Integrated Access Partnership (IAP)
Quality and Assurance Standard Operating Procedure (SOP)

Mental Health
Integrated Access Partnership
Intelligent Mental Health System Response

Integrated Access Partnership (IAP) Quality and Assurance Standard Operating Procedure

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NHS Integrated Collaboration Between BrisDoc South Western Ambulance Service NHS Foundation Trust Avon and Wiltshire Mental Health Partnership NHS Trust SevernSide Integrated Urgent Care

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Purpose

This Standard Operating Procedure (SOP) outlines the governance, oversight, and assurance processes necessary to maintain clinical safety, service quality, and staff competency within the Integrated Access Partnership (IAP). It establishes a structured framework for the review and escalation of any concerns relating to patient safety, including staff performance, incidents, complaints, and other sources of assurance. This SOP ensures that all relevant issues are appropriately identified, reviewed, and escalated through defined pathways, promoting continuous learning and improvement across the service.

Governance Framework

Patient safety and clinical assurance will be reviewed using multiple sources including:

- Incidents (AWP and SWASFT) and learning events (BrisDoc)
- Audits
- Staff development and clinical assurance
- Induction and onboarding
- Complaints
- Training
- Patient/staff feedback.

Commented [MT1]: what about training

The IAP leadership team will consider information from the sources above to report thematics through the IAP governance structure to support strategic decisions and service design. Thematics relating to clinical audit, incidents and complaints will be reported monthly via the IAP Quality Report to the IAP Delivery Board. Information relating to individual staff performance, sign-off and induction will be reported into the IAP Workforce Oversight Group. The flow of this high-level thematic information is detailed in Figure 1 below.

Information from these sources will also support review of individual staff development and highlight where staff require additional support through individual support plans, or escalation for further review at the IAP quality assurance panel (QAP). The escalation process for convening a QAP can be seen in Figure 2 and within the QAP terms of reference.

Commented [MT2]: structure of sentence.

Figure 1: Governance for Routine Reporting and IAP Service Learning (Thematics Only)

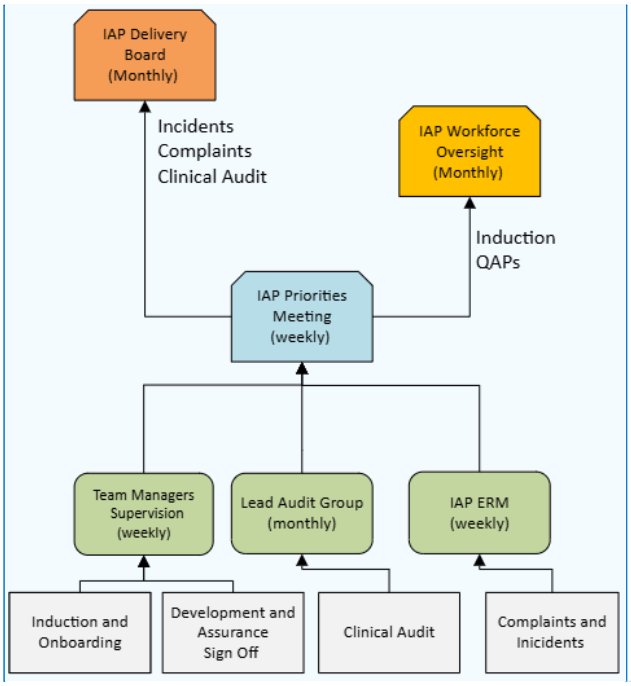
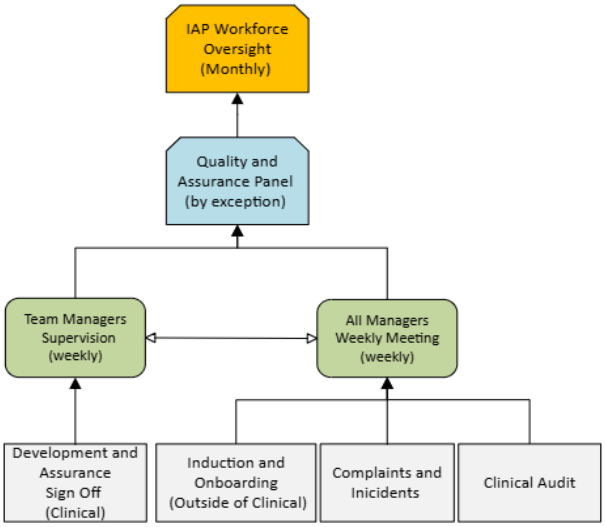


Figure 2: Governance flow for Review of Individual IAP Staff



Commented [MT3]: reporting for QAPS and induction

Commented [MT4R3]: can be brought together in quality report ?

