2gether NHS Foundation Trust

Quality Report

2gether NHS Foundation Trust HQ
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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Wotton Lawn The Stonebow Unit	RTQ02 RTQX1
Long stay/rehabilitation mental health wards for working age adults	Honeybourne Laurel House Oak House	RTQ13 RTQXZ RTQX2
Forensic inpatient / secure wards	Wotton Lawn, Montpellier Unit	RTQ02
Wards for older people with mental health problems	Charlton Lane Centre Stonebow Unit	RTQ01 RTQX1
Wards for people with a learning disability or autism	Hollybrook Westridge	RTQ54 RTQ05
Community-based mental health services for adults of working age	Trust HQ, Rikenel, Montpellier, Gloucester, GL1 1LY	RTQXX
Mental health crisis services and health based places of safety	Trust HQ Wotton Lawn	RTQXX RTQX2
Specialist community mental health services for children and young people	Trust HQ, Rikenel, Montpellier, Gloucester, GL1 1LY	RTQXX

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Community-based mental health services for older people	Trust HQ, Rikenel, Montpellier, Gloucester, GL1 1LY	RTQXX
Community mental health services for people with a learning disability or autism	Charlton Lane Centre Trust HQ Hollybrook Oak House	RTQ01 RTQXX RTQ54 RTQX2

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

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Ratings

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

Overall rating for services at this Provider	Good 
Are Mental Health Services safe?	**Requires improvement** 
Are Mental Health Services effective?	**Good** 
Are Mental Health Services caring?	**Good** 
Are Mental Health Services responsive?	**Good** 
Are Mental Health Services well-led?	**Good** 

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

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

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

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

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Overall summary

We found that 2gether NHS Foundation Trust was performing at a level which led to a judgement of good because:

We rated two of the 10 core services that we inspected as 'outstanding' overall and seven 'good' overall.

- 2gether NHS trust has much to be proud of. The majority of patients and carers were positive about their experiences of receiving care and treatment. Staff were caring, enthusiastic and committed to delivering high quality care and treating patients and carers with dignity and respect. Across the majority of services patients had good access to emotional support and clear evidence that staff considered patient's diverse and cultural needs.
- The trust was well-led with an experienced, skilled and committed board, including an inspirational, astute and dedicated executive leadership team, insightful and supportive non executives and a dedicated board of governors who provided a robust level of challenge. There were many skilled and enthusiastic leaders and staff throughout the organisation who were working hard to manage the day to day delivery of care, whilst striving to improve the quality of services and provide evidence based and innovative approaches to care and treatment to ensure services would be sustainable and fit for the future. Staff morale was very good across the trust and staff spoke highly of the leadership of the organisation.
- Two of the trust services received an overall rating of 'outstanding. The crisis and health based place of safety service and acute inpatient services for adult of working age. Both of these services were able to demonstrate excellent practice and innovation which went above the standards expected.
- The crisis and health based place of safety services received a rating of 'outstanding' for the key questions, 'are services caring' and 'are services responsive' and a rating of 'good' for all other key questions; giving an overall 'outstanding' rating. There was a strong person centred culture within the teams where staff supported patients with wider needs including physical health, emotional wellbeing and social needs. The heath-based place of safety was well managed and was purpose built to provide a safe and effective service. The crisis teams saw patients quickly and patients had thorough, up-to-date risk assessments and care plans, which looked at both their physical and mental health needs.
- The acute in patient services received an 'outstanding' rating for the key questions, 'are services safe' and 'are services well-led' and a rating of 'good' for all other key questions; giving an overall 'outstanding' rating. There was an underlying philosophy of providing care in partnership with patients and tailoring interventions to meet patient's individual needs. There was excellent relational security on all wards and an open door policy which allowed patients to come and go as they wished but clear and positive management of patients who were detained under the Mental Health Act. Traditional seclusion was not used, instead staff worked with patients to effectively manage challenging behaviour and interactions were considered and supportive. The environment supported the delivery of high quality care and there was a culture of continuous improvement.
- We found that there were some aspects of care and treatment in some services that needed improvements to be made to ensure patients were kept safe. However, the vast majority of services were delivering effective care and treatment. Staff fully supported patients with their wider needs including physical health, emotional wellbeing and social needs, treating them with kindness and respect while involving them in their care and treatment. Across all services the staff were good at recognising when patients and carers needed safeguarding and the trust encouraged staff to report incidents; incident reporting in all services was good. There was a widespread culture of learning from incidents and there was shared learning across services, through regular 'briefing notes' and bulletins.
- Bed management practices were good and we saw effective systems in place for access and discharge across all adult inpatient areas. The trust had only recorded five delayed discharges in the last six months and these were reasons outside of its control. We

heard of plans which commissioners had in relation to the new provision of children's inpatient beds (known as tier 4), as there are non-available within the trusts catchment area.

- The trust had a programme to reduce the use of restrictive interventions on wards which was in the early stages of development. The aim was to work towards eliminating the use of these approaches as reflected in the "positive & safe" national programme. The trust had adopted two nationally recognised models of behavioural management; positive behaviour management (PBM; for learning disability & older adult services in Gloucester) and preventing and managing violence and aggression (PMVA; for working aged adult and older people's services in Herefordshire). Both these models advocated the least restrictive intervention being used.
- Staff across the trust had good access to mandatory training, there was good induction programmes for all staff, as well as opportunities for continuous professional development. In the majority of services 80% (or above – up to 100% in some services) of staff had completed mandatory training. The trust declared that 48% of staff had received training about the Mental Health Act (MHA). The trust provided MHA training but this was not mandatory. However, it was incorporated into the matrix of 'professionally required' training and recommended for clinical staff working at bands five and above. All new health care assistants participated in training for the Care Certificate, a national induction standard for healthcare assistants. The trust planned to ensure that all HCA had access to this training.
- Staffing levels were generally good across all inpatient and community teams. Where bank and agency staff was used, the wards and community teams tried to use the same staff for continuity of care and often trust staff would work bank shifts. The highest proportion of staff vacancies was across the inpatient learning disability services. The trust was managing these vacancies within a plan agreed with commissioners in order to minimise the potential impact on staff redundancies from the ongoing reconfiguration of the service. We observed excellent multidisciplinary working across the trust.
- The trust had its own occupational health service called "working well" and was led by a consultant occupational health physician. The service aimed to improve the health and wellbeing of staff, both within the trust and for external public and private sector organisations.
- The trust had a clear vision; to "make life better" for the patients in its care and the carers who supported them. It had established this through a consultation process and aimed to achieve this through delivering high-quality care which would have been suitable for "their own family members". Staff we met across all services and at all levels showed a high awareness of the trust's vision, priorities and commitments.
- We found that the trust had developed a detailed governance system to support it to achieve its vision. The process for monitoring risk was robust and the board were sighted on both the corporate and operational risks facing the organisation. These were presented in board meetings via a comprehensive risk register. Local services also maintained local, operational risk registers which fed into the strategic risk register.
- The structure of committees and meetings, which provided the board with assurance, were well established and effective. Most had non-executive director oversight. This ensured an objectivity and appropriate challenge. The trust achieved 'ward to board' assurance through a number of mechanisms. The trust governance committee oversaw all aspects of quality (patient safety; outcomes and experience) for the organisation. This included; safeguarding; infection control; patient safety and serious incidents; safer staffing levels for inpatient units; complaints and user experience; locality risk register monitoring and triangulation of information. This committee gave assurance to the board and provided notification on exceptions/ areas of concern. The trust had the right policies in place to support staff in their work.
- The board actively engaged with service users. We observed that board meetings started with a patient experience presentation, undertaken by someone who had first-hand experiences of using the trusts services. Each quarter the board received a service experience report which identified the experience of patients and

carers, provided examples of the learning that has been achieved, emergent themes from clinical services, complaints, concerns, comments and compliments and survey information.

- The trust had a strong track record of working in partnership with the independent sector using an integrated model to provide services in Gloucestershire. However, with the recent decision by Herefordshire council to remove social workers from the trust we had concerns about how well the system would operate in the future. We received many positive comments about the trust from clinical commissioning groups, local authorities and health watch groups. They told us the trust was proactive in its local relationships and provided an open and transparent dialogue. However, some third party organisations, representing specific patient groups, were less complimentary about the trust performance and how it engaged with them.
- We found the trust had effective systems in place for financial reporting. These along with key performance indicators for all teams ensured the trust management team were aware of the organisation's performance throughout the year. The trust planned to report deficit of £0.5m for 2015/16. It intended to return to breakeven in 2016/17, but this statement was based upon the full delivery of next year's cost improvement plan. This would be the first time the trust had forecast a deficit in 31 consecutive quarters of reporting a financial surplus.
- The friends and family test showed that an average of 75% of staff said they would be likely or extremely likely to recommend the trust as a place to receive care or treatment; 60% of staff said they would be likely or extremely likely to recommend the trust as a place to work and 85% of patient respondents were likely or extremely likely to recommend the trust services.
- The trust was committed to developing its services and had developed a number of excellent and innovative areas of practice including:
- The trust had established a recovery college. The college had been developed and co-delivered with service users. The recovery college provided courses and educational workshops that taught patients to become experts in their own recovery and self-care. The courses that were offered had been co-produced with patients
- There was a programme of Experts by Experience who were involved in a wide variety of trust activity including: recruitment of trust staff; research; committee activity; development and scrutiny activity etc.
- The Gloucestershire Young Carers organisation delivered an integrated project to support young carers of adults with mental illness
- The trust participated in the 'national viewpoint' study last year. The trust had been selected as one of two sites in the UK to pilot a survey about mental health stigma with Time to Change
- The trust participated in a number of Royal College of Psychiatrists' quality improvement programmes or alternative accreditation schemes. Acute wards for adults of working age had an 'excellent' accreditation rating from the accreditation for inpatient mental health services programme.
- Throughout the inspection the trust was very receptive to any comments that we made and we saw immediate action taken when we raised a concern. For example, it rectified a concern immediately about the environment at Lexham Lodge, a temporary facility used by the managing memory team in Gloucestershire whilst their facilities were being rebuilt. It made provision for patients to be seen at home if they could not attend another facility and stopped using Lexham Lodge to see patients altogether. The trust also made the decision to make Mental Health Act and Mental Capacity Act training mandatory for all clinical and appropriate other staff.

However,

- There were some area of care and treatment that clearly needed improvement. We received a number of negative comments from patients and carers. Some patients and carers expressed some serious concerns about the care, treatment and services they

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had received from the trust. They made it clear that they felt the trust needed to make improvements in some areas and take more appropriate action to deal with their complaints and concerns..

