to the patients.

Victoria Centre - Liddington and Hodson wards

Kindness, dignity and respect

People were treated with dignity and respect by the staff. We saw that staff showed patience and gave encouragement when supporting people. One relative commented, "The staff have the patience of angels".

Another relative said, "I just wish I could take them and everything that happens here home with me to help support my relative when they return home. I simply can't fault them".

People using services involvement

People using the service, their relatives, friends and other professionals involved with the service completed annual satisfaction surveys. Where shortfalls or concerns were raised these had been addressed.

People's preferences, interests, aspirations and diverse needs had been recorded and care support had been provided in accordance with people's wishes.

Emotional support for care and treatment

We found that advocacy was available and well used. A range of information was provided to patients and carers. Comments from staff, patients and friends and family were all very positive. Patients told us they were supported by kind and attentive staff.

St Martins Hospital - Ward 4

Kindness, dignity and respect

All of the patients we spoke with during our visit were positive about the staff. The positive comments were mirrored by feedback captured through the friends and family test, which included: "nursing staff fantastic - very attentive."

Some patients were not happy with the lack of privacy due to shared rooms. One patient's carer explained that their family liked to "keep themselves to themselves" and this was difficult in a shared dormitory.

People using services involvement

There was a range of information available for patients and carers about the ward, its facilities and services. A patient information booklet was given to each patient. There was helpful information about mental illness and sources of support. An independent advocate visited the ward regularly and this service was publicised on the ward.

There were regular ward (community) meetings where patients and visitors could discuss their views about the ward. Minutes of a meeting held on 6 June 2014 recorded an interactive and engaging discussion with two patients who were invited to offer their views about all aspects of care on the ward.

Patients were allocated named nurses who coordinated and took the lead in their care. Carers were invited to meet

Are services caring?

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

with the named nurse for their relative or friend. This provided them with an opportunity to discuss their on-going care needs and any concerns they may have. They were also invited to complete the "this is me" profile on behalf of their relative or friend.

Patients were offered copies of care plans, depending on their ability to understand them. It was evident from records whether patients had been given copies and if not, why not. Carers were also offered copies where appropriate.

Emotional support for care and treatment

The trust had developed a carers' charter which set out its commitment to involve people in a supporting role as partners in the care of patients. Visiting times were open and flexible and visitors were made to feel welcome. A relative had commented in the friends and family test, "I found the service and personalities of the staff kind and considerate, extremely helpful in arranging visits and allowing my (relative) to come out." Another relative who we spoke to during our visit told us that they were always made to feel welcome and involved on the ward and described it as "a home from home".

Callington Road - Laurel and Aspen wards

Kindness, dignity and respect

On Laurel Ward staff were observed treating patients in a very respectful, compassionate and caring manner. We saw that staff spoke kindly and appropriately to patients, using their preferred names, not standing over them to speak but bending down to their level. We heard staff asking the patients permission before performing a task and explaining what they were doing during the task. We spoke to carers who were unanimous in their high praise for the compassionate care their relative received, saying they felt included, welcomed and involved.

On Aspen Ward staff were observed treating patients in a respectful manner. The patients that we spoke to said that staff were kind and looked after them. However, there was little active interaction and conversation between staff and patients that went beyond what was a basic necessity. We did not see staff offering activities as a form of therapy and stimulation. We saw that scheduled activities did not always take place. We spoke to visitors about the care their relative was receiving and they did not express any concerns. They described the care as 'OK'.

People using services involvement

When we spoke to people using the service they had mixed knowledge about whether they had been involved in their care planning and discharge plans.

Staff told us that the arrangements for patients' laundry had changed recently. Where possible, relatives were encouraged to take the laundry home. Where this was not possible, a dedicated healthcare assistant would take on this responsibility. We were later sent a comment that this was not considered to be a satisfactory and suitable way to manage people's laundry. Concerns were raised that some carers were transporting soiled laundry, that was sometimes heavy to carry, on public transport, thus potentially posing a health and safety concern.

Emotional support for care and treatment

In patient records, we saw there was good use of the 'This is Me' document, providing important, individual personal data about the patient. The ward manager said white boards had recently been put on the wall in every patient's bedroom to aid staff in their communication with people they are caring for. These were seen to be highly personalised and completed with information such as family names and people's preferences for their care needs. We also saw that copies of patients care plans were located in their bedrooms for relatives to read.

Longfox Unit - Cove and Dune wards

Kindness, dignity and respect

On Cove Ward patients were seen to be treated respectfully and with kindness. Patients told us that the staff were good to them. The relatives we spoke with said they felt involved and the care provided was good and safe. However, we had serious concerns about one patient's privacy and dignity and this is documented in the responsive domain.

On Dune Ward patients were overall seen to be treated respectfully and with kindness. They told us that the staff were good to them. Relatives said they felt involved in all the decisions made and they could approach staff with any concerns. They said the care their relative received was safe and compassionate.

On Dune Ward, at tea time, we saw that staff served pieces of cake to patients and put the cake directly onto the table in front of them without either a plate or a napkin. We considered this to be institutionalised practise and not respectful.

Are services caring?

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

People using services involvement

Information packs were given to service users and carers. We saw that patients also had good access to advocacy including independent mental health advocates (IMHA).

We noted that in one of the patient records we reviewed, the patients name changed midway through the care plan, indicating this may not have been fully person centred. Not all care plans indicated people's involvement.

Emotional support for care and treatment

On Cove Ward patients told us that the staff were good to them. The relatives we spoke with said they felt involved and the care provided was good and safe.