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Quality and Assurance Panel (QAP)

The QAP provides formal oversight of clinical safety, competency, and service quality issues. It reviews cases escalated from service and team manager meetings, and ensures appropriate actions are taken (Figure 2 above). The QAP is responsible for reviewing serious incidents, complaints, risks, and staff requiring extended support. It refers cases to organisational HR and quality routes, as needed, and escalates broader concerns to the Workforce Oversight Group.

The QAP is supported by a terms of reference.

The QAP:

- Reviews staff requiring extended induction or where safety concerns are raised.
- Reviews serious incidents or complaints.
- Makes decisions on competency, training needs, and remedial actions where there is ambiguity or disagreement.
- Refers to professional bodies or respective HR where necessary.
- Reports to the Workforce Oversight Group and IAP Delivery Board.
- Maintains a record of decisions and actions.
- Ensures staff are informed and supported throughout the process.

The Roles and Responsibilities of IAP Leaders in Quality and Assurance

IAP Strategic Leadership

The IAP strategic leaders hold overarching responsibility for quality and assurance of the IAP. They ensure the process is functioning effectively, safely, and in line with clinical governance standards.

The strategic leaders are:

- SWASFT Head of Mental Health
- BrisDoc Director of Allied Health Professionals, Nursing and Governance
- AWP Head of Urgent and Emergency Care

The strategic leaders are responsible for:

- Chairing the QAP
- Reviewing escalations from the weekly service and team managers meeting
- Responding to urgent concerns regarding the clinical safety or conduct of staff
- Ensuring alignment with the AWP Conduct and Competency Policy.

Senior Managers

The term ‘senior managers’ is used to refer to Band 8A managers within the IAP. Senior managers:

- Chair the weekly managers meeting
- Chair weekly team manager supervision
- Review feedback from supervisors
- Ensure decisions made at the weekly meeting are formally recorded in writing, as per the Terms of Reference (ToR)
- Request to stand up a Quality Assurance Panel to sign off inductions or review individual staff performance

- Are accountable for timely completion and oversight of:
- Clinical audit
- Investigation of incidents and complaints
- Induction and onboarding
- Completion of development and assurance milestones

Team Managers

- Provide day to day clinical oversight to support clinical competency and development of IAP staff
- Ensure staff receive regular clinical exposure across all competency domains of the Development and Assurance Framework
- Conduct staff reviews, which may include direct clinical observation
- Oversee completion of statutory and mandatory training
- Complete or allocate to senior practitioners:
- Clinical audit
- Investigation of incidents
- Induction and onboarding
- Completion of development and assurance milestones

Senior Practitioners

- Complete clinical reviews of IAP staff
- Are allocated by team managers to:
- Undertake clinical audit
- Investigate incidents
- Sign off development and assurance milestones
- Deliver training.

Complaints

Complaints relevant to the IAP will be received through the respective organisations:

- BrisDoc – via Governance Team
- AWP – via PALS
- SWASFT – via Patient Experience Team
- Other – via Police and Acute Trusts

Complaints are subsequently received, recorded and overseen by the IAP Business Manager, and are forwarded to IAP managers to investigate. These will usually be allocated to the line manager of the staff member/s involved.

All complaints are to be responded to within 25 working days, except where necessary extensions are arranged via the respective organisation's relevant department, owing to complexity or unforeseeable circumstances.

Oversight and governance of complaints is managed through the following meetings/boards:

Weekly:

- Team and Service Manager meeting
- Event Review Meeting
- Priorities Scrum

Monthly:

- IAP Delivery Board (via IAP Quality Report).

Incidents

The IAP receives incident reports through respective organisations:

- AWP incidents (via Ulysses)
- SWASFT incidents graded low or no harm (via InPhase)*
- BrisDoc learning events (via BrisDoc Governance Team)
- External teams (requests to review and respond to incidents reported externally, eg. via acute trusts).

*Incidents that are moderate/severe harm remain with SWASFT Patient Safety to investigate, with advice sought from the mental health team as indicated.

Allocation of Incidents for Investigation

Incidents will usually be allocated to the line manager of the staff member/s involved.

AWP incidents (Ulysses)

The IAP Mental Health Quality and Training Lead is responsible for allocating each incident reported via Ulysses to the appropriate team manager.

SWASFT (InPhase)

The IAP Mental Health Quality and Training Lead is responsible for allocating each incident reported via InPhase to the appropriate team manager.

BrisDoc (Learning Events)

The BrisDoc Governance team are responsible for allocating each learning event reported to the appropriate team manager.