- Overall, we rated the trust as 'requires improvement' for the key question 'are services safe'? We found pockets of poor practice and poor services that needed improvement in wards for older people, rehabilitation wards, wards for people with learning disabilities and community services for older people and those for adults of working age. None of these were generic in nature or widespread across the trust.
- Whilst we welcomed the trusts approach to not using seclusion, we were concerned that staff within the learning disability wards were using a form of it but not recording it as such appropriately. The trust had been working with Gloucestershire clinical commissioning group and Gloucestershire county council to agree and develop a new model of care for patients with learning disabilities for some considerable time. Whilst there was a commitment by all to provide high quality services close to home for patients with complex needs and some redevelopment work has started at Hollybrook there had been several setbacks with the plans to develop a community supported living facility. In addition, there was no clear discharge process for patients and those with discharge plans had no timeframe for discharge.
- On one older person's ward (Jenny Lind); standards for privacy and dignity on mixed sex wards were not always met. There were no en-suite washing facilities or separate sleeping and washing areas for males and females but we saw plans the trust had for refurbishing the rooms to provide en-suite facilities.
- On rehabilitation wards policies and procedures were not always followed in ensuring incidents were reported and the facilities at Oak House needed significant improvement.
- In community services for older people staff working at the memory assessment services had caseloads of over 300 patients per full time worker, resulting in 11% of annual reviews being missed. There was a long wait of up to six months for access to psychological therapy in Herefordshire. Sickness levels were high in Herefordshire with one team at 9%; there was a lack of clinical supervision for staff and a lack of managerial supervision for staff in Gloucestershire.
- In community services for adults of working age sound proofing in the team base for Herefordshire meant that patient confidentiality could be compromised as conversation could be clearly heard outside of rooms used to see patients and cleaning arrangements needed attention to ensure all areas were clean and suitable for patients.
- In a number of services across the trust we had some concerns that staff did not always record all relevant information in electronic patient records (RiO). This included staff not recording risk assessments, risk alerts and medication reviews in care plans. Care plans were not always comprehensive and it was not always clear whether patients had been involved in developing their care plans. Crisis plans, outcome scales and consent to care documentation was missing from patient records some information was either not located in the correct sections or was missing altogether. Staff in community services experienced particular difficulties around the completion of records on RiO, travelling long distances to see patients, the inability to input information in 'real time' and having to go back to bases to input information impacted on their ability to maintain robust and contemporaneous records. However, the trust had developed a number of programmes of work to help address/improve this. The director of quality was leading work to ensure the trust met its milestones for delivering improvements.
- 2gether NHS Foundation Trust provided caring, effective and responsive services to the people it serves. In the main services were safe although some improvements were needed in some services. It was a well-led organisation and we are confident that the trust will continue to ensure it delivers high quality, contemporary and innovative services and will ensure improvements are made in all the areas that we have identified as needing improvement. We will be working with the trust to agree and action plan to assist it in making improvements were needed.

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated safe as requires improvement because;

- Prior to the inspection the trust was seeing patients in the memory assessment clinic at Lexham Lodge. The environment at Lexham Lodge was unsafe and unsuitable for older people accessing the building. The trust quickly arranged for all patients to be supported to attend appointments in other facilities or provided home visits.
- In learning disability in patient units we were concerned there may had been episodes of seclusion that were not recognised or recorded as such by staff. Staff did not always followed the trust policy on seclusion. Staff lacked a clear understanding of policies and how these should be applied.
- On one older persons' ward, standards for privacy and dignity on mixed sex wards were not met. There were no en-suite washing facilities or separate sleeping and washing areas for males and females. Ligature risks were not identified, lines of sight were obscured and the risks had not been mitigated against on older peoples wards.
- On rehabilitation wards policies and procedures were not always followed in ensuring incidents were reported and the facilities at Oak House needed significant improvement.

However:

- We welcomed the approach the trust had adopted with its 'no seclusion' policy. The PICU had reinvented their seclusion space into a 'tranquil room' which was equipped with soft lighting and furnishings. Patients reported that they enjoyed using this facility to help with relaxation.
- There were effective systems in place to ensure staff safety when working alone. Each team had local procedures in place for lone working and staff were aware of and adhered to the lone working policy. Security was good at each of the sites and each team adopted a code word should a staff member contact the office to raise concerns about their safety.
- Staffing levels were good across all inpatient and community teams. Where bank and agency staff was used, the wards and community teams tried to use the same staff for continuity of care and often trust staff would work bank shifts.

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- The trust had clear policies in place relating to safeguarding and whistleblowing procedures. Additional safeguarding guidance was available to staff via the trust's intranet. We saw guidance on how to effectively report safeguarding concerns throughout the trust

Are services effective?

Good

We rated effective as good because;

- All teams across the trust had access to a range of multi professional staff including medics, psychologists, occupational therapists, pharmacists, nurses (both qualified and unqualified) and other support staff, including catering and domestics.
- All patients in mental health services were assessed and monitored using the health of the nation outcome scales (HoNOS), which covered twelve health and social care domains.
- All services across the trust would meet on a regular basis to review the care and treatment of patients. These varied form daily reviews, to weekly to monthly depending on the type of service and level of contact patients required.
- Generally NICE guidelines were followed for prescribing medication and the management of medicines across the trust was good. Medicines were stored correctly and overall monitoring of medications, sell by date and stock, was undertaken by the pharmacists.

However:

- Some patients in the older adult wards and one patient within the learning disability wards had received medication covertly and the team had not followed the trust policy.
- In the older adults community teams in Herefordshire, only one out of 16 staff had received clinical supervision, two out of 16 staff had received peer supervision and four out of 16 staff had received management supervision in the past 12 months. Ten out of 20 appraisals had not been completed within the past 12 months. Staff said this was due to a lack of management structure since April 2015. Staff told us they felt stressed and unsupported as a result. The senior management team were not regularly supervising managers in the later life team in Gloucestershire.

Are services caring?

Good

We rated caring as good because;

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- Patients who used services and carers spoke very positively about the care they received and told us staff listened to them and responded with kindness and understanding.
- We observed dedicated, supportive and motivated staff. We observed staff delivering exemplary care during some home visits which involved and respected patients and their carers
- Carers were routinely involved in the provision of care and treatment to patients. Consent to share information with carers was documented. Staff ensured that patients were given the opportunity to change their consent if they wanted to. The majority of carers told us they felt supported and informed about the care and treatment provided by the teams.
- We found patients were orientated to the wards which they were admitted. They were provided with a welcome pack, including information about the wards, the Mental Health Act, and advocacy. Family and carers also received an information pack, including information about the wards and where they could access support.
- The service was developing the "Triangle of Care" which is a national programme advocating a therapeutic alliance between patients, staff and carers to promote safety, support recovery and sustain wellbeing. We did find some variations on how this was being rolled out across services.
- On many wards patients, family and carers were included in the decisions about their care. They were listened to by the professionals involved. On inpatient mental health wards for older adults, care plans were holistic and took into account the patients' views, and those of the family and carers.
- There were some examples of patients on long stay rehabilitation wards being involved in the recruitment of staff in local teams, as well as more senior positions within the trust.

However:

- Care records did not always show patient and carer involvement or appropriate documentation of consent in specialist community teams for children with mental health problems. The inspection team spoke with children and young people and carers. They reported that they were involved in care planning but this was not documented.
- Consent to care was sometimes not well documented on electronic care records held by community based mental health teams for older people.
- On inpatient wards for older adults with mental health problems, there was not consistency around the 'triangle of care', and evidence of the triangle of care assessment tool being used with patients. The triangle of care is a best practice guide

for how professionals, service users and carers can better work together. It was seen in the bedrooms on some wards, including documentation with the names of the people involved in that patient's care.

Are services responsive to people's needs?

Good

We rated responsive as good because;

- The crisis teams acted as "gatekeepers" of inpatient mental health beds. The proportion of admissions to acute wards gate kept by the crisis teams was higher than the England average for the year prior to the inspection and reached 100% in quarters three and four. This ensured patients only had to go into hospital if it was absolutely necessary, and every effort was made to support them at home in their own environment. The crisis team were able to prevent unnecessary admissions to acute hospital beds by effectively supporting patients in their own homes.
- Both community settings and inpatient services were fully accessible for people requiring disabled access. This included the provision of wheelchair access to bedrooms and assisted bathrooms.
- We found the trust was very responsive to concerns we highlighted during the inspection One example was about the environment at Lexham Lodge, a temporary facility used by the managing memory team in Gloucestershire, whilst their facilities were being rebuilt. The environment at Lexham Lodge was unsafe and unsuitable for older people accessing the building. The trust quickly arranged for all patients to be supported in appointments and home visits, rather than outpatient appointments at Lexham Lodge.
- We reviewed complaints information during the inspection. This detailed the nature of complaints and a summary of actions taken in response. We found that complaints had been appropriately investigated by the trust and included recommendations for learning. The trust had recognised that it had been struggling to complete the complaint responses within 28 days and had devised an action plan to remedy the situation.

However:

- There was lack of an identified crisis team for patients with a learning disability in Herefordshire. The mental health crisis team would not respond where the person had a learning

disability as this did not meet their referral criteria. However, in Gloucestershire a specialist team had been developed to support learning disability patients in crisis which had helped to prevent hospital admissions.

Are services well-led?

Good

We rated well led as good because;

- Staff knew about the trust's vision and values and the service had a staff charter based on the trust values and expectations which they discussed during appraisals. Managers conducted value based interviews for potential new staff.
- The trust had governance processes in place to manage quality and safety within the service. Managers attended local meetings where trust wide incidents were reviewed, service quality and risk was discussed and audit results were considered. The information was then discussed with staff at team meetings and in supervision sessions to ensure consistency and make improvements to the service.
- Staff morale was generally good and it was reported that the trust was a good employer. Staff felt listened to and valued and were very complimentary about the support received from their immediate line manager. However, the morale of some staff was low which they attributed to poor staffing and lack of line management. Some staff told us they felt uninformed of imminent changes within the service, but these were not directly related to the trust although would inevitably impact on effective working relationships.

However:

- Within the learning disability wards we identified that care plans and risk assessments were reviewed on a regular basis, however this process had not identified issues around the use of seclusion and covert medication. We did not identify any peer reviewing or other quality checking processes in place.

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Our inspection team

Our inspection team was led by:

Chair: Vanessa Ford, director of nursing standards and governance, West London NHS Trust

Team Leader: Karen Bennett-Wilson, head of inspection, Care Quality Commission

The team of 77 people consisted of:

CQC staff -

- an inspection manager
- 13 inspectors
- nine assistant inspectors (inputting evidence from inspection to pilot electronic evidence table)
- two observing inspectors
- two pharmacist inspectors
- a CQC operational development lead
- a governance specialist advisor
- a CQC report writing coach
- seven Mental Health Act reviewers
- an inspection planner
- two analysts

Specialist advisors –

- 22 nurses with a variety of specialties including mental health nursing and learning disability nursing
- five specialist advisors with experience in managing services
- one consultant psychiatrist
- two social workers
- a physiotherapist
- an occupational therapist
- a clinical psychologist
- three experts by experience (people who had personal experience of using either mental health or community health services or caring for someone who had used these services).