On Dune Ward patients told us that the staff were good to them. Relatives said they felt involved in all the decisions made and they could approach staff with any concerns. They said the care their relative received was safe and compassionate.

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

Community services

There was a detailed discharge process in place, and the teams communicated well with each other.

Staff we spoke with knew about the independent mental capacity advocacy (IMCA) service and patient advice and liaison service (PALS), and there was information available for people about these.

Although there was an effective complaints system in place, we did not see any evidence of feedback from this. In addition, staff seemed unaware of the policies relating to the service.

Access to beds was an ongoing problem. One of the community teams did not have an out-of-hours service. This meant that they had to use general medical services if someone needed support out-of-hours.

Inpatient services

We found that sleeping and bathroom arrangements at some wards that did not meet the guidance on single sex accommodation.

We were told about issues such as people being placed 'out of area', which made it hard for relatives to visit and be involved in their care. Another comment was that there was less support for older people with functional disorders as opposed to organic disorders.

In general, care plans were adequate, but they did not always include input from the person or their relatives. Also, risk assessments were not updated consistently to reflect learning from incidents.

We heard comments that the food was good and nutritious. However, on one ward, there were no arrangements in place if a person wanted their food kept for them.

The multidisciplinary team worked well together with strong links out to the community teams, but awareness of the advocacy service varied across the inpatient services.

We saw that staff had made applications under the Deprivation of Liberty Safeguards (DoLS). Except for one case, the paperwork appeared to have been completed correctly. However, details of applications were not recorded fully on the trust electronic recording system.

There was also a lack of consistency in people's care records. For example, names changing midway through care plans and inaccuracies on the 'do not resuscitate' forms.

Our findings

Wiltshire South Complex Intervention & Treatment Team

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 acted on those plans to design and deliver the service. The trust actively engaged with local authorities and GPs to provide a co-ordinated and integrated pathway to meet people's needs.

We saw good clear discharge pathway in place with letters going to the GP together with copies of care plans, a recent Care Plan Approach (CPA) review and a clinical and discharge summary. We noted the 'Step-Down' policy to primary care was clearly visible within the service.

Right care at the right time

People told us that they knew what to do to seek advice and access the service. People said they had utilised the service and had no issues or concerns. We noted there was an effective approach to managing referrals and assessments and there were plans in place to tackle any identified problems.

The service provided in the community was flexible to fit in with people's lives where possible for example, work and family commitments.

Care pathway

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. We noted good care pathways in place which were designed to be flexible while 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. However, staff told us they had not received feedback in relation to complaints raised.

BaNES Complex Intervention & Treatment Team

Planning and delivering services

All of the staff we spoke with expressed concern and frustration about the lack of appropriate in-patient beds in the local area, particularly for older people with functional illness. This meant that people were frequently admitted to hospitals which were not close to their home and their families. They told us there was also a shortage of appropriate day care facilities.

Right care at the right time

The service was provided from 9am to 5pm, Monday to Friday. There was an emergency duty team out of hours and a telephone number was included in the service's information leaflet for patients and carers. We were told that the BaNES intensive service offered urgent support to patients with functional mental health illness.

Three of the seven carers we spoke with raised concerns that the service they received had stopped and alternative arrangements had not been put in place. One person said, "They just disappeared and nothing else was put in their place." A second person told us, "All of a sudden they just stopped coming because they said we had had all the help they could give us. They told me if things got worse to go back to the GP. The GP has now sent us another person and we are starting all over again. We were without anyone for five to six months". A third person told us "It was excellent for ages, then they suddenly stopped coming. They were there and then they were gone and didn't let us know."

Care pathway

There was evidence of different groups working together effectively to ensure that patients' needs continued to be met when they moved between services. This included GPs, the local authority, residential, nursing, domiciliary and day services. There was a care home liaison service which helped to facilitate placement of people requiring residential or nursing care and supported staff in these services. The team worked closely with the two older people's wards in Bath (Ward 4 and Hillview Lodge) to ensure continuity of care, and attended ward rounds and visited inpatients regularly. The consultant for the community team had shared responsibility for inpatient and community services for older people meaning consistent care for service users.

Learning from concerns and complaints

The service information leaflet given to patients and carers included information about how to complain about the service and the contact details of the patient advice and liaison service (PALS) were provided.

Complaints were discussed at risk and safety meetings. Reports detailed the nature of complaints and a summary of actions taken in response. However, we saw no evidence that there was learning at team level following complaints. Complaints were not a standing agenda item at business meetings. None of the staff we spoke with had any awareness of the themes of complaints received about their service or other community based teams within the trust.

We asked a senior staff member about complaints and were told that these were dealt with by the trust's patient advice and liaison service. We asked if local records were kept and we were referred to the team administrator who subsequently requested the information from PALS. We judged that there was no ownership of complaints or understanding amongst the team of any themes which could identify opportunities for learning and improvement

Are services responsive to people's needs?

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

South Gloucestershire Complex Intervention & Treatment Team

Planning and delivering services

The team did not operate a duty system, although the manager stated that there was always capacity for someone to oversee urgent contact to the team. The team and service manager were not aware of a current operational policy for the service. We obtained one from the trust, dated 2010, which did not reflect how services had been redesigned and were currently working. We were told that referrals were taken from primary care services and secondary mental health services.