External Incidents:

External incidents will be allocated in line with the IAP organisation through which it is reported.

All incident allocation is reviewed weekly by the IAP Quality & Training Lead.

Allocation Resilience

To prevent any delays in incident investigation caused by staff absence, the IAP Quality and Training Lead will review allocations to ensure appropriate cover or reallocation of investigating officer if necessary. In the absence of the IAP Quality and Training Lead, senior managers will be designated to allocate incidents.

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Event Review Meeting

A weekly event review meeting (ERM) provides a structured forum to review patient safety incidents, complaints and concerns to ensure appropriate, proportionate and timely responses.

The ERM is chaired by the Quality and Training Lead or Deputy Head of Mental Health. A minimum of two members must attend, at least one of whom must be a senior manager.

The ERM will:

- Review all incidents and complaints received via the identified systems.
- Determine the appropriate PSIRF response:
- Local learning
- Patient safety review (PSR)
- No further action (with documented rationale)
- Identify themes, trends and emerging risks.
- Review whether the allocated investigator is appropriate in terms of independence, seniority and capacity.
- Agree timescales.
- Allocate deputy investigation leads where applicable.
- Ensure Duty of Candour requirements are considered where applicable.
- Escalate significant themes to relevant forums.
- Monitor progress of open investigations and actions.
- Ensure proportionate, timely and compassionate responses to patient safety incidents.
- Identify if an After-Action Review (AAR) should take place.
- Ensure learning is identified, shared and embedded into practice.
- Review responses to complaints.
- Allocate responsibility for completing and disseminating learning reports.

Investigations and Learning

The IAP is committed to a non-punitive culture of openness, learning and continuous improvement, where incidents, mistakes and near-misses are openly reported, addressed quickly, and learning shared to prevent recurrence.

Investigations will follow the policies of the organisation where the incident or complaint was raised, with resulting learning shared across IAP partners in line with the Integrated Governance Framework.

Commented [MT5]: do we explicitly describe this within the IGF?

Commented [OC6R5]: No

Reporting

There is a live document detailing all incidents reported, allocations, and discussions held at the weekly ERM meeting, available for all IAP managers to access via Glasscubes.

Commented [MT7]: where will this be accessed?

Activity, timeliness, themes, and learning from incidents and complaints will be reported into the MHCAS Operational Delivery Group and the Mental Health Oversight Group.

These reports will feed into the IAP Delivery Board via the IAP Quality Report.

All incident investigations are to be completed within 25 working days from initial receipt of the incident.

Oversight and governance of incidents is managed through the following groups/meetings and boards:

Weekly:

- Team and Service Manager meeting
- Event Review Meeting
- Priorities Scrum

Monthly:

- IAP Delivery Board (via IAP Quality Report).

Induction and Onboarding

All new starters will follow a structured induction programme, which includes a competency sign-off process. Existing staff requiring support will follow the same process. Extensions to induction must be approved by the QAP.

Commented [MT8]: To provide link to onboarding SOP

Induction and onboarding is supported by the IAP Induction and Onboarding SOP.

Competency Sign-Off Process

Staff will be signed off across four key areas:

- Remote assessment
- Advice and guidance
- Clinical navigation (registered practitioners only)
- Mental health response vehicle (registered practitioners only)

The standards required for sign-off are captured within the IAP Development and Assurance Framework booklet.

The competency sign-off process requires feedback to be completed by senior practitioners. Responsibility for obtaining feedback lies with the member of staff undertaking their induction/development and a record maintained within their booklet. The line manager supporting sign-off will present the evidence to the relevant meeting.

Cases meeting the following criteria will be escalated for review and approval by the QAP:

- Completion of all areas of induction and the IAP Development and Assurance Framework.
- Extension of the induction period beyond the standard timeframe.
- Concerns relating to patient safety or staff performance during the induction period.
- Staff member has previously failed sign off or required remedial support.
- Requests for accelerated sign-off.

All decisions, feedback, and sign off records must be stored centrally with records accessible for audit, review, and assurance purposes.

Clinical Audit

Commented [MT9]: To check terminology of SLT as this can conflict with other documents?

The IAP will audit clinical contacts across all IAP service lines, which include:

Commented [MT10]: Embed clinical audit

- Mental Health Specialist Desk (MHSD): all cases
- Mental Health Response Vehicle (MHRV): BNSSG & BSW cases only
- Mental Health Clinical Assessment Service (MHCAS): all cases
- Emergency Services Mental Health Professional Line (MHPL): all cases.

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Audits will be conducted in accordance with the criteria that follow and will also assess alignment with the IAP Development and Assurance Framework standards, including communication, clinical decision making, documentation, safeguarding, and risk management, to support continuous professional development.