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection, the inspection team:

- Requested data and policies from the trust and reviewed this information.
- Conducted 16 focus groups with staff across 4 sites.
- Asked a range of different organisations for information, including Monitor, NHS England, clinical commissioning groups, Healthwatch, Health Education England, Royal College of Psychiatrists and local patient representative groups
- Distributed comment cards and comment boxes to various trust sites to gather feedback from patients, visitors and staff.

During the announced inspection the team:

- Visited 18 wards and 28 community teams.
- Spoke with 124 patients, 2 ex patients and 81 carers of people who used the service, and received back 149 comment cards.
- Reviewed 270 patient records
- Held two open events to gather feedback from the local community.

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- Spoke with 271 members of staff.
- Attended 29 handovers and multidisciplinary team meetings.
- Joined five service user meetings
- Joined 22 clinical appointments and visits
- Made additional requests for information to clarify what had been gathered on-site
- Interviewed eight senior executives and directors

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

Information about the provider

2gether NHS Foundation Trust provides mental health and learning disability services across the counties of Gloucestershire and Herefordshire to a population of 761,000 people. It has an annual budget of £106,300,000. The trust has three main hospital sites; Wotton Lawn, Stonebow Unit and Charlton Lane Centre". Greyfriars is only a 12 bedded PiCU and is part of the Wotton Lawn campus. The total number of inpatient beds within the trust is 226.

We inspected the following core services:

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Forensic inpatient / secure wards
- Wards for older people with mental health problems
- Wards for people with a learning disability or autism
- Community-based mental health services for adults of working age
- Mental health crisis services and health based places of safety
- Specialist community mental health services for children and young people
- Community-based mental health services for older people
- Community mental health services for people with a learning disability or autism

We did not inspect substance misuse services or the specialist services including the eating disorder and improving access to psychological therapies services.

In Gloucestershire Health and Local Authority mental health services are fully integrated in services for adults of working age. Children and young peoples services, learning disability and older people's services are not integrated. In Herefordshire services for adults of working age, older people's and learning disabilities services were integrated but the integration arrangements ended in March 2104 and ended in March 2015 for services for adults of working age and older people's services. Children and adolescent mental health services in Herefordshire have never operated as an integrated service.

The trust has been working with Gloucestershire clinical commissioning group and Gloucestershire county council to agree and develop a new model of care for patients with learning disabilities for some considerable time. The strategy is to provide a range of health and social care support, including, inpatient services, intensive support services to help patients stay in their own home (normal place of residence) when in crisis and community supported living placements.

2gether NHS Foundation Trust received foundation trust status in 2007. The organisation now provides services from more than 34 places in Gloucestershire and more than 18 places in Herefordshire. It has an income of about £106 million, and employs more than 2300 staff.

The trust has nine locations registered with the Care Quality Commission. Previously the trust had received 10 inspections across five locations between 2011-14 and there had been only 2 concerns identified at the Charlton Lane centre.

What people who use the provider's services say

During the inspection took place we met with a variety of different groups of patients, carers and other user

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representative groups during two listening events. In the main comments were positive -.with people saying they had received good care and treatment and that services were responsive. Patients and carers praised staff for their kindness and thoughtfulness.

We also had written feedback from both local Healthwatch groups and also received feedback from two independent mental health advocacy services.

However, received a number of negative comments from patients and carers. Some patients and carers expressed some serious concerns about the care, treatment and services they had received from the trust. They made it clear that they felt the trust needed to make improvements in some areas and take more appropriate action to deal with their complaints and concerns..

We received 149 comment cards that were left in patient areas before our inspection, of which 72% (107) were positive, 7% (11) negative, with the rest neutral. Positive comments included that staff worked hard, were helpful, listened and had a positive impact on patient care. Patients mainly felt listened to and treated with dignity and respect.

During the inspection the teams spoke to 124 patients using services, two ex-patients and 81 carers, either in person or by phone. We also received individual comments from people through our website or by phone.

Good practice

Trust wide

- The recovery colleges provided patients with opportunities to socialise, learn, develop their self-confidence and acquire relapse prevention skills. They also provided psycho-education in understanding mental health difficulties and gave patients the opportunity to become trainers themselves.

Core services

Crisis team and Health based place of safety

- Staff went over and above their remit by supporting patients before a formal referral had been received. While referrals were being taken, we saw staff busy gathering as much information as possible to ensure that they were as prepared as they could be to support the patient without delay.
- Staff ensured that each patient was followed up after they had been discharged or transferred to another team. They made contact with the patient and new team to ensure that care and treatment was progressing. This meant that patients were provided with a seamless service as they moved on from the crisis teams. This also meant that the risks of a patient not receiving a follow-up service were significantly reduced.
- Gathering feedback was embedded within all teams. Staff gathered information verbally and by using formal questionnaires. Staff used the information to improve their services and demonstrated the value they placed on listening to patients.

Community services for people with a learning disability

- The Intensive health outreach team provided intensive support to patients with a learning disability in Gloucestershire to ensure the physical health needs of patients with a learning disability were met. This service was dynamic and responsive and looked for innovative ways to help patients achieve good health outcomes. For example, a gentleman with a heart condition was non-compliant with blood pressure monitoring, EEG's and taking fluids. Staff within the team worked intensively to help him accept the blood pressure cuff and ensure his fluid intake improved.
- The Hereford CLDT had developed a range of good, preventative groups to help patients who used services remain physically and mentally well. For example the healthy options group was an interactive session that included six service users and one carer. It focussed on healthy eating and mindfulness. It provided opportunities for patients who use services to learn about physical well-being and interact with other patients in the community.

Wards for older adults

Summary of findings

- In response to the increase in patients with palliative care needs, the trust had made a decision to offer end of life care on the older age adult wards, where the patient has been in the service for a short time (unless they chose to go home). This was consistent with the local strategic priorities. End of life care was delivered in accordance with the shared care pathway. The Stonebow Unit had recruited a doctor who was a specialist in end of life care. Both sites had strong relationships with the palliative care teams, palliative care consultants and the hospices, and were supported by them. GPs, geriatricians and physical health care nurses also supported the end of life care packages in line with the leadership alliance for the care of dying people "one chance to get it right" guidelines. The modern matrons sat on the internal steering group that fed into the local authority end of life care agenda.

Community services for older adults

- The managing memory team ran a dementia training and education programme. They had recently won a community dementia link award after training 400 fire fighters about aspects of supporting people with dementia. They had also won a dementia leadership award, which recognised their outstanding contribution to training in dementia. The team had written an intergenerational play using their established links with schools and funded the delivery of the play from local charities and the 'big lottery'. The local university filmed the play, called 'Al's yellow slipper', which the audience said sent a strong person centred message about living with dementia.

Specialist community services for children and young people

- The children and young people's team in Gloucester provided the reunification project that supported the safe return of children and young people in care, back to their families using a multi-agency approach.
- Hereford CAMHS had been working with the local military base providing a prompt and responsive service to children of military personnel so that they can access support at the earliest opportunity.

Areas for improvement

Action the provider MUST take to improve

Inpatient wards for older people

- The trust must enable patients to participate in decision-making as far as they are capable of doing so in relation to the care plan and Section 17 leave according to the Mental Health Act (MHA) Code of Practice 1.10.
- The trust must ensure patients are aware of any contingency plans put into place for their support when they are on Section 17 leave, including what they should do if they think they need to return to hospital early. Leave should take into account the patient's wishes, and those of carers, friends, and others who may be involved in any planned leave of absence in adherence to 27.10 of the MHA Code of Practice.
- The trust must ensure that there is evidence in all files of the responsible clinician's record of their assessment of the patient's capacity to consent at first administration of treatment for mental disorder in all records.

Community learning disability teams

- The trust must ensure there are local systems and processes in place to assess, monitor and drive improvements in the services they provide.

Community older adult teams

- The trust must improve the safety of the temporary premises at Lexham Lodge to ensure the premises are suitable for the purpose for which they are being used.
- The trust must provide regular supervision for staff in the Herefordshire teams and managers in the community Gloucestershire teams
- The trust must improve the accurate recording of patient information onto one shared data system

Community mental health teams for adults of a working age

Summary of findings

- The trust must ensure cleaning schedules and procedures are in place and that buildings and equipment are being kept clean and being adequately maintained.

Long-stay or rehabilitation wards

- The trust must ensure that facilities are clean and that environmental hazards are managed safely.
- The trust must ensure that all incidents are reported and managed appropriately.
- The trust must ensure that physical health checks are conducted following oral rapid tranquilisation.

Ward for people with a learning disability

- The trust must ensure staff fully understand the policies and procedures relating to seclusion, patients have a robust care plan in place for using the seclusion room and are aware of their rights and that up to date and accurate records are kept when using the seclusion room for non-seclusion purposes.
- The trust must ensure patients have copies of their care plans in a format they can understand.
- The trust must ensure they keep a record of why the patient does not have a copy of their care plan.
- The trust must ensure they review patient's ability to consent and all appropriate people are included in review meetings.
- The trust must ensure all covert medication is given in accordance with trust policy.

Action the provider SHOULD take to improve

Long-stay or rehabilitation wards

- The trust should ensure that appropriate measures are taken to ensure patients privacy and dignity is maintained when conducting observations.

Ward for people with a learning disability

- The trust should ensure that all equipment in the clinic rooms is in date and replaced when necessary
- The trust should ensure the reason for any cancelled leave is recorded
- The trust should ensure the uniform is appropriate to the patient group while meeting the needs of the staff
- The trust should continue to engage with other stake holders and providers to facilitate a timely discharge of all patients
- The trust should ensure the complaints procedure is suitable for the patient group.
- The trust should ensure the supervision policy is consistently applied.
- The trust should ensure there is suitable management cover at Hollybrook

Community CAMHS

- The trust should consider the management of recording on the electronic recording system and the quality of this across all specialist mental health services for children and young people. This would ensure care plans were person centred, crisis plans were completed, and consent for treatment was recorded.
- The trust should place more emphasis on complaints ensuring that children and young people know how to make them.
- The trust should improve access to suitable waiting areas in Hereford and ensure appropriate soundproofing to maintain confidentiality at Evergreen House and the Linden centre.
- The trust should improve the management of waiting lists to reduce the number of children and young people waiting for the CYPS and CAMHS services.
- Advocacy should be offered to all children and young people receiving a service and staff should be trained to understand why independent support is needed. The trust need to address this with commissioners and partners.

Inpatient wards for older people

- The trust should ensure that the ligature risk assessment actions and outcomes are detailed on the assessments held at ward level.
- The trust should ensure that there is a consistent approach to the handover discussions on the wards for older people with mental health problems.