Staff reported it was very difficult to find a local inpatient bed if a person needed to be admitted to hospital. Recent closure of beds, due to safety concerns on the ward, had increased pressure. The team acted as `gatekeepers` for older people's mental health beds. The team jointly worked with the South Gloucestershire intensive service where appropriate, to facilitate early discharge from the older people's ward.

Right care at the right time

There was no waiting list at the time of inspection. Referrals were discussed and allocated by the multidisciplinary team in weekly meetings. People were usually seen within two weeks of referral, or more urgently if indicated. The team were undertaking a pilot with the clinical commissioning group (CCG) to identify if additional support, out of hours, for older people was needed. This was currently available until 8pm, Monday to Friday, and is to be evaluated in August 2014. There were no mental health crisis support services for older people to access outside of working hours or at weekends.

Care pathway

Transfer of care between teams and shared care within teams was effectively managed. Weekly care pathway meetings ensured that people were on the most appropriate care pathway. Relationships with other teams in the trust were described as good.

The team manage the local older people's mental health beds. Staff told us that there was a significant challenge in finding appropriate beds for people and people were sometimes admitted out of area. This meant that people were not close to their home or family. At the time of inspection, there were seven people in out of area hospitals. This had an impact on how frequently the care co-coordinators could attend the ward. There were bed management meetings held fortnightly, which were also attended by social services.

Learning from concerns and complaints

The service had a system in place to learn from complaints about the service. Information about the complaints process was given when people first started receiving a service. People who use the service told us that they knew how to make a complaint and felt able to do so if they needed to. The manager gave us an example of a recent complaint and how this had been resolved.

Swindon Complex Intervention & Treatment Team

Planning and delivering services

The team operated a duty system, which ensured that the service was always able to oversee urgent contact to the team. There was no current operational policy for the service. We were told that referrals were taken from a number of health and social care providers, both within primary care services and secondary mental health services. The team also worked closely with the Great Western Hospital.

Staff reported it was difficult to find a local bed if a person needed to be admitted to hospital. The team assumed the role of managing admissions for older people's mental health beds. Staff reported some boundary issues, related to working with different county councils and local variation in how local authority teams worked.

Right care at the right time

Referrals were discussed and allocated by the multidisciplinary team in weekly meetings. People were usually contacted immediately following referral, with full assessment completed within four weeks. There was no out-of-hours service available, other than the emergency social services.

Care pathway

Transfer of care between teams and shared care within teams was effectively managed. Staff were clear about the lines of accountability and who to escalate any concerns to. Staff were able to describe the other services involved in people's care pathways and how the team fitted into it. Relationships with other health and social care services were described as good. The team attended weekly care pathway meetings and ensured that people were on the most appropriate care pathway.

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

Information about the complaints process was given when people first started working with the service. People who use the service told us that they knew how to make a complaint and felt able to do so. There were systems in place to learn from complaints.

Bristol Complex Intervention & Treatment Team

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. For example, we saw good links with private residential and nursing care homes.

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

We identified a clear discharge care pathway in place with letters going to the GP together with copies of care plans, a recent Care Plan Approach (CPA) review and a clinical and discharge summary. We noted the 'Step-Down' policy to primary care was clearly visible within the service.

Right care at the right time

People spoken with knew how to seek advice and access the services in an emergency. We identified a concern about a family member whist talking to a person who used the service. These concerns were brought to the attention of staff and promptly addressed.

We noted there was an effective approach to managing referrals and assessments and there were plans in place to tackle any identified problems. For example, we noted flexible treatment appointments being offered to people.

Care pathway

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. The records seen showed us that people and their families were 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. We saw good examples of innovative practice to ensure that discharge or other transition arrangements met the needs of people. This meant that the trust had processes in place to ensure that discharge 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. 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 redirect people to the PALS service if they felt they were unable to deal with their query. People also had access to a local independent advocacy service and information about this service was given to people on initial assessment.

North Somerset Complex Intervention & Treatment Team

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. For example, we saw good links with private residential and nursing care homes.

During the initial admission assessment observed we saw evidence of clear planning and discharge planning as part of this process.

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

We reviewed care and treatment records and these demonstrated to us that the service was being provided in a person and carer centred approach.

Right care at the right time

People told us that they generally received the right care at the right time. Carers spoke highly of the flexibility and responsiveness of the service provided.

Are services responsive to people's needs?

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

The care plans seen provided evidence that there was an effective approach to managing referrals and assessments and there were plans in place to tackle any identified problems. We noted that flexible treatment appointments being offered to people.

Care pathway

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. The records seen showed us that people and their families were 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 the individual needs of people who used the services were being met.

Learning from concerns and complaints

Staff confirmed that arrangements were in place to learn from concerns and complaints. We saw examples of where individual concerns had been discussed by staff as part of team meetings and individual clinical supervision. We found that people 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.

Later life mental health liaison team

Planning and delivering services

Evidence was seen that showed us that this service understood the support and treatment needs of the people who had been referred to the service. The trust actively engaged with referrers from the local acute NHS trust to provide a co-ordinated approach to meet people's needs. For example, we saw evidence of training sessions on mental health care being provided to front line staff on acute NHS hospital wards.

We identified clear mental health care plans in place and these were designed to support the person and their carer throughout their care and treatment in the acute hospital service.

Right care at the right time

The feedback reviewed from people who had used this service showed us that people appreciated the additional support provided by this service. Evidence was seen of a prompt response to referrals and of discussions within the multidisciplinary team where specific concerns had been assessed.

Care pathway

Those care and treatment records reviewed showed us that the service took into account people's needs for emotional and other support when planning their specific interventions. We noted multidisciplinary care pathways in place which ensured that the services involved in providing care and treatment worked collaboratively. This ensured that the individual needs of people who used the services were being met.