As well as assuring the quality and standards of the service, the results of audits and any identified learning will be used to contribute to staff supervision and development, and service improvements, referencing assurance domains from the Development and Assurance Framework, as appropriate, to promote reflective practice.

Clinical audits will primarily consist of records reviews, supported by listening to call recordings.

Clinical Records

The below table identifies the primary and secondary written clinical recordings made within each of the IAP service lines.

Service Line	Primary Record	Secondary Record
Mental Health Specialist Desk (MHSD)	CAD (C3)	RiO*
Mental Health Response Vehicle (MHRV)	RiO*	ePCR
Mental Health Link Officer (MHLO) (situated at MHSD)	RiO	N/A
Mental Health Clinical Assessment Service (MHCAS)	CLEO	RiO*
Emergency Services Mental Health Professional Line (MHPL)	CLEO	RiO*

*Where there is a clear mental health need, IAP staff must duplicate records onto the relevant instance of RiO (providing access is available) according to the location of the patient. Therefore, all face-to-face contact should result in a RiO referral being open. The record of the assessment must always be copied verbatim to capture all the relevant clinical details.

*IAP staff will only be expected to submit information into the contemporaneous record (progress notes) of the relevant RiO record.

Mental Health Specialist Desk (MHSD)

Cases are received via 999 calls through SWASFT, across the Trust's footprint in South West England.

Records

The primary record is held in SWASFT CAD (C3) with the secondary record in RiO for the relevant area. Cases are managed via outbound calls on SWASFT recorded lines.

Audit Sample

- Five per cent of cases audited monthly, with a random sample generated by the IAP Data Analyst, representative of geographic spread.
- CAD and RiO notes are reviewed against audit criteria.
- For five per cent of audited cases, call recordings are checked for accuracy.
- Extraordinary reviews include both notes and call recordings.

Process

- Audits logged via Microsoft Form (standards met/not met).
- For each case that is 'passed', a feedback email will be sent to the relevant clinician.
- Cases not meeting the expected standard will be referred for group review; feedback from this review will be shared constructively in the most appropriate manner with the clinician in conjunction with the clinician's line manager and the audit team.

Mental Health Response Vehicle (MHRV)

Cases are received via 999 calls through SWASFT, or via trusted assessment pathway from MHCAS or the MHLO.

Records

The primary record is held in RiO with the secondary record held in the SWASFT ePCR. Cases are managed through face-to-face attendance to scene.

Audit Sample

- Five per cent of cases in both BNSSG and BSW are audited monthly through RiO notes, with a random sample generated by the IAP Data Analyst.
- Results recorded in Microsoft Form (standards met/not met).
- For each case that is 'passed', a feedback email will be sent to the relevant clinician.
- Cases not meeting the expected standard will be referred for group review; feedback from this review will be shared constructively in the most appropriate manner with the clinician in conjunction with the clinician's line manager and the audit team.

Mental Health Clinical Assessment Service (MHCAS)

Cases are received via NHS 111 (phone or online) in BNSSG. Audit of cases is completed through Clinical Guardian, a web-based programme that selects cases for audit for each practitioner.

Records

Primary records are held in CLEO, with secondary records in AWP RiO. Cases are managed via calls on BrisDoc recorded lines.

Audit Sample

- A random, five per cent of cases for each practitioner who has been signed off and has 'green' status within Clinical Guardian.
- Cases are automatically transferred to Clinical Guardian on a daily basis.

Clinician Status

- Purple (new clinicians): 100 per cent cases audited until at least 10 cases and up to three telephone calls reviewed.
- Green (standard status): five per cent of cases audited.
- Amber (additional monitoring needed): 25 per cent of cases audited.

Auditors will email awp.IAPTeamManagers@nhs.net to request a status change within Clinical Guardian. Status changes will be confirmed by team manager and updated within the system.

Process

- Audits reviewed in Clinical Guardian, then logged in Microsoft Form.
- Passed cases receive automated feedback; cases not meeting expected standard go to group review for constructive feedback.
- Cases not meeting the expected standard will be referred for group review; feedback from this review will be shared constructively in the most appropriate manner with the clinician in conjunction with the clinician's line manager and the audit team.

Emergency Services Mental Health Professional Line (MHPL)

Cases received from Avon and Somerset Police, Avon Fire and Resue, British Transport Police, or SWASFT crews in BNSSG.

Records

Primary records are held in CLEO, with secondary records in AWP RiO. Cases are managed via calls on BrisDoc recorded lines.

Audit Process

MHPL operates as part of MHCAS, with audit incorporated within MHCAS audit through Clinical Guardian.