Summary of findings

- The trust should ensure that there is a system in place to safeguard children whilst they are visiting the service.
- The trust should ensure that female only lounges are clearly identified for patients.
- The trust should ensure that medications in the clinic room are kept within the required temperature range through monitoring the temperature.
- The trust should consider positive risk taking on the wards for older adults with mental health problems and accept that patients could be cared for in a less restrictive environment, and that all risk should be documented and care planned as appropriate.Where restrictions are in place, the provider should consider how to make the staff and patients aware of these restrictions.
- The trust should ensure that the service actively promote advanced decisions with the patients on the wards.
- The trust should ensure that the service reviews their practice for patients receiving "extra care" to be clear that this is not long term segregation, and takes into account the views of the person's family and carers, and involve an Independent Mental Health Advocate where a patient has one, in line with 26.150 of the MHA Code of Practice.
- The trust should ensure that staff in the service have a clear understanding of evidence based psychosocial interventions as recommended by NICE, and their role in applying these in their practice. The provider should ensure that the planned reviewed of psychosocial interventions is completed for each ward.
- The trust should ensure
- The trust should ensure
- The trust should ensure that there is consistency around the 'triangle of care', and evidence of the triangle of care assessment tool.
- The trust should ensure that the patients on t
- The trust should make a decision regarding the use of the two additional beds that are not commissioned on the Cantilupe ward and define their purpose and effectiveness
- The trust should ensure
- The trust should assure itself that all administration of covert medication is subject to 'scrupulous adherence' to good practice and legislation.

Community older adult teams

- The trust should review caseloads in the memory services so there are enough staff to review patients annually and update their care records accurately following assessments.
- The trust should consider how waiting times for psychological therapies in Herefordshire could be improved so patients have timely access to services to meet their needs.
- The trust should improve communication and consider how to reform links with the recently departed social services departments in Herefordshire.
- The trust should ensure patients know how to complain and feedback about their services.
- The trust should improve the supervision and support issues in Herefordshire so staff feel less stressed, more supported and sickness absence levels decrease to the trust's benchmark of 4%.
- The trust should consider how it could engage with and involve staff more in decisions about service development.

Community mental health teams for adults of a working age

- The trust should ensure staff know which incidents to report.
- The trust should ensure all patients who need them have appropriate crisis and contingency plans in place and advanced decisions if they wish to make them.
- The trust should ensure refrigerator temperatures are checked daily in line with their policy.
- The trust should ensure patients are always offered a copy of their care plan.
- The trust should ensure all rooms are sound proofed to ensure patient confidentiality.

Community learning disability teams

Summary of findings

- The trust should ensure that all risk assessments completed are recorded on RIO and that regular reviews are undertaken.
- The trust should ensure that governance is embedded within all teams and that clear audit responsibilities are identified and audits are carried out across all teams
- The trust should ensure that robust performance management processes are developed.
- The trust should ensure there is effective monitoring of waiting times and that caseload management is undertaken.
- The trust should ensure staffing establishments are reviewed against a safer staffing tool.
- The trust should ensure there is a robust and consistent system of recording formal supervision and that this is monitored and reported.

Mental health crisis services and health-based places of safety

- Mental capacity assessments are consistently recorded in the same place, so that staff can easily reference and find them.
- Physical health screening checks and updates are consistently recorded in the same place, so staff can easily reference and find them.
- Staff supervision is effectively recorded and stored by local managers.

Acute wards for adults of working age and psychiatric intensive care units.

- The trust should ensure that it is able to provide evidence that it complies with section 132 of the Mental Health Act. We found evidence that patients do not always have their rights explained to them.
- The trust should ensure that they develop more effective ways of recording that patients understand and agree with time limits set for community leave.
- The trust should ensure effective recording of assessments of capacity. We were informed that capacity assessments are undertaken weekly but could find no evidence of this in patient's notes.
- We found two cases where medication had been prescribed which had not been authorised by a second opinion doctor. We pointed this out and this was rectified immediately. The trust should ensure that they develop systems or audit measures to monitor second opinion adherence.
- The trust should ensure that all patients detained under the MHA are routinely and regularly provided information under Section 132 of the MHA surrounding their rights. The Trust should ensure that there are systems in place to monitor compliance with this.
- The trust should ensure that all relevant staff are provided with training on the use of the MHA and CoP and MCA. It should ensure that staff understand their responsibilities under these acts.

2gether NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

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

- Appropriate arrangements were in place for the safe management and administration of the Mental Health Act and the Code of Practice. Administrative and legal support was provided by the head of health records and his team.The team were based on three sites.
- The head of health records and his team covered the administration of the Mental Health Act, and the deputy director of nursing took a lead with clinical practice and policies relating to the Mental Health Act. There was no post with overall Mental Health Act responsibility within the trust.
- The records manager produced a quarterly Mental Health Act key performance indicator report, which was presented to the trust's mental health legislation scrutiny committee. This committee met every two months and was chaired by a non-executive director of the trust. The committee was multi-disciplinary and had representation from the head of health records, the head of profession for social care and approved mental health professionals, modern matrons, section 12 approved doctors, and community teams. The committee's purpose was to ensure the trust's compliance with the Mental Health Act, Mental Capacity Act, and Human Rights Act and associated codes of practice. It reviewed Mental Health Act specific policies. Medical recommendations were scrutinised by two designated consultant psychiatrists.
- The responsibilities under the Mental Capacity Act and Deprivation of Liberty Safeguards were not dealt with by the Mental Health Act team. A nurse consultant was the trust lead for the Mental Capacity Act, and was a member of the Mental Health Act Scrutiny Committee.
- The trust was conducting a number of audits to ensure it was applying the Act correctly. These included audits on section 132 rights, capacity and consent, second opinion appointed doctors, section 17 leave, and consent to admission and treatment.
- There were two multi-agency Mental Health Act groups, one in Herefordshire and one in Gloucestershire at which the trust, the AMHP service, the police, the ambulance service and other agencies involved in mental health services were represented.
- There were a number of lay individuals who acted as Mental Health Act managers. We met with some of the managers, who told us about their work. They spoke positively of the local situation.
- During our inspection we undertook nine Mental Health Act review visits in inpatient settings. These were spread across older persons', adult acute, rehabilitation, and learning disability services. We examined a significant number of legal detention records and found them in good order. There was an effective scrutiny process, which had identified some mistakes in the legal documentation, which had been corrected. Adherence to the consent to treatment requirements was to some

extent limited and further work was required to improve practices. Patients' rights were explained in accordance with section 132 but in a number of situations this had not been done in a timely manner. Patients were regularly accessing leave. However, we noted that leave forms were not always fully completed so it was not possible to see if patients had been given a copy of the leave form. In some services we saw very good examples of care plans, however there were some examples of care plans with insufficient patient involvement and recording of patient views, and standardised care plans.

- There were some examples of concerns identified in the recording and interpretation of practice around both covert medication and restrictive practice. These issues were identified in some records for older people and those with a learning disability.Access to and uptake of Mental Health Act and Mental Capacity Act training for staff was considered to have been a contributory factor. In learning disability services some staff expressed concern at the lack of a senior service manager with overall responsibility for learning disability. The revised Code of Practice has significant new advice impacting on practice in learning disability services, yet staff had not received any service wide training on this.
- The older adult wards did not actively promote advanced decisions with the patients on the wards and some patients were not always involved in the decisions in relation to their care plan and Section 17 leave. This leave did not always take into account the patient's wishes, and those of carers, friends, and others who may be involved in any planned leave of absence. Patients were not always aware of any contingency plans put into place for their support when they were on Section 17 leave, including what they should do if they think they needed to return to hospital early.
- We had contact with the independent mental health advocacy service, who commented positively on its links with the trust. Details of the service were available throughout the trust.
- In Gloucestershire Health and Local Authority mental health services are fully integrated in services for adults of working age. Children and young peoples services, learning disability and older people's services are not integrated. In Herefordshire services for adults of working age, older people's and learning disabilities services were integrated but the integration arrangements ended in March 2104 and ended in March 2015 for services for adults of working age and older people's services. We met with senior social care staff involved in the approved mental health professional (AMHP) service. AMHPs reported good partnership working. When a mental health act assessment was undertaken, the AMHPs reported that beds were generally available within the trust. In Herefordshire, health staff who had trained as AMHPs were now not required to practice as such in that county following the de-integration of services.
- Training on the new Code of Practice had been incorporated into a professional development day for a small number of staff. However, many staff that we spoke with had not received this training and so did not fully understand the changes. The revised Code of Practice was not available on all wards. Mental Health Act and Mental Capacity Act overview sessions were available for staff to attend, however Mental Health Act training was not mandatory for clinicians at the time of the inspection. Although the trust did change this during the week of the inspection. Approved mental health professionals (AMHPs) accessed external training.
- The trust had updated some of its policies in line with the revised Code of Practice; however this was still a work in progress. Mental Health Act Administration policies came under the remit of the mental health legislation scrutiny committee; however the wider clinical implications of the revised Code of Practice did not. We did not identify a clear programme of policy implementation to cover all policy changes indicated in the revised Code of Practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

- There were 13 Deprivation of Liberty Safeguards (DoLS) applications across the trust between 1st May 2014 and 30th April 2015. Eight were granted. Chestnut ward was the only ward with successful DoLS applications. They had the most applications: five applications were made and three were granted.There were no applications made on the Hereford wards in this time period. Where

applications were not granted, the patient's care and any restrictive practice was reviewed in the multi-disciplinary meeting using the standard meeting agenda we observed.

- Prior to the inspection, training on the Mental Capacity Act 2005 (MCA) was not mandatory across the trust. The trust reported that 51% of staff were compliant with regards to MCA training. MCA training was not on the statutory and mandatory agenda, although it was included on the corporate induction.Staff demonstrated a good awareness of the MCA and the implications this had for their clinical and professional practice.
- The RiO system allowed for capacity assessments for patients. However, this was not always recorded in the specific section of the database and was sometimes recorded in the daily record of contact / activity. This meant that there was the potential that assessments and decisions relating to mental capacity could be missed by staff. Mental capacity was also discussed in multidisciplinary meetings and daily handover meetings.
- The trust had a MCA and DoLS policy on the intranet. Staff told us that they could access further support from a consultant nurse who was the trust lead on MCA and DoLS.
- The implementation of Mental Capacity Act and Deprivation of Liberty Safeguards was overseen by the Mental Health Act scrutiny committee, and actions implemented, evidenced through the scrutiny committee Board report.
- We saw evidence of mental capacity being reviewed in the standard multi-disciplinary team meeting agenda, as well as in the discharge plans. There was evidence in the records of the capacity assessments, and clinical and best interest assessments for each individual decision. The best interest decisions took into consideration the person's wishes and took account of their history.

Requires improvement

Are services safe?