Learning from concerns and complaints

Staff confirmed that arrangements were in place to manage and address concerns and complaints. These would be addressed using the complaint policy procedures of the relevant acute trust. Staff reported that people were given a copy of the patient advice and liaison service (PALS) leaflet which outlined the relevant trust's complaints procedure together with information about the service.

Fountain Way - Amblescroft North and South

Planning and delivering services

Staff and patients told us the ward was always busy. Patients did not express any concerns about this affecting the quality of their care but did express concern for the staff with such the high stress levels.

The wards appeared to have a positive working relationship, supporting each other with staffing and administration issues. The staff team worked well together with the occupational therapist, physiotherapist, and the advocacy service and community teams.

The issue raised was about delayed discharges. The managers told us the problem lied with lack of funding for placements and the availability of these placements for patients. The senior medical staff identified this as a particular problem for the locality but it was also a trust-wide issue.

Right care at the right time

During our inspection, several senior staff spoke about the challenges posed by the geographical area of the trust. They told us patients are often long distances away from their home area due to bed availability and this impacted

Are services responsive to people's needs?

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

on the care provided and the potential for families to visit. It is worth noting that throughout the discussion, repatriating people to the home area was stressed as a high priority.

Care pathway

The ward worked with other services to provide all aspects of care. These included social services, psychological therapies, physiotherapy and occupational therapy and the community team. Together they worked with the patient towards stabilising their mental health and were looking to move them to a more appropriate service. Ward rounds happen regularly to review care and medical staff were available daily to assist staff to overcome any challenges that arose.

Learning from concerns and complaints

Patients told us they knew to speak to the staff if they were not happy with anything. Staff told us they know how to support patients and their relatives to make complaints. The advocacy service was visiting the ward regularly and told us that they felt they had a good relationship with the wards and that staff were aware of and supportive of their role. We found staff and patients to be very open with their views throughout the inspection.

Some staff voiced their concern that the managers did not always seem to take their concerns seriously and actions were not always taken or seen to be taken as a result. This was particularly around staffing and training issues. They did, however, understand some issues were trust-wide and acknowledged the management had escalated issues as far as they could.

Victoria Centre - Liddington and Hodson wards

Planning and delivering services

Patients and carers did not report any concerns with regard to accessing the service promptly. However, we did see evidence of long stays up to three months due to no appropriate community places to move to.

We noted that the matron and ward manager knew every patient by name. There was good use of patient information and feedback via audits to staff. The service worked well with other agencies and services to make sure that people received their care in a joined up way.

Care pathway

There was evidence of different groups working together effectively to ensure that patients' needs continued to be met when they moved between services. The ward team worked closely with community mental health services, including the complex intervention and treatment team for older people, and social services, to ensure continuity of care when patients were discharged from hospital.

Learning from concerns and complaints

People knew how to make a complaint if they were unhappy. No one we spoke to felt the need to make a complaint as they were very happy with the service they received. We looked at how complaints had been dealt with and found that the responses had been open, thorough and timely. People could therefore be assured that complaints were investigated and action was taken as necessary.

The unit takes into account peoples personal needs. We saw 'This is me' folders in everyone's rooms and examples of use of advocates.

St Martins Hospital - Ward 4

Planning and delivering services

The ward did not provide an acceptable environment which was conducive to maintaining patients' privacy and dignity. Bedroom accommodation was provided in male and female dormitories, with bed spaces separated by curtains. There was a separate lounge for women only. Staff made efforts to ensure this separation was maintained but they told us they were not always successful. They told us that there had been two recent occasions when the female lounge was used as a male bedroom. This meant that male patients had to walk through communal areas of the ward to access male bathrooms and toilets. This does not meet the Department of Health single sex accommodation requirements or the Mental Health Act Code of Practice. This states 'all sleeping areas (bedrooms and bays) must be segregated, and members of one sex should not have to walk through an area occupied by the other sex to reach toilets or bathrooms.' It also meant that women did not have a separate lounge area.

Right care at the right time

Patients and carers did not report any concerns with regard to accessing the service promptly. However, staff told us that discharges were often delayed due to a lack of suitable placements in the community for people with dementia.

Care pathway

There was evidence of different groups working together effectively to ensure that patients' needs continued to be met when they moved between services. The ward team

Are services responsive to people's needs?

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

worked closely with community mental health services, including the complex intervention and treatment team for older people, and social services, to ensure continuity of care when patients were discharged from hospital.

Learning from concerns and complaints

There was information given to patients and carers which told them how to make a complaint or a suggestion to improve practice. People were encouraged to raise their concerns in the first instance with ward staff. Complaints were regularly discussed at safety and risk meetings.

Callington Road - Laurel and Aspen wards

Planning and delivering services

On Aspen ward we found that there was one female patient being accommodate in a male bedroom area. Prior to us pointing it out, the ward manager did not seem to be aware of the situation.

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 reviewed care records for three people and found they were up-to-date, regularly reviewed and well completed. Care plans were in place to address identified needs and risks, including discharge planning and reasons for delayed discharge. Where best interest meetings had been held, they were well attended and clearly documented. Patient individual needs were assessed and recorded using various screening tools such as diet and nutrition, and skin integrity. Where concerns were noted, care plans had been developed. We saw that nurse call bells were answered promptly.

Right care at the right time

Patients and carers did not report any concerns with regard to accessing the service promptly. However, staff told us that discharges were often delayed due to a lack of suitable placements in the community for people with dementia.