Audit Summary

Service Line	Audit Method	Monthly Audit Sample	Audit Record
Mental Health Specialist Desk (MHSD)	• Review of CAD • Review of RiO notes • Review of call recordings	• 5% of cases, geographically representative • Call recordings reviewed for 5% of audited cases	• IAP Audit MS Form
Mental Health Response Vehicle (MHRV)	• Review of RiO notes	• 5% of cases (BNSSG & BSW cases only)	• IAP Audit MS Form
Mental Health Link Officer (MHLO) (situated at MHSD)	• Audit by Police		
Mental Health Clinical Assessment Service (MHCAS)	• Review of CLEO case notes • Review of RiO notes • Review of call recordings	• Minimum of 10 cases for each new clinician • Up to three call recordings for each new clinician • 5% of each clinician's cases following initial period	• Clinical Guardian • IAP Audit MS Form
Emergency Services Mental Health Professional Line (MHPL)	• Audited as part of MHCAS		

Audit Criteria

All audit will be carried out in accordance with the criteria below for both audio recordings and written clinical notes.

Call Audit Requirements

- At scene safety confirmed
- Introduces self, role and purpose of call
- Patient demographics, location, and ABCs documented.
- Makes effort to speak directly to patient (including voice of a child patient)
- Professional, caring and compassionate approach
- Maintains professional tone even under pressure
- Demonstrates active listening and de-escalation as appropriate
- Uses appropriate questioning techniques and avoids jargon
- Accurately determines the presenting complaint
- Seeks collateral input (especially for safety assessment/planning) from carers, friends, relatives, and relevant professionals or services wherever practicable.
- Where appropriate leads discussion relating to hope-promoting elements for safety planning ie: reasons for living
- Applies Mental Health Act, Mental Capacity Act, and Safeguarding legislation appropriately
- Safeguarding concerns identified and escalated correctly (where relevant)
- Manages risk accurately to arrive at a timely outcome
- Patient preferences taken into account (options offered, declined, and reasons).
- Reaches a safe and appropriate outcome and communicates this effectively
- Health promotion discussed where relevant (smoking, alcohol, drugs)
- Targeted and general worsening advice provided
- For professional liaison, communicates a clear plan to support emergency services to positively hold risk at scene as appropriate

Clinical Records Audit Requirements

- Primary record (CAD/CLEO) and RiO entries are consistent and reflective of each other
- Risk documented as a narrative formulation integrating historical, current, and protective factors (not solely numeric scores or predictive tools).
- UK Mental Health Triage Scale is recorded
- New RiO safety assessment form completed for patients without an existing record
- Safety Plan states key headlines, including points of escalation and follow up.
- Key abnormal mental state findings are documented (e.g., pressured speech, low mood, suicidal thoughts).
- Any reference to capacity is decision-specific
- Where appropriate, details of Interpreter use documented (language, consent).
- Non-registered staff reference a registered clinical supervisor in relation to all clinical decision making
- Records show a final impression and formulation that captures risk and clinical impression
- Clear rationale documented, showing options considered and reasoning for chosen action.
- Demonstrates review of collateral sources, specifying relevant notes reviewed and significant findings

- Plans are clear and proportionate to the presenting situation
- Includes details of any incident or learning event form completed, specifying where concerns were identified and documented.

Overall

- Was the management of this case satisfactory?

Monthly Audit Group Review Meeting

Membership

The Mental Health Quality and Training Lead facilitates a monthly meeting to include the Business Manager and clinical auditing team. Minutes and actions are recorded and distributed to the group attendees.

Purpose

Review Monthly Themes

- Examine the spreadsheet of thematic outcomes from the previous month.
- Highlight areas of learning, including team-wide themes and any individual learning needs or concerns.

Audit Tracker Review

- Ensure the audit tracker provides clear evidence of ongoing learning and completed actions, accessible to all staff.

Delegation of Actions

- Assign tasks arising from identified themes or other learning needs for example:
- Writing IAP bulletin articles
- Preparing training sessions or bite-size learning
- Supervision
- Personal support plans

Quality Assurance

- The Mental Health Quality and Training Lead will review audit inputs for accuracy and consistency.
- Ensure regular completion of audits to maintain up to date quality assurance and safe clinical practice.

Audit Schedule Review

- Confirm staff commitment to allocated audit tasks.
- Review the audit schedule for consistency and feasibility.
- Arrange group audit reviews involving two or more members of the audit team for the upcoming month.

Monitoring & Change Register

The IAP SOP will be reviewed at least annually and more regularly to account for service changes and expansion.

Date	Version	Author	Change
24/03/2026	1.0	IAP Leadership Team	Initial version