Good

2gether NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

2gether NHS Foundation Trust
Trust HQ,
Rikenel, Montpellier,
Gloucester, GL1 1LY
Tel: 01452 894000
Website: http://www.2gether.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RTQX2	Trust HQ, Rikenel, Montpellier, Gloucester, GL1 1LY	North Cotswold and Cheltenham recovery team	GL53 9DZ
RTQX2	Trust HQ, Rikenel, Montpellier, Gloucester, GL1 1LY	North Cotswold and Cheltenham Assertive Outreach Team	GL53 9DZ
RTQX2	Trust HQ, Rikenel, Montpellier, Gloucester, GL1 1LY	Gloucester Recovery Team	GL1 1PY
RTQX2	Trust HQ, Rikenel, Montpellier, Gloucester, GL1 1LY	Gloucester Assertive Outreach Team	GL1 1PY

Summary of findings

RTQX2	Trust HQ, Rikenel, Montpellier, Gloucester, GL1 1LY	Herefordshire East Recovery	HR1 2JB
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RTQX2	Trust HQ, Rikenel, Montpellier, Gloucester, GL1 1LY	Herefordshire Assertive Outreach Team	HR1 2JB
RTQX2	Trust HQ, Rikenel, Montpellier, Gloucester, GL1 1LY	StroudRecovery Team	GL5 2HZ
RTQX2	Trust HQ, Rikenel, Montpellier, Gloucester, GL1 1LY	Stroud Assertive Outreach Team	GL5 2HZ

This report describes our judgement of the quality of care provided within this core service by 2gether NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by 2gether NHS Foundation Trust and these are brought together to inform our overall judgement of 2gether NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Good 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Good** 

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We rated 2gether NHS Foundation Trust community mental health services for adults of working age as good because:

- Staffing levels were safe and caseloads were manageable. There was good access to psychological therapies and to group activities. We observed very good care being delivered and patients gave very positive feedback about their treatment in the service.
- Teams worked well together, met regularly to discuss their work and were supportive of one another. There were opportunities for leadership development and career progression. Managers at all levels were available and supportive.
- The service were referring to National Institute for Health and Care Excellence guidelines to ensure best practice.

However

- There were sound proofing issues in the team base for Herefordshire which could compromise patient confidentiality. Cleaning arrangements did not ensure all areas were being cleaned sufficiently.
- Risk assessments were missing from some patients records. Care coordinators were not completing their own mental capacity assessments and were deferring this task to social workers and doctors. This meant the person assessing the patient's capacity was not necessarily the person making the decision on behalf of the patient. This was not in line with the procedures of the Mental Capacity Act.
- There was no mandatory training on the Mental Health Act or Mental Capacity Act and some staff felt they needed a better understanding of these areas.
- Some management reports were inaccurate and out of date. This made it difficult for them to ascertain compliance with key performance indicators.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The trust's cleaning arrangements did not ensure that all areas were being cleaned and maintained. In particular, the clinic room at Hereford was dirty.
- Risk assessments were missing from some patients' records and in some cases they were not up to date.
- There were inconsistencies in the way crisis plans were written. Staff had not completed crisis plans within the required time for a number of patients.
- Incidents were being reported but there was disparity about what should be reported.

However

- Staffing levels were safe and therefore caseloads were manageable.
- Safeguarding procedures were in place and all staff were trained in safeguarding.
- Care records were generally of a good quality.

Are services effective?

Good

We rated effective as good because:

- Staff were being clinically supervised by their managers and also had access to additional clinical supervision.
- Assessments were comprehensive and completed in a timely manner.
- There was good access to National Institute for Health and Care Excellence guidelines recommended psychological therapies.
- Teams were staffed with a full range of disciplines.
- There were effective handovers and transitions between the teams and other services in the trust.

However

- There was no mandatory training on the Mental Health Act or Mental Capacity Act. Not all staff were aware there had been changes to the Mental Health Act code of practice.
- Care coordinators were not completing their own capacity assessments but were deferring to social workers and doctors who may not have known the patient and were not the decision maker under the act.
- Staff were not actively involved in clinical audits.

Summary of findings

Are services caring?

Good

We rated caring as good because:

- We observed warm, compassionate, respectful and supportive care being delivered.
- Comments from patients showed that staff were highly committed to delivering safe, compassionate care.
- Patients were involved in their care planning and patients were given choices about their care.
- Staff were described as polite, caring and supportive at all levels of the service.
- Patients were involved in the development of the service and were invited to give feedback about it.
- There was support for carers and staff ensured carers were involved in patients' care if the patient wished them to be.

However

- Patients had not all been offered copies of their care plans.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- There was flexibility around the criteria for the service to ensure patients who might benefit were not excluded.
- Active steps were taken to engage people who were reluctant to use the services.
- Staff took a flexible approach to working hours to accommodate their patients.
- All rooms were accessible to those with a disability.
- Patients knew how to complain and staff knew how to handle complaints effectively.
- There were targets for patients to be seen promptly and there were mechanisms in place to alert managers quickly if waiting times targets were not being met. Over half of routine referrals were seen within 2 weeks with over 70% of newly referred patients seen within 4 weeks.