Care pathway

There was evidence of different groups working together effectively to ensure that patients' needs continued to be met when they moved between services. The ward team worked closely with community mental health services, including the complex intervention and treatment team for older people, and social services, to ensure continuity of care when patients were discharged from hospital.

Learning from concerns and complaints

Information leaflets were available for patients, carers and staff. We saw that over the last year the ward has received only five complaints, which were managed through the PALS service, and had received 46 letters of praise and thanks.

Longfox Unit - Cove and Dune wards

Planning and delivering services

On Cove ward one corridor was occupied solely by male patients. The other corridor was being used to accommodate men and women. All but one of the rooms was for single occupancy and there were en-suite toilet and shower facilities. In the mixed sex corridor, the male bed rooms were clustered together near to the entrance to the corridor.

We were very concerned to find an example where a female patient's dignity was not protected. We discussed our concern immediately with one of the registered nurses on duty. The nurse seemed unconcerned by the situation even when it was suggested that the behaviour compromised the patient's privacy and dignity. Neither did there seem to be any consideration that the patient's behaviour could cause embarrassment for other patients, visitors and members of staff. When we looked at the patient's records, there was no care plan in place telling staff how the patient's dignity could be managed. Nor did there seem to have been any attempt to creatively manage the situation.

We spoke to two people who were sharing a room. Both patients said they were not happy to share a room, stating that their recovery was hampered because of it. They did not find it easy to share a room and the en-suite facilities with someone they didn't know.

At Dune ward the bedroom areas are split into two five bedded areas, one for men and one for women. However, one corridor was used to accommodate both men and women. Doors to the en-suite rooms are lockable from the inside but patients are not provided with keys to their rooms. We observed a female patient wander into male patients' room.

We found that in the care plans for one patient the patient name changed midway through the document. We thought this might be because care plans were being copied and pasted between patients. We also thought that this might indicate that the care plans were not active documents as this had not been picked up by staff.

Are services responsive to people's needs?

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

Care plans were in place to address identified needs and risks, including discharge planning and reasons for delayed discharge. Patient individual needs were assessed and recorded using various screening tools such as diet and nutrition, and skin integrity. Where concerns were noted, care plans had been developed.

Right care at the right time

Patients and carers did not report any concerns with regard to accessing the service promptly. However, staff told us that discharges were often delayed due to a lack of suitable placements in the community for people with dementia. Staff told us that a meeting is held to review unmet patient needs and identify the people who are ready to be discharged but there is nowhere for them to be moved to.

Care pathway

There was evidence of different groups working together effectively to ensure that patients' needs continued to be met when they moved between services. The ward team worked closely with community mental health services, including the complex intervention and treatment team for older people, and social services, to ensure continuity of care when patients were discharged from hospital.

Learning from concerns and complaints

We were made aware of the increasing number incident reports made by staff. The head of professional staff for the unit was analysing the data to distinguish active reporting from a rising incident rate. She was also planning to access the Health Authority falls risk network.

There was information given to patients and carers which told them how to make a complaint or a suggestion to improve practice. People were encouraged to raise their concerns in the first instance with ward staff. Complaints were regularly discussed at safety and risk meetings.

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

Community services

The trust's senior managers had visited some of the teams and this appeared to contribute to a shared vision throughout the service.

At a local level, staff were aware of their roles and understood the challenges they faced. However, this did not translate into the overall vision for the trust.

There were regular multidisciplinary meetings and audits at a local level to measure progress. Advocacy services were promoted and supported, and staff described managers as supportive, approachable and said that there was an open door policy.

At one site, there was no risk register. Across the services, we did not find any benchmark for standards in relation to national guidance such as from the National Institute for Health and Care Excellence. Also, information from complaints was not fed back consistently.

Inpatient services

Local managers appeared to be forward thinking, supportive and have a strong vision of the trust. Staff on one ward described a 'no blame' culture, which was supported by the high level of incident reporting. While we heard varying reports about the support from ward managers, these were mostly positive.

During our inspections, we highlighted several issues to ward managers, which were addressed quickly in most cases.

We were more concerned about the wider trust management. Many staff told us that there was a sense of detachment between local services and senior trust management. In addition some staff were unable to name the chief executive and many said they would not recognise any of the trust senior management team if they visited the ward.

Our findings

Wiltshire South Complex Intervention & Treatment Team

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 said they were aware of the trust's triumvirate management structure bud didn't feel they made the effort to support them.

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. Staff told us they knew their responsibilities and the limits of their authority. Staff were aware of their particular lead roles and duties. The managers attended regular performance meetings and informed us they passed the information to their teams via supervision and team meetings.

We noted there was no risk register in place which identified specific risks although the manager was currently developing this using the red, amber, green (RAG) system. We found no benchmarking of national audits to assess the performance of the service.

The training records reviewed showed us that mandatory training was up-to-date.

Leadership and culture

We observed staff morale within the team to be good which was reflected by the doctor we spoke with. We observed staff working together with good communication between the multidisciplinary teams and people who use the service.

Staff said that the chief executive had visited the service and that the operations manager's presence was visible within 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

People were supported to make complaints through the PALS service. We found that feedback was not shared

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across the teams with regard to concerns and complaints. People were given access to the independent mental health advocate (IMHA) whose role would be to support people within the Mental Health Act (MHA) 1983 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.

We found no specific evidence of feedback from people who use the service although a person said they were happy with the service provided and would recommend the service.