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

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

Summary of findings

Our findings

We rated safe as requires improvement because;

Safe Environment

- Wards and community bases where patients were seen were clean and safe, with the exception of the community facilities at Hereford, Lexham Lodge and Oak House. Oak House in particular, was poorly maintained. The wall paper was peeling and the skirting boards were stained. The layout of the building made it difficult for staff to ensure the safety of patients as staff could not ensure observation could take place. The environment at Lexham Lodge was unsafe for older people accessing the building.
- With the exception of older people's wards, ligature risks were well identified throughout trust and all areas had

up to date and complete ligature audits with actions. Where lines of sight were obscured, all wards had taken action to mitigate risks through the use of wall mounted / ceiling mounted mirrors.

- The majority of the wards that were mixed gender had separate facilities for men and women. However, on Jenny Lind older persons' ward, standards for privacy and dignity on mixed sex wards were not met. There were no en-suite washing facilities or separate sleeping and washing areas for males and females.
- 'Patient-Led Assessments of the Care Environment' (PLACE) survey scores showed that the Trust exceeded the national average for food provision at 94% with national average being 90%, treating people with dignity and providing privacy being 95% with the national average being 89% and the condition, appearance and maintenance of buildings being 98% with the national average being 91%.
- The trust operated a 'no seclusion' policy. The PICU had converted their seclusion space into a 'tranquil room' which was equipped with soft lighting and furnishings. Patients reported that they enjoyed using this facility to help with relaxation. Learning disabilities did have the ability to seclude and had padded rooms that patients were encouraged to use in order to minimise self-harming behaviours.

Safer Staffing

- Staffing levels were generally good across all inpatient and community teams. Where bank and agency staff was used, the wards and community teams tried to use the same staff for continuity of care and often Trust staff would work bank shifts. The PICU ward at Wotton lawn, Westridge and Hollybrook units all reported the highest use of bank and agency use over the three month period prior to inspection, with 495, 466 and 450 (respectively) shifts being covered.
- The trust operated a three shift system on the wards in Gloucester. Hereford staff worked 12 hour shifts over a three and four day week. The Trust intended to introduce 12 hour shift working at Gloucester.
- Most staff had completed the training which the trust had deemed mandatory. For example, 86% of staff for community learning disability (LD) and autism services were compliant with statutory and mandatory requirements. 86% of staff were complaint within community mental health teams. Long stay rehabilitation ranged between 87% and 97%. 75% of staff working within old people inpatients were compliant and old people's community services ranged between 94% and 95%. Some examples of statutory and mandatory training are health and safety, manual handling, physical interventions, Infection control and safeguarding.
- Westridge and Hollybrook units all reported the highest use of bank and agency use over the three month period prior to inspection with 495, 466 and 450 (respectively) shifts being covered. This was in the main a supported planned use of bank and agency staffing which had been agreed with commissioners to minimise the likelihood of redundancies associated with the redesign of these LD in-patient services.
- The highest proportion of staff vacancies was across the in-patient LD services, where the trust were managing vacancies within a plan agreed with commissioners to minimise the potential impact on staff redundancies from the ongoing reconfiguration of the service. The lowest proportion of vacancies was within the older peoples services with the trust reporting 3% of staff vacancies.

Track record on safety

- The trust reported a total of 2603 incidents to the National Reporting and Learning System (NRLS) between 1 April 2014 and 31 March 2015.This was an average reporting rate for NHS trusts. Incident analysis showed the highest proportion were listed as patient accidents and accounted for 700.
- Trust staff reported 45 serious incidents (SI) between 1 April 2014 and 30 March 2015, 22 of which involved the death of a patient. One SI unfortunately was a homicide of a member of staff on the forensic ward. There were no 'never events 'reported. We saw how these incidents were thoroughly investigated using a root cause analysis process to investigate and made recommendations for improvements in practice.

Learning from incidents

- Arrangements for reporting incidents were in place. Staff had access to an online electronic system to report and record incidents. Staff had received mandatory safety training which included incident reporting and were able to describe their role in the reporting process.
- Serious incidents were reviewed by the governance committee which was chaired by a non-executive director with the director of quality taking the executive lead. All lessons learned were contained in the board reports which trust leaders confirmed and minutes we reviewed showed were discussed at the monthly board meetings.
- Team managers confirmed clinical and other incidents were reviewed and monitored both through trust wide and the local governance meetings. They were then shared with front line staff through team meetings and bulletins. Most were able to describe learning as a result of past incidents and how this had informed improvements or service provision.

Safeguarding

- The director of quality was the executive with safeguarding responsibility and had a named lead who was clear about their role and responsibilities. Most staff knew who the trust lead was and felt comfortable with contacting the safeguarding teams if they had any significant queries.
- The trust had clear policies in place relating to safeguarding and whistleblowing procedures. Additional safeguarding guidance was available to staff via the trust's intranet. We saw guidance on how to effectively report safeguarding concerns throughout the trust
- The trust had an effective safeguarding monitoring process that regularly reviewed safeguarding issues at both a strategic business unit and wider trust level.
- There were 13 deprivation of liberty (DoLS) applications made by services across the Trust in the past 12 months. Of these, eight (61.5%) were not granted and two were repeat applications that were due to expire.
- Training requirements were managed in line with individual staff's job description and appraisal. Safeguard training ranged between 29% and 100% throughout all wards and community teams. Staff understanding of safeguard procedures and processes was good overall and staff were able to describe situations that would constitute abuse and could demonstrate how to report concerns. Staff were aware of the Trusts policies surrounding safeguarding and knew where and how to access them.
- The trust reported that there were 16 safeguarding alerts and concerns since April 2014 to the date of inspection. These occurred at the Stonebow unit, Wotton Lawn, Oak House and the Trust Headquarters. These were in relation to an unexpected death, serious injury, DoLs and the admission of a child into an adult psychiatric ward.

Assessing and monitoring safety and risk

- There were 160 incidents of restraint within the trust over the previous 6 months involving 79 patients, 35 of these incidents involved prone restraint recorded. Analysis showed that this occurred with one patient with a learning disability. Staff informed us this was because the patient dropped to the floor, during an incident, on to their front. The staff team facilitated a supine position as soon as they could.
- We found the staff understanding of seclusion practice was not always clear on the two bungalows used for patients with a learning disability. We were concerned that episodes of seclusion were not recognised or recorded as such by staff and they had not always followed the trust policy on seclusion.
- In the crisis teams there were clear arrangements in place to respond to a sudden deterioration in patients' mental state. The teams provided a service 24 hours a day, 7 days a week. There was access to an out-of-hours on-call system for managers and psychiatrists. Patients told us that they were able to get assistance out hours and the teams responded quickly, almost all of the time. There were no waiting lists and patients were seen quickly, based upon risk.
- There were effective systems in place to ensure staff safety when working alone. Each team had local procedures in place for lone working and staff were aware of and adhered to the lone working policy. Security was good at each of the sites and each team adopted a code word should a staff member contact the office to raise concerns about their safety.
- With the exception of community services for older people and adults, risk assessments relating to patients were up to date, complete and comprehensive.

Detailed findings

Potential risks

- We were concerned about the potential use of seclusion, and in the future what placements for the patients at the two bungalows providing residential learning disability services within Cheltenham.
- In the long stay rehabilitation service, a physical health check had not been routinely conducted on one patient, after oral rapid tranquilization medication had been administered.

Duty of Candour

- Staff across the trust understood the importance of being candid when things went wrong including the need to explain errors, apologise to patients and to keep patients informed.
- The trust operates an effective complaints system. Information relating to complaints past and present were orderly and up to date. The complaints staff were able to speak with knowledge, confidence and transparency of past and present complaints.

Good

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

We rated effective as Good because:

Assessment and delivery of care and treatment

- With the exception of Gloucester community child and adolescent mental health service (CAMHS) and the crisis and health based place of safety (HBPoS), records reviewed showed patients were receiving physical health assessments on admission and routinely thereafter. The Crisis and HBPoS and CAMHS staff were not consistently recording patient physical health information in the same section of RIO meaning that information was being missed and or duplicated.
- Care plans we reviewed throughout the Trust were largely up to date, comprehensive and goal orientated. Kingsholm, Abbey, Priory, PICU at Wootton Lawn Hospital and Mortimer ward at the Stonebow unit did not contain information to show that care plans had been done in a collaborative manner with patients. However, the service had highlighted this is an issue and were taking steps through an initiative to improve the quality of care plans. At the community learning disability (LD) services we did find that there were care plans missing for two patients and information missing within care plans for four patients.
- Care and treatment across the trust was generally delivered in line with relevant national guidelines, such as those produced by the National Institute for Health and Care Excellence (NICE). Staff knew that up to date guidelines were available electronically but could not always accessed them.
- Overall, NICE guidelines were followed for prescribing medication and the management of medicines across the Trust was good. Medicines were stored correctly and overall monitoring of medications, sell by date and stock, was undertaken by the pharmacists. However, in older people's services and LD we had concerns with regards to the recording and interpretation of practice around covert medication.

Outcomes for people using services

- Patients in mental health services were assessed and monitored using the health of the nation outcome scales (HoNOS), which covered twelve health and social care domains.
- In most community and inpatient mental health services we found good access to psychological therapies. However, we found that a shortage of psychology staff in some older adult and learning disability community services meant that they were not all able to offer psychological therapies in line with NICE guidance.
- The trust had a planned schedule of 'top priorities' for 2015/16. Examples included; improving the physical health care of patients with serious mental illness, ensuring that patients are discharged from hospital with personalised care plans, ensuring appropriate access to psychological therapy, improving the transition processes for children and young people who move into adult mental health services.
- We found community teams offered practical support for patients with employment, housing and welfare benefits. They had developed links with local employment, voluntary and housing providers in order to support their patients.

Skilled Staff

- Staff told us that they received supervision regularly across eight of the core services. In the older adults community teams in Herefordshire, only one out of 16 staff had received clinical supervision, two out of 16 staff had received peer supervision and four out of 16 staff had received management supervision in the past 12 months. Ten out of 20 appraisals had not been completed within the past 12 months. Staff said

Good

Are services effective?

this was due to a lack of a manager since April 2015. Staff told us they felt stressed and unsupported as a result. The senior management team were not regularly supervising managers in the later life team in Gloucestershire. The trust however, was not always able to locate records to corroborate this. We looked at nine supervision records on Hollybrook ward and none had received the required amount within the year. Eight out of nine had not had any formal recorded supervision in 2015.

- All new starters attended a trust induction. All new health care assistants were training for the Care Certificate, a national induction standard for healthcare assistants. The trust planned to ensure that all HCA had access to this training. In addition to the mandatory trust training staff could access additional training. Staff had received training in working with personality disorders, search training, motivational interviewing and family work.