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

Performance Improvement

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

The team conducted regular team audits undertaken to monitor quality. Staff told us that they had good support and had opportunity to reflect on any performance or learning outcomes in management supervision. The trust had an IQ system in place to monitor and audit the care management records and the quality of records in line with the outcomes set out by the Care Quality Commission.

South Gloucestershire Complex Intervention & Treatment Team

Responsible governance

The manager reported that the trust IQ governance system allowed them monitor quality and assurance at a local level. The manager attended the monthly South Gloucestershire quality and standards meeting, where governance and performance issues were discussed. We saw meeting minutes which reflected action points agreed from these meetings.

Leadership and culture

The team was well led. Staff told us that they felt supported and were encouraged to share concerns and ideas. The team manager and the service manager were supportive and accessible. The staff felt listened to and told us that concerns were acted on by the senior management team, South Gloucestershire triumvirate.

Engagement

Staff positively promoted the 'triangle of care' with people who use the service and carer's. The team was working with the service user involvement co-ordinator to identify how they could improve the response rate to surveys in order to gain more feedback about the service.

There were regular interface meetings between primary care services, other community mental health teams, senior management and the inpatient ward. Staff we spoke with were generally aware of the trust's whistleblowing policy, and felt confident to report to their team management any concerns they had.

Performance improvement

The team conducted regular team audits undertaken to monitor quality. Staff told us that they had good support and had opportunity to reflect on any performance or learning outcomes in management supervision. We saw supervision records which reflected how a specific performance issue was being managed.

Swindon Complex Intervention & Treatment Team

Responsible governance

The manager reported that the trust IQ governance system allowed them monitor quality and assurance at a local level. There was a locality quality and safety meeting where governance information was shared and discussed.

Leadership and culture

The team was well-led. There was clear evidence of supportive leadership. Staff told us that they felt supported and were encouraged to share concerns and ideas. The team manager and the service manager were supportive and accessible. The staff felt listened to and that concerns were acted on by the senior management team. We saw that staff were passionate about their work and showed a genuine compassion for people.

Engagement

Staff positively engaged with service users and carer's and asked for regular feedback. People who use the service and carers told us that they felt well informed about their treatment and communication with staff was clear. Good quality information was given to carer's and individuals throughout their time with the team.

The trust was in the process of establishing a number of staff, service and carer engagement forums and a service

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user involvement co-coordinator was in post to support local projects. There were regular interface meetings between primary care services, other community mental health teams, senior management and the inpatient ward.

Staff we spoke with were generally aware of the trust's whistleblowing policy, and felt confident to report to their team management any concerns they had.

Performance improvement

Staff we met with understood their aims and objectives in regard to performance and learning. We saw that the team meeting focussed on team objectives and direction, particularly through ensuring the service was needs led and person centred. Staff told us that they had good support and had opportunities to reflect on any performance or learning outcomes in management supervision. We saw that regular team audits undertaken to monitor quality.

Bristol Complex Intervention & Treatment Team

Vision and strategy

Staff told us that they we were aware of the trust's vision and values and strategic objectives. We found evidence of the trust's vision and values on display within the service. Staff were aware of the trust's triumvirate management structure but some staff were unsure of how this structure worked in practice.

Responsible governance

We saw clear clinical governance arrangements were in place at a local level. We saw that the trust reviewed the quality of the services provided. 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.

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 found staff morale within the team to be good which was reflected by those staff that we met. We observed staff working together with good communication between the multidisciplinary teams and people who use the service.

Staff confirmed that they had been visited by senior trust managers and felt supported by their direct line manager. One member of staff confirmed that the trust and their line manager had been very supportive upon their return to work from a long illness.

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.

Engagement

People had access to the advocacy service and were supported to make complaints through the PALS service. We found that concerns and complaints were discussed at team meetings and during individual clinical supervision.

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

People who use the service were positive about the care and treatment given by front line staff. One person told us they were happy with the service provided and would recommend the service to their friends and family.

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 Integrated Quality (IQ) system in place which was used to review the quality and record management of the service with the findings being disseminated to the team. We saw that this was being effectively used by senior managers.

North Somerset Complex Intervention & Treatment Team

Vision and strategy

Staff we spoke with said they were aware of the trust's vision and values and strategic objectives. We found 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. 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 found staff morale within the team to be good which was reflected by those staff that we met. We saw that staff worked effectively together. There were good communication systems within 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.

Engagement

We found that any concerns and complaints were discussed at team meetings and during individual clinical supervision. Staff told us that they were aware of the trust's whistleblowing policy and informed us they knew the processes to follow should they have any concerns.

People who used the service were positive about the care and treatment given by front line staff. One person told us they were satisfied with the service provided and someone else spoke highly of their specific care co-ordinator.

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 integrated 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.

Later life mental health liaison team

Vision and strategy

Staff we spoke with said they were aware of the trust's vision and values and strategic objectives. We found evidence of this strategy and vision on display within the service. Staff knew of how these impacted upon this specialist service. They confirmed that they received regular trust updates via the trust's intranet and other bulletins, and updates from the acute trusts where applicable.

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 meetings with the local acute trust. They informed us they cascaded information to their teams via supervision and team meetings. Staff told us that they felt valued and listened to and had a good working relationship with their line manager.

The training records reviewed showed us that mandatory training was up-to-date and that any identified specific training needs had been met.

Leadership and culture

We found staff morale within the team to be good which was reflected by those staff that we met. We observed staff working together with good communication between the team and the local acute NHS hospital trusts' worked with. Staff confirmed that they had been visited by senior trust managers and felt supported by their direct line manager.

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

Engagement

We found that any concerns and complaints were discussed at team meetings and during individual clinical supervision. Staff told us that they were aware of the trust's whistleblowing policy and informed us they knew the processes to follow should they have any concerns.

The feedback seen showed us that people were positive about the support and treatment provided by this service. For example one person had reported an excellent service. Feedback from referrers was seen and this demonstrated the added value and support provided by this service.

Are services well-led?

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Performance improvement

We found clear systems in place to monitor and improve the performance of this service. For example we saw regular multidisciplinary team meetings and clear audit results with actions identified where applicable.

Fountain Way - Amblescroft North and South

Vision and strategy

Staff we spoke with had varying levels of awareness about the vision of the trust. It appeared that the medics, consultants and managers had a much clearer vision of the trust purpose than the ward staff. Staff received information about the trust via email and the intranet. They told us they didn't often have time to read emails and there were issues about being able to access a computer at work to read emails.

Staff told us they knew the onsite management well and most felt they had a good working relationship with them. Staff told us they would probably not recognise the senior trust management if they came on the ward. Most could name the chief executive but no other management personnel.

Responsible governance

Staff we spoke with were aware of their roles and responsibilities on the ward. They told us that if they were not sure of anything, they would ask the manager or modern matron for advice. They demonstrated a depth of understanding of the challenges faced by the trust but also a frustration that trust-wide issues did not seem to be addressed with any urgency such as training provision and staffing levels.

Leadership and culture

Some staff expressed their feelings for the need for stronger, more visible leadership and direction. Staff told us they felt more valued by their immediate management than the trust management. Staff spoke of the recent changes in trust structure creating a feeling of unease and some chaos, with the potential for important issues to be missed, as we found to be the case.

Engagement

Patients told us that staff engaged with them as much as they were able to under the high demands of the ward. They said they saw the professional team regularly and most felt included in their care on a daily basis. However, we did find that relatives were not always involved in care reviews where appropriate and some did not have copies of the care plans.

Staff told us they felt they worked closely as a team at ward level but felt isolated within the trust. Communication came to them via email or on the intranet. This was not easily accessible due to lack of computers and time to be able to sit a read correspondence.

Performance Improvement

We saw evidence from several meetings focusing on current provision and identifying concerns. However, it was clear that some issues were spoken about each time with little if any action being taken to remedy the situation. It appeared that trust-wide issues and concerns were not being highlighted or escalated assertively enough to trust level management for attention. On our return we found issues were being given greater priority.

Victoria Centre - Liddington and Hodson Wards

Vision and strategy

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

Responsible governance

We saw clear clinical governance arrangements in place at a local level. The managers attended monthly integrated governance meetings and monthly meetings. They informed us they cascaded information to their teams via supervision and team meetings. Staff told us that they felt valued and listened to and had a good working relationship with their line manager.

Leadership and culture

Staff told us they were clear about their roles and responsibilities. And were passionate about what they did. We were advised that the managers have an open door policy and that the staff felt valued and supported.

Engagement

Staff friends and family comments were audited on a three monthly basis and findings fed back by the matron and

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ward manager to the staff on a regular basis. The latest friends and family test audit said that 70% of people would be extremely likely to recommend the unit to friends and family, 30% said likely.

Performance improvement

The service had a quality assurance system, records seen by us showed that identified shortfalls had been addressed promptly. As a result the quality of the service was continually improving.

St Martins Hospital - Ward 4

Vision and strategy

Staff demonstrated a shared vision driven by quality, safety, compassion, dignity and respect. Staff said they were aware of and signed up to the trust's motto 'you matter, we care'. Staff were clear about what their ward did well and where it could improve.

Responsible governance

The trust used a performance monitoring tool known as integrated quality (IQ) which measured performance against a range of local and national key performance indicators. There was a local delivery unit (LDU) governance structure led by a triumvirate management team (clinical director, managing director and head of professions and practice) which monitored quality and safety. Monthly meetings LDU governance meetings were attended by the matron and ward manager and regular ward reports, including IQ reports fed into this process.

Leadership and culture

Staff told us the Chief Executive had recently visited the ward and spoken with patients and staff. This was one of a number of regular quality visits to different trust locations by board members.

Staff portrayed themselves as a cohesive, positive and committed team. Quality and patient experience was seen as a priority and was everyone's responsibility. The ward manager and matron were visible and accessible. The staff felt well supported. There was, however, some anxiety and uncertainty expressed about plans to re-locate the ward.

Engagement

The locality had appointed an involvement co-ordinator who chaired the BaNES people's group, which captured views from patients and carers. Feedback was reported to the locality quality and standards meeting.

Performance Improvement

Staff we met with understood their aims and objectives and were passionate about providing quality services and improvement.

Callington Road - Laurel and Aspen wards

Vision and strategy

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

Leadership and culture

Laurel ward staff were awarded the trust-wide accolade of team of the month for May 2014. The team was well led locally with a visible and responsive modern matron. The multidisciplinary team appeared to function well together and there was good consultant psychiatrist and junior doctor input. The ward manager was open and reflective during the visit, readily taking on board minor issues we raised and finding pro-active solutions. The ward manager and the modern matron had clear plans and ideas for improvements to the ward. There was a no blame culture on the ward, evidenced by the high number of incident reports. All staff we spoke to said they liked working with each other and were a close knit team.