Multi-disciplinary working

- All teams across the trust had access to a range of multi professional staff including doctors, psychologists, occupational therapists, pharmacists, nurses (both qualified and unqualified) and other support staff, including catering and domestics.
- In Gloucestershire Health and Local Authority mental health services are fully integrated in services for adults of working age. Children and young peoples services, learning disability and older people's services are not integrated. In Herefordshire services for adults of working age, older people's and learning disabilities services were integrated but the integration arrangements ended in March 2104 and ended in March 2015 for services for adults of working age and older people's services. We met with senior social care staff involved in the approved mental health professional (AMHP) service. AMHPs reported good partnership working. In Herefordshire, health staff who had trained as AMHPs were no longer required to practice as such in that county following the de-integration of services.
- All services across the trust would meet on a regular basis to review the care and treatment of patients. These varied form daily reviews, to weekly to monthly depending on the type of service and level of contact patients required.

Information and Records Systems

- The trust operated across both Hereford and Gloucester an electronic records system called RIO. The trust had entered into a contract to directly manage RiO itself in October 2014, prior to the national Connecting for Health IT programme ending in October 2015, which had originally commissioned RiO. We spoke to a range of staff across both Hereford and Gloucester who all told us that the RIO support team were effective and helpful and were able to sort issues in a timely fashion.
- Community staff told us when they were out on home visits they were unable to update RiO records due to a lack of connectivity and mobile IT equipment. They had to come back to the office to update records which meant a delay in updating patient records.
- All staff that accessed electronic records and confidential information all had their own passwords to RIO and were aware of information governance protocols.

Consent to care and treatment

- Within the LD wards patients did not receive a copy of their care plans and there was no record kept of their opinion of their care. The patient view section of each care plan only identified that the patient did not have capacity. We did not see any detailed information recorded in the care plans as to why the patients lacked capacity.
- Staff told us the approach to consent was implied in most of the teams we inspected. We saw how staff would make a general note in the progress notes to say a patient had consented to their treatment. However, a manager told us to show consent was gained they would tick the box on the electronic records system, but they were unable to run a report to check. Psychiatrists were aware of the need to gain consent when giving injectable medicines.

Good

Are services effective?

- In community adolescent mental health team's capacity to consent for treatment was not recorded consistently in case notes. Recording of consent appeared in only two cases out of the 24 looked at in Gloucestershire. Records on the electronic recording system did not consistently show consent to treatment discussions had taken place in Hereford.

Assessment and treatment in line with Mental Health Act

- The trust reported that 48% of staff had undertaken MHA training. At the time of the inspection this was not a mandatory requirement, as was considered 'professionally required' training. However, the trust senior management decided to amend this during the week of the inspection, so it would form part of the mandatory training programme.
- Training on the new Code of Practice had been incorporated into a professional development day for a small number of staff. However, many staff that we spoke with had not received this training and so did not fully understand the changes. The revised Code of Practice was not available on all wards. Approved mental health professionals (AMHPs) accessed external training.
- The older adult wards did not actively promote advanced decisions with the patients on the wards and some patients were not always involved in the decisions in relation to their care plan and Section 17 leave. This leave did not always take into account the patient's wishes, and those of carers, friends, and others who may be involved in any planned leave of absence. Patients were not always aware of any contingency plans put into place for their support when they were on Section 17 leave, including what they should do if they think they needed to return to hospital early.
- The trust had updated some of its policies in line with the revised Code of Practice, although this was still work in progress. Mental health act administration policies came under the remit of the mental health legislation scrutiny committee, although the wider clinical implications of the revised Code of Practice did not. We did not identify a clear programme of policy implementation to cover all policy changes indicated in the revised Code of Practice.
- During our inspection we undertook nine Mental Health Act review visits in inpatient settings, including older people, adult acute, rehabilitation and learning disability wards. We examined a significant number of legal detention records and found them in good order. There was an effective scrutiny process, which had identified some mistakes in the legal documentation, which had been corrected. Adherence to the consent to treatment requirements was to some extent limited and further work was required to improve practices. Patients' rights were explained in accordance with section 132 but in a number of situations this had not been done in a timely manner. Patients were regularly accessing leave. However, we noted that leave forms were not always fully completed.

Mental capacity act

- There were 13 Deprivation of Liberty Safeguards (DoLS) applications across the trust between 1st May 2014 and 30th April 2015. Eight were granted. Chestnut ward was the only ward with successful DoLS applications. They had the most applications: five applications were made and three were granted. There were no applications made on the Hereford wards in this time period. Where applications were not granted, the patient's care and any restrictive practice was reviewed in the multi-disciplinary meeting using the standard meeting agenda we observed.
- Prior to the inspection, training on the Mental Capacity Act 2005 (MCA) was not mandatory across the trust. The trust reported that 51% of staff were complaint with regards to MCA training. MCA training was not on the statutory and mandatory agenda, although it is included on the corporate induction. This was also changed during the inspection to become mandatory. Staff demonstrated a good awareness of the MCA and the implications this had for their clinical and professional practice.

Good

Are services effective?

- The RiO system supported staff through prompting capacity assessments for patients. However, this was not always recorded in the specific section of the electronic database and was sometimes recorded in the daily record of contact / activity. This meant that there was the potential that assessments and decisions relating to mental capacity could be missed by staff. Mental capacity was also discussed in multidisciplinary meetings and daily handover meetings.
- The trust had a MCA and DoLS policy on the intranet. Staff told us that they could access further support from a consultant nurse who was the trust lead on MCA and DoLS.
- The implementation of Mental Capacity Act and Deprivation of Liberty Safeguards was overseen by the Mental Health Act scrutiny committee, and actions implemented, evidenced through the scrutiny committee Board report.
- We saw evidence of capacity being reviewed in the standard multi-disciplinary team meeting agenda, as well as in the discharge plans. There was evidence in the records of the capacity assessments, and clinical and best interest assessments for each individual decision. The best interest decisions took into consideration the person's wishes and took account of their history.
- Staff demonstrated a good awareness of the Mental Capacity Act 2005 (MCA) and the implications this had for their clinical and professional practice. Staff we spoke to across all services were clear in their ability to assess mental capacity and able to demonstrate examples of when to use the MHA and the MCA.
- Records relating to the MCA showed that staff routinely assessed mental capacity for patients. However, this was not always recorded in the specific section RIO. This meant that there was the potential that assessments and decisions relating to mental capacity could be missed by staff.

Our findings

Good

Are services caring?

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

Summary of findings

Our findings

We rated caring as good because:

Dignity, respect and compassion

- We observed high quality care in all of the interactions we observed on inspection. Staff were respectful and caring. On the rehabilitation ward, we saw an example where a member of staff left a meeting immediately in order to provide escorted leave for a patient who requested to take leave. It was evident to us that staff cared for the patients on the ward and went the extra mile in order to help their recovery. On the acute wards there were no distinctions made between patient and staff areas other than the nursing office and clinic area. Patients had full access to all areas at all times. We observed all staff, including housekeeping and administration staff, interacting with patients in a friendly and supportive way.
- In all of the teams and wards, patients, family and carers spoke highly of the staff and consistently told us they were impressed with the services and staff who supported them.

Involvement of people using services

- Most wards orientated people to the environment and this helped patients to feel more comfortable in their surroundings. We saw examples of information being given to patients and their relatives or carers to introduce them to the service.
- Across most wards and teams, carers and family members were involved in the care for patients and people who used the service. An example of this was in specialist community teams for children with mental health problems. Family and carers reported that services were flexible to individuals needs and that they were actively involved in planning of care and treatment for their child. One parent explained how appointments now took place at home, as her son had found the waiting area in Hereford stressful.
- Consent to share information with carers was clearly documented and staff ensured that patients were given the opportunity to change their consent if they wanted to.
- In most wards and teams, there was access to advocacy. Both patients and staff knew about the advocacy service and advocates were able to attend relevant meetings. However, we did not find good promotion of advocacy services in specialist community teams for children with mental health problems.
- On almost all inpatient wards there were community meetings where patients had the opportunity to feedback on the service and decide ward activities. These meetings were not held on inpatient wards for older adults, despite some of the patients being able to actively participate.
- Patients in the trusts forensic and long stay rehabilitation wards were encouraged to maintain independence; there was opportunity for patients to self-cater and to take part in preparing the Sunday roast for the whole unit.

Good

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

Our findings

We rated responsive as good because:

Planning and delivery of services

- Staff across the services and at all levels, told us there was good involvement of commissioners and an open relationship with local commissioners. Staff thought that there was a good understanding of the relevant local issues and where there were identified gaps in service delivery this was openly discussed.
- Both Gloucestershire and Herefordshire clinical commissioning groups (CCG's) attend the trust governance committee meetings, in order to ensure transparency in relation to the assurance process. The trust attend both CCG's clinical quality review groups and to both commissioners mental health clinical programme groups to provide assurance to the CCG's.
- The trust priorities for 2015/16 had been developed in partnership with the CCG's, and the quality priorities identified demonstrate a high level of engagement. The trust had been actively engaged in partnership working in Gloucestershire through the Mental Health and Wellbeing partnership arrangements.
- The trust had been working with Gloucestershire clinical commissioning group and Gloucestershire county council to agree and develop a new model of care for patients with learning disabilities for some considerable time. Whilst there was a commitment by all to provide high quality services close to home forpatients with complexneeds and some redevelopment work has started at Hollybrook there had been several setbacks with the plans to develop a community supported living facility.
- The trust's overall score during their patient led assessment of the care environment assessments was better than the England average for other similar trusts for cleanliness and condition and appearance and maintenance.
- Most patients told us that the food was good. The trust score for food however, was below the England average for similar trusts.
- The trust immediately rectified a concern about the environment at Lexham Lodge, a temporary facility used by the managing memory team in Gloucestershire whilst their facilities were being rebuilt. The environment at Lexham Lodge was unsafe and unsuitable for older people accessing the building. The trust quickly arranged for all patients to be supported in appointments as home visits rather than outpatient appointments at Lexham Lodge. If a home visit was inappropriate for any reason, an outpatient appointment was offered from the Charlton Lane site main hospital or at the patient's GP Practice as most appropriate.
- All the older adult wards had a range of fully equipped rooms including clinic rooms, activity rooms and therapy rooms on all sites. There was a gym, kitchen area and laundry facilities where occupational therapists could work with patients. There was a room containing sensory and reminiscence equipment at the Charlton Lane Centre for the patients with organic illnesses like dementia. There was an assistive technology room at the Charlton Lane Centre where patients and carers could learn how to use the technology ready for when they returned home.
- Both Wotton Lawn and the Stonebow Unit were well equipped with a range of rooms and equipment including music rooms, practice kitchens, physiotherapy suites and art studios. Both Wotton Lawn and the Stonebow Unit were spacious and modern and offered a range of activities. Equipment was purchased as per patient need and was of good quality. We were shown a range of musical instruments at Greyfriers that had recently been purchased to start a music group. All the wards had access to garden areas in which patients could get fresh air.
- There was access to activities from 9am until 9pm seven days a week at Wotton Lawn. We witnessed high levels of activity delivered on the wards by enthusiastic staff. The activity coordinators used information gathered on admission to ensure that the activities were person centred and individualised. Though the Stonebow Unit

delivered a timetable of sessions from 9am until 5pm, including OT sessions, music and art therapy and psychology, patients were still able to access activities outside of these times. Nursing staff were continually developing groups, that could be delivered on the ward, including a men's' health group.