There appeared to be a flat management hierarchy on the ward, with all members of staff valued for their individual contribution. We saw that when a patient spilled their drink, the junior doctor mopped up the spillage himself instead of asking a member of the housekeeping staff to do this.

Aspen ward has recently appointed a new ward manager who was keen to tell us her vision for changes to the ward. Based on feedback received, changes will then be made. The ward manager was able to give us specific examples of changes she has initiated during the four weeks she had been in post, including changing and improving staffing levels. She recognised that the ward and its staff are caring but comparatively institutionalised in their approach. She told us that she is requesting assistance from the psychologist in improving psychological mindedness in the staff group.

Are services well-led?

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Engagement

On Laurel ward we found the environment to be calm and well controlled and this was reflected in the very positive feedback we received from visiting carers.

The manager on Aspen told us that she is working closely with the service user representative to 'bring the ward into the 21st century'. Questionnaires have been devised to gather feedback from patients, their relatives and carers and staff. The manager told us she plans to reorganise the team so they are able to gather an in depth knowledge of their patients. Ward rounds will be changed to become smaller clinical reviews that actively involve the person using the service and their relative.

Performance improvement

Staff we met with understood their aims and objectives and were passionate about providing quality services and improvement. However, when we compared our observations with Laurel Ward, we found staff on Aspen Ward to be largely undirected and not proactively engaging with patients. The ward manager was aware of this and is taking steps to make changes with a group of long standing staff.

We were told of several plans to improve Aspen Ward including making the therapy room a more active environment, making staff handovers more meaningful and developing team working.

Longfox Unit - Cove and Dune wards

Vision and strategy

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

Responsible governance

There is a trust-wide governance and information system called integrated quality (IQ). This measures compliance with key issues such as records and supervision. Managers and staff have access to the system and are able to compare the performance of individual wards. Managers attended weekly governance meetings and they told us that information from these was passed to the teams via their team meetings and at supervision.

Leadership and culture

We found the local leadership on Cove and Dune wards to be supportive and visible. The unit manager oversees both Cove and Dune wards. She demonstrated a good understanding of the issues and challenges faced by accommodating men and women in non-segregated areas. She said she has raised this on many occasions but senior management had not responded.

While we found that the ward management and leadership to be supportive and visible to ward staff, we were concerned by the seeming lack of direction at a more senior level. During our inspection we raised a number of situations of concern, however, some of the issues where not recognised as a problem.

Staff on both wards reported to us that senior management from the trust was neither visible nor accessible.

Engagement

People gave us mixed feedback about their involvement in their care and care planning. Some said they felt very involved in the process, whereas others said they were not. In the care records we reviewed, care plans and risk assessments were in place, were in date and regularly reviewed. We saw evidence that best interest meetings were held. Staff told us that they were aware of their professional objectives and these were reviewed regularly at supervision and appraisal.

Performance improvement

A number of issues had been raised with senior management without any remedial action being taken.

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 taken proper steps to ensure that people were protected against the risk of receiving inappropriate or unsafe care.** **How the regulation was not being met:** • On some wards there were not clear arrangements for ensuring that there was single sex accommodation in adherence to guidance from the Department of Health and the MHA Code of Practice, to protect the safety and dignity of patients. • Individual patient risk assessments had not always been reviewed and updated following incidents of potential or actual harm • Care plans were not always person centred • Discharge arrangements were not clear and effective at the BaNES Complex Intervention & Treatment Team **Regulation 9**

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

Compliance actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	The registered person had not ensured that as far as reasonably practicable there were suitable arrangements to ensure the dignity, privacy and independence of service users and that service users are enabled to make, or participate in making, decisions relating to their care or treatment. How the regulation was not being met: • Not all patients were involved in the planning of their care and treatment • On Cove ward we evidenced a female patient undressed who could be observed by other patients and visitors. • On Dune ward we saw that patients were served cake which was placed directly on the table in front of them without using a plate or napkin Regulation 17—(1)

Regulated activity	Regulation
Treatment of disease, disorder or injury	The registered person had not ensured that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises How the regulation was not being met: • On a number of wards we found potential ligature risks that had not been effectively mitigated or managed • Dune ward was unsafe because the fire extinguishers had been removed and signage for alerting a fire was inaccurate. • On some wards we found that design and decoration of the ward did not support a therapeutic environment Regulation 15(1)

Regulated activity	Regulation
Treatment of disease, disorder or injury	The registered person did not have suitable arrangements to protect patients from the risk of unsafe or unsuitable equipment:

Compliance actions

How the regulation was not being met:

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

Regulation 16 (1) (b)

Regulated activity

Treatment of disease, disorder or injury

Regulation

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

How the regulation was not being met:

- A number of units were experiencing significant staff shortages which may have impacted on patient care and safety.

Regulation 22

Regulated activity

Treatment of disease, disorder or injury

Regulation

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:

- At Fountain Way, the Longfox Unit and the North Somerset Complex Intervention & Treatment Team we found that there was not appropriate procedures in place for the administration, management and audit of medications
- On a number of units we found that temperature checks necessary for ensuring the integrity of medications had not been undertaken

Regulation 13

Compliance actions

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	The trust must had not ensured that suitable arrangements were in place in order to ensure that persons employed for the purposes of carrying on the regulated activity were appropriately supported in relation to their responsibilities by receiving appropriate training, professional development, supervision and appraisal; • Staff at the South Wiltshire Complex Intervention & Treatment Team had not received training in the application of the assessment tools that they work with • Not all staff had received training in safeguarding, management of aggression and life support Regulation 23