- Staff, patients and carers on the older adult wards told us that there were not enough activities on the wards and that they sometimes get cancelled. We observed "you said we did" information displayed where patients had requested more activities. We observed activity calendars for each ward. On three of the wards there were no weekend activities. There were only activities for a full seven days on the Chestnut ward and Mulberry ward. Cantilupe and Jenny Lind Ward staff told us that activities were only available Monday to Friday when the occupational therapists are in work.
- There were sound proofing problems at the CMHT team base and clinic rooms in Hereford.
- Payphones were provided to enable patients to make a phone call. Patients could also use their own mobile phones, following a risk assessment.

Diversity of needs

- Both community settings and in-patient services were fully accessible for people requiring disabled access. This included the provision of wheelchair access to bedrooms and assisted bathrooms.
- Patient information leaflets were readily available across the sites we inspected. Information was provided in other languages which could be printed quickly when required by staff. Information leaflets in other languages were updated on the internal internet system as were those written in English. This system appeared easy for staff to navigate so patients did not need to be kept waiting for written information if appropriate to the patient's needs.
- Details of advocacy and interpreting services were readily available. Staff did not require managerial approval to book an interpreter. Translation services were also available if required.
- There was a trust wide chaplaincy service to support patients with a diverse range of spiritual and religious needs. At in-patient services multi-faith rooms were available for patients to use.
- There was a range of choices provided in the menu that catered for patients dietary, religious and cultural needs.
- Information packs were routinely given to patients. These included important information to support their recovery and independence within the community settings.
- For Gloucestershire crisis teams they enhanced equality standards by developing a pathway and referral process for clients from a black or minority ethnic background. The interface arrangement offered BME service users the opportunity to engage back into their communities through volunteering in community led projects. A goal for next year is to deliver Cultural Competency training to 80 members of staff working in Crisis Teams.

Right care at the right time

- The number of days from initial assessment to onset of treatment was the highest at 55 days within the community learning disability service; followed by the criminal justice liaison service at 30 days. No targets were provided by the trust.
- The trust had set its own targets for the times from referral to assessment for a wide range of its community teams. These included; 98% of emergency referrals being seen by the crisis team within 4 hours, improving access to psychological therapies within 2 weeks for 85% of all referrals. The only services not meeting the targets were adult eating disorder (30 days in excess of target) and CAMHS (17 days in excess of target).
- The trust was above the England average of 97% for CPA follow ups over the last 12 months.
- We found bed management processes for mental health beds were effective. Patients were generally able to access an acute or PICU bed when required. Average bed occupancy was at 86% (it is generally accepted that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital) but figures showed this had been increasing over the last year in all areas. This meant that whilst there was constant pressure on beds, we did not find any significant issues when somebody in crisis required a bed. This also enabled a good availability of a local bed if someone urgently required re-admission whilst on leave.
- The crisis teams acted as "gatekeepers" of inpatient mental health beds. The proportion of admissions to acute wards that were gate kept by the crisis teams was higher than the England average for the whole of the year leading up to the inspection and reached 100% in

Good

Are services responsive to people's needs?

quarters three and four. This ensured that patients only had to go into hospital if it was absolutely necessary and every effort was made to support them at home in their own environment.

- There were no children's mental health inpatient (Tier 4) beds within the trust's catchment area. Twelve young people had been admitted to an adult ward in the last 12 months; the longest stay was in Gloucestershire and was for 193 days on the Greyfriars PICU. The children and young people's team provided support to the wards until a bed was available out of area. There was a small team of dedicated community staff (called tier 3.5) within Gloucestershire to provide additional community support to children.
- Patients were discharged when clinically appropriate. Analysis of evidence showed there were no delays in discharge attributed to the trust. Between March 2015 and Oct 2015 the number of patients who experienced delayed discharge had been consistently below the England average and only totalled 5. These were on older adult wards and were associated with arranging external accommodation issues or complex care packages. All other patients had comprehensive discharge plans in place identifying individually tailored ongoing support. Patients were discharged at times negotiated and arranged to suit them.
- Some patients in learning disability inpatient units had been in the units for a number of years with no clear plans in place for their discharge.

Learning from concerns and complaints

- The trust received 158 complaints in 2014/15 which was one less than the previous year. Of these 7 had been referred to the health service ombudsman. 21 local resolution meetings were undertaken and 63 complaints were upheld.
- We reviewed complaints information during the inspection. This detailed the nature of complaints and a summary of actions taken in response. We found that complaints had been appropriately investigated by the trust and included recommendations for learning. The trust had recognised that it had been struggling to complete the complaint responses within 28 days and had devised an action plan to remedy the situation. This plan also included the allocation of additional resources to the complaints department and we interviewed the new manager during the inspection.
- The majority of patients in the adult services we spoke with knew how to make a complaint. However we found Children and young people didn't know how to make complaints and information was in an adult format in some areas, although the trust had a children and young people's complaint leaflet.
- Staff felt confident in handling complaints from patients. All staff we spoke to about complaints said they would make efforts to resolve any complaint before it became formal. Staff were also happy to support patients in making formal complaints. The complaints service fed back the outcome of complaints to the relevant team manager.
- Staff received feedback on the outcome of the investigation of complaints through their team manager, either individually or more generally through team meetings.

Good

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

Our findings

We rated well led as good because:

Vision, values and strategy

- The trust's clear vision was to "make life better" for the people in its care and the carers who support them. It had established this through a previous consultation process and aimed to achieve this through delivering high-quality care which would have been suitable for "their own family members". The trust had set itself three strategic priorities which were to:

1. Continually improve the quality of services provided.
2. Continually improve engagement internally and externally.
3. Ensure the sustainability of services and the trust as an effective partner, employer and advocate of services.

- The trust set out to achieve the priorities through its values, which were clearly stated in all areas we visited. These were entitled SERVICE and stood for:

Seeing from a service user perspective – in order to identify opportunities, problems and risks at an early stage

Excelling and improving – striving for excellence to ensure we deliver innovation, best practice and learn from what we do

Responsive – an adaptable and flexible approach to deliver services in new ways which meet the needs of service users

Valuing and respectful – valuing and involving staff and investing in training and development to drive collective ownership and shared decision making

Inclusive, open and honest – effectively communicating with staff, service users, partner agencies and the public by being honest and open and welcoming constructive feedback and recognising accountability

Can do – having a proactive 'can do' approach which delivers on what we say and allows for productive working across professions and agencies

Efficient – securing value for money and a culture of making the most of resources through robust evaluation and effective assessment of information.

- Staff we met across all levels of the services showed a high awareness of the trust's vision, priorities and commitments. Information was displayed in every ward and every location. Information surrounding the trust's vision was also displayed in the Trust intranet page. Staff we spoke on the majority were aware of the Trust visions and values and thought them to be realistic and in line with their own visions and values.

Good governance

- The trust board were accountable for the running of the trust and the overall strategic leadership to the trust. There was an established council of governors who provided a link between the wider community and board of directors. We met with three of them during the inspection. They clearly understood their role to hold the non-executive directors to account and provided assurance to members, stakeholder organisations and the public, on the delivery of the strategic direction and quality of services.
- The governance structure in place for the board included eight committees that directly reported to i.e. found these enabled the board to understand its business at an operational and strategic level. These committees were:

1. Audit
2. Appointment and terms of service
3. Charitable funds
4. Delivery
5. Development
6. Executive
7. Governance
8. Mental health legislation scrutiny

- The trust had developed four separate locality management structures for Herefordshire,

Good

Are services well-led?

Gloucestershire, county wide services, children and young people service. Assurance was delivered through these locality governance structures up to the board. We looked at a number of minutes from the locality governance groups which took place monthly. The minutes followed a set agenda which included; risk registers, clinical audits, learning themes, complaints and incidents. Clinical teams had localised clinical governance meetings which linked to the relevant locality management group. This meant there was a robust governance structure in place which enabled the flow of information from each area up to the board and back.

- The trust had a comprehensive board assurance process in place. This identified the areas of risk and the measures of progress for assurance. The associated risk register included all operational and strategic risks. This was supported by a quality and performance dashboard. Senior executives we spoke with told us they were concerned about the inclusion of all risks for board papers. The senior management team had set up a task and finish group to design a new high level more strategic risk register. This was due to complete its work by the end of 2015.
- The trust achieved 'ward to board' assurance through a number of mechanisms. The Trust Governance Committee oversaw all aspects of quality (patient safety; outcomes and experience) for the organisation. This included; safeguarding; infection control; patient safety and serious incidents; safer staffing levels for inpatient units; complaints and user experience; locality risk register monitoring and triangulation of information. This Committee gave assurance to the Board and provided notification on exceptions/ areas of concern.
- Staff we spoke with at the team manager and matron level described the trust governance structures and reporting systems in detail, and thought the arrangements worked well. Staff below this level were not as clear about the wider governance systems although they knew about the local ones.
- Mandatory training levels across the services were good, ranging between 75% and 95%.
- With the exception of the older adult's community, staff we spoke to across all services told us that they received supervision regularly across eight of the core services. Staff in the older adult community teams told us that this was due to a lack of management structure since April 2015. Staff told us they felt stressed and unsupported as a result.
- NICE audits are integrated into the Trust Clinical Audit programme with executive led responsibility from the Director of Quality and the Medical Director. During the past 12 months the Trust has undertaken 6 out of the planned 17 NICE audits with 7 audits are either at final draft report stage or currently underway.
- We saw from the trust's own complaints monitoring system that the response time of 25 days to a complaint, had not been consistently met over the last 12 months. We randomly selected four files for assessment and none met the 25 day response deadline. The quality of the investigations and content of the replies we saw was good though. We met with the recently appointed complaints manager and heard about his plans to improve the timeliness of the responses in order to meet the 25 day target.
- Monitoring of nursing staffing levels occurred on all inpatients services and these were monitored on a shift by shift basis by the nurse in charge. Further assurance comes via the matron using our escalation policy if required.
- The trust had a programme to reduce the use of restrictive interventions on wards which was in the early stages of development. The aim was to work towards eliminating the use of these approaches as reflected in the "Positive & Safe" national programme. The Trust had adopted two nationally recognised models of behavioural management; positive behaviour management (PBM; for learning disability & older adult) and preventing and managing violence and aggression (PMVA; for working aged adults). Both these models advocated the least restrictive intervention being used.
- We found the trust had effective systems in place for financial reporting. These along with key performance indicators for all teams ensured the trust management team were aware of the organisation's performance throughout the year.
- We received positive comments about the trust from clinical commissioning groups, local authorities and health watch groups. They told us the trust was proactive in its local relationships and provided an open and transparent dialogue. However, some third party organisations representing specific patient groups were less complimentary about the trust performance.

Good

Are services well-led?

Leadership and culture

- We reviewed the personnel records of the seven senior directors within the trust in line with the fit and proper person requirement (FPPR). There were copies of directors' professional qualifications and evidence of registration with their professional governing bodies in the files. In addition, the files contained application forms, references, educational achievements etc. We concluded from the evidence we saw that the trust were fully meeting the requirements of the new FPPR regulation at the time of the inspection.
- The trust had its own occupational health service called "working well" and was led by a consultant occupational health physician. The service aimed to improve the health and wellbeing of staff, both within the Trust and for external public and private sector organisations. The service offered independent advice to both managers and employees which included staff counselling, return to work guidance; the working environment; and assessment of health risks associated with the workplace.
- The average sickness absence over the last twelve months was 5.7%. This was a slight increase from the previous year where the average was 5.4%. Montpellier Ward had the highest proportion of staff absence within the trust at 15.6%.
- We held 12 focus groups for staff across four different areas. These were attended by a wide range of staff which included; nurses, therapists, psychiatrists, junior doctors, support workers, team managers etc. Overall staff told us the trust was a very positive place to work and they felt supported. They also thought the quality of care was good and the trust board provided effective leadership. Staff told us that the senior team were visible around the Trust on a regular and routine basis.
- The trust had carried out quarterly staff friends and family tests since April 2014. Analysis of responses showed an average of 75% of staff said they would be likely or extremely likely to recommend the Trust as a place to receive care or treatment; with the national average for the same time period being 79%. 60% of staff said they would be likely or extremely likely to recommend the Trust as a place to work, with the national average for the same time period being 62%. In the last quarter 149 comments were received from 339 respondents.
- The trust undertook a staff survey annually. The response rate for this year was 46% compared to 56% in the previous year. The Trust highlighted three issues which were increasing workloads, absenteeism and improved communications. 51% of the staff survey key findings were in the best 20% of the country (England), compared to mental health trusts.
- The trust had renewed its Investors in People accreditation in October 2014. This provided a best practice people management standard to organisations that adhere to the Investors in People framework.
- The trust had a well-established joint negotiation and consultation committee, which met bi-monthly with locally recognised union representatives. A range of staff issues were discussed and formally recorded. We met with two representatives of this group whom spoke very positively of the professional relationship with senior management.
- The trust had established four working groups, each chaired by a member of staff with the support and guidance of an executive director. The membership of the groups were drawn from across the Trust and included Staff Side representatives and staff from various clinical and corporate support services backgrounds. The groups addressed any proposed changes to policies and organisational change.
- The director of quality undertook clinical shifts within services to ensure frontline staff could raise issues directly to her. In addition, the executive team told us that they undertook 'executive walkabouts' around the trust. Staff we spoke to told us that the senior team were visible around the trust on a regular and routine basis.
- Executive directors lead monthly 'team talk' staff engagement meetings across both Counties. These open forums are without fixed agendas and offered staff the opportunity to raise issues or concerns for discussion.
- The Trust had a senior management and clinical leadership forum for clinicians to discuss and raise issues.
- We saw how duty of candour considerations had been incorporated into relevant processes such as the serious investigation framework and complaints procedures. Staff across the trust were aware of the duty of candour requirements in relation to their role.

Engagement with the public and with people who use services

Good

Are services well-led?

- The trust's senior managers expressed a commitment to engaging those using services and their carers in developing services. The triangle of care is an initiative within the trust that aims to promote safety and recovery for patients with mental health issues and encourage their wellbeing by including and supporting their carers. All inpatient wards and crisis teams are currently involved. Carers are able to get involved through group work, feedback directly to the Trust and taught face to face sessions.
- The trust had established a recovery college / discovery college (for young people) though grant and charitable funding over the past two years (Health Foundation Shine grant and internal charitable fund investment). This had now been substantively funded by Gloucestershire CCG. The college had been developed and co-delivered with service users. The recovery college provided courses and educational workshops that taught patients to become experts in their own recovery and self-care. The courses that were offered had been co-produced with patients.
- The board actively engaged with service users and we saw evidence how each board meeting started with a patient experience presentation, undertaken by someone who has first-hand experiences of using the trusts services. Any subsequent actions were minuted and led on by an executive director.
- Each quarter the board receives a service experience report which identified the experience of patients and carers, provided examples of the learning that has been achieved, emergent themes from clinical services, complaints, concerns, comments and compliments and survey information.
- A programme of Experts by Experience who are involved in a wide variety of trust activity including: Recruitment of Trust staff; research; committee activity; development and scrutiny activity etc.
- Young Carers Gloucestershire delivered an integrated project to support young carers of adults with mental illness.
- The trust participated in the 'national viewpoint' study last year. The Trust had been selected as one of two sites in the UK to pilot a survey about mental health stigma with Time to Change. Part of this agreement would be to implement a practice development 'intervention', being co-produced with staff and experts by experience.
- The trust used the Friends and Families Test (FFT) and in the 12 months prior to our visit there had been almost 2756 responses to this survey. The results indicated that 85% of patient respondents were likely or extremely likely to recommend the trust services.
- 'Patient-Led Assessments of the Care Environment' (PLACE) visits had taken place to a number of inpatient services. This is a self-assessment process undertaken by teams including service users and representatives of Healthwatch. The trust exceeded the national average for food provision at 94% with national average being 90%, treating people with dignity and providing privacy being 95% with the national average being 89% and the condition, appearance and maintenance of buildings being 98% with the national average being 91%.

Quality improvement, innovation and sustainability

- The trust were able to demonstrate their commitment to innovation, quality and improvement of services. For example, 'improving the cardio vascular health of patients with serious mental illness. This enabled staff to identify patients who were at risk of poor cardio vascular health and ensure that they were monitored closely.
- The trust had participated in a number of applicable Royal College of Psychiatrists' quality improvement programmes or alternative accreditation schemes (insert here). Acute wards had an excellent accreditation rating from the accreditation for inpatient mental health services programme. Wards and teams across the Trust were involved in several accreditation schemes including the ECT Accreditation Service, the Home Treatment Accreditation Scheme, and the Quality Network for Forensic Mental Health Services, the Memory Services National Accreditation Programme and the Quality Network for Community CAMHS.
- During 2014 the trust participated in the national audit of schizophrenia, national audit of psychological therapies, national confidential inquiry into suicide and homicide by people with mental illness, the national audit of intermediate care , epilepsy 12 (Childhood Epilepsy), and the national Parkinson's audit.
- The trust had developed a 'social inclusion strategy' that set out a vision to remove mental health inequalities and tackle the stigma that surrounds mental illness. It aimed to improve the quality of life of patients with mental illness, their carers and their families. The

Good

Are services well-led?

strategy was also supported by other organisations including NHS Gloucestershire, Gloucestershire County Council, Carers Gloucestershire, Gloucestershire Media and Jobcentre Plus.

- The trust was financially sustainable despite reporting a planned deficit of £0.5m for 2015/16. It intended to return to breakeven in 2016/17, but this statement was based upon the full delivery of next year's cost improvement plan. This had been the first time the trust had forecast a deficit in 31 consecutive quarters of reporting a financial surplus. This was also in line with the five year strategic plan submitted to Monitor.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12: Safe care and treatment** Long-stay/ rehabilitation wards The environment at Oak house was of a poor standard and the building layout did not facilitate safe observation of patients. Staff could not easily observe or respond to incidents. This was a breach of Regulation 12 (1) and (2d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At Laurel house physical health checks were not always carried out after administration of oral rapid tranquilisation medication. This was a breach of Regulation 12 (1) and (2g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Some patients were smoking indoors at Laurel house. The risk had not been reported via the trusts reporting system. This was a breach of Regulation 12 (1) and (2b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment must be provided in a safe way for service users. The registered person must do all that is reasonably practicable to mitigate any risks, ensure that

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15: Premises and equipment Community mental health teams for older adults The temporary premises at Lexham Lodge were unsafe and not suitable to support older people with mental health problems. This was a breach of Regulation 15 (1c) (1d) (1e) (1f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Community mental health teams for adults of a working age The trust's cleaning arrangements did not ensure all areas were being adequately cleaned. The clinic room at 27a St Owen Street, Hereford was not being cleaned and the equipment in it was not being maintained. It was visibly dirty and liquid from an unused refrigerator was leaking onto medical equipment. This was a breach of Regulation 15 (1a) (1c) (1d) (1e) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. All premises and equipment used by the service provider must be clean, suitable for the purpose for which they

the premises used by the service provider are safe to use for their intended purpose and are used in a safe way and ensure the proper and safe management of medicines.

Requirement notices

are being used and properly used and properly maintained. The registered person must in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17: Good Governance. Community learning disability teams The trust did not have appropriate systems and processes in place to ensure the quality of services were planned, monitored and maintained. There was no audit plan and staff did not participate in any local or national clinical audits. This was a breach of Regulation 17 (1) and (2a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems or processes must be established and operated effectively to ensure compliance with good governance. Such systems or processes must enable the registered person, in particular, to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17: Good Governance. Community mental health teams for older adults Staff in all community older adult teams were not updating electronic patient records accurately. Identified risk was not reflected in patient care plans. There were undue delays in adding information to patient records. Consent to treatment was not always present in care records. This was a breach of Regulation 17 (1) and (2c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems or processes must be established and operated effectively to ensure compliance with good governance. Such systems or processes must enable the registered person, in particular, to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11: Need For Consent Learning disability wards Consent was not reviewed regularly and all appropriate people were not included in relevant meetings.

This section is primarily information for the provider

Requirement notices

Inpatient wards for older people

Patients were not routinely involved in decision-making as far as they are capable of doing so in relation to their own plan of care and Section 17 leave. Conditions of leave did not always take into account the patient's wishes, and those of carers, friends, and others who may be involved. There was not always evidence in patients files to show that the responsible clinician's had made a record of their assessment of the patient's capacity to consent at first administration of treatment for mental disorder.

This was a breach of Regulation 11 (1) (2) (4) and (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care and treatment of service users must only be provided with the consent of the relevant person.

If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act. If Part 4 or 4A of the 1983 Act applies to a service user, the registered person must act in accordance with the provisions of that Act and ensure that nothing in this regulation affects the operation of section 5 of the 2005 Act (as read with section 6 of that Act (acts in connection with care or treatment).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA (RA) Regulations 2014 – Safeguarding service users from abuse and improper treatment Staff did not understand the procedures relating to seclusion and the derogation of seclusion policy.

This section is primarily information for the provider

Requirement notices

Seclusion practice was inappropriate. When patients were using the seclusion rooms, without being secluded, there were no robust care plan that ensured patients were not being secluded appropriately and aware of their rights. Records were not accurate or up to date records of the use of seclusion rooms for non-seclusion purposes. Staff did not follow the trusts policy on the administering of covert medication.

This is a breach of regulation 13(1)(2)(4)(b)