However

- There were sound proofing problems at the team base and clinic rooms in Hereford.

Are services well-led?

Good

We rated well-led as good because:

- Staff described senior management as being visible and taking a hands on approach.
- There was good support for staff from managers.

Summary of findings

- Morale was good.
- There were opportunities for leadership, development and career progression.
- All staff were appraised and supervised.

However

- There was a lack of clarity about which incidents should be reported across the teams.
- Not all appraisals were individualised or comprehensive.
- Herefordshire managers were not ensuring the building, including the clinic room was clean and the equipment maintained.

Summary of findings

Information about the service

- 2gether NHS Foundation Trust provides adult community mental health services across the counties of Herefordshire and Gloucestershire. The teams that deliver community services for adult mental health are assertive outreach and recovery teams. These integrated locality teams serve adults with mental health problems including patients with learning disabilities and those in later life.
- There are three recovery teams across Herefordshire and five in Gloucestershire. The teams provide care to patients of all ages. The recovery teams provide mental health care for people experiencing serious acute mental ill health. The recovery teams offer treatment for discreet episodes of mental ill health as well as longer term engagement according to need. They aim to promote recovery and social inclusion and they monitor physical health. They enable patients to engage in training, vocational or employment and recreational activities. They enable relapse prevention. They also support patient's carers.
- Assertive outreach teams provide supportive and therapeutic relationships to patients experiencing severe and enduring mental health difficulties who have complex needs and who are having difficulty engaging in services. They offer intensive home-based assessment and treatment and facilitate social inclusion.
- Early intervention teams work with patients who are experiencing their first episode of psychotic illness or other severe mental health problem. They work primarily with patients from the ages of 14-35.

Our inspection team

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

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

The team that inspected this core service comprised two CQC inspectors and four nurses, all with experience of delivering community mental health 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 services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection:

- Visited and looked at the quality of the environments the teams were based in.
- Observed how staff were caring for patients.
- Spoke with 31 patients who were using the service and 11 carers of people who were using the service.

Summary of findings

- Collected feedback from 25 patients using comment cards.
- Attended three outpatient appointments and one home visit with patients and their healthcare providers.
- Spoke with seven managers who were managing the teams we visited.
- Spoke with 33 other staff members including doctors, nurses and social workers.
- Attended and observed three multi-disciplinary team meetings.
- Looked at 56 care records of patients.
- Looked at 20 staff appraisal records.
- Looked at 19 staff clinical supervision records.
- Looked at 11 mental capacity act assessments.
- Looked at training records, team meeting minutes, complaints and incident reports.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Patients were highly satisfied with the service and gave very positive feedback. Patients found staff to be kind, polite, respectful, supportive, caring and encouraging. Patients described staff as going above and beyond that which was expected. Patients and carers said they felt heard and that staff were interested in their well-being. One service user commented they had a good response when they phoned in to the service. Several patients commented on the kindness of reception staff. One patient said their nurse was outstanding in their personal commitment and empathy

Carers were satisfied with the service they received and appreciated the support they were getting individually. One carer said staff were respectful, polite, caring and interested and they had been equipped with coping strategies, however, one carer said there was a lack of warmth and empathy.

Patients felt involved in their care and had been part of the care planning process. They felt they had choices and were informed about care options and about the care they had chosen to receive. People had been given written information in the form of leaflets and websites to describe the care they were receiving and the conditions they were being treated for. Most patients had copies of their care plans. Carers were also involved as far as the patient wanted them to be.

Patients and carers knew how to complain and most felt able to do so if they needed to. They also said they were able to speak to their care coordinator about anything they were unhappy with.

Good practice

- Following an initiative to extend the availability of psychological interventions for patients in Herefordshire there were no waiting times there and both long and short term therapy could be provided. The team had made the service more equitable and were providing some form of psychological input to 35% of the whole patient caseload. This included brief interventions, such as a psychologist accompanying a care coordinator to a visit, but did not include the many times when a psychologist would offer input to a team to help formulate a patient's difficulties. The psychology team were offering groups on acceptance and commitment therapy and emotional regulation and a consultation service on complex trauma. The psychology team were training staff in team formulation. Although a psychotherapy service had not been commissioned, cognitive analytical therapy, eye movement desensitisation and reprogramming and attachment therapy were available.
- The recovery colleges were providing 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.

Areas for improvement

Action the provider MUST take to improve

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

Action the provider SHOULD take to improve

- 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.

2gether NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
North Cotswold and Cheltenham recovery team	All locations listed registered at Trust HQ, Rikenel, Montpellier, Gloucester, GL1 1LY
North Cotswold and Cheltenham Assertive Outreach Team	<Placeholder text>
Gloucester Recovery Team	<Placeholder text>
Gloucester Recovery Team	<Placeholder text>
Herefordshire East Recovery	<Placeholder text>
Herefordshire North Recovery Team	<Placeholder text>
Herefordshire North Recovery Team	<Placeholder text>
StroudRecovery Team	<Placeholder text>
Stroud Assertive Outreach Team	<Placeholder text>

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.

- Training in the Mental Health Act was not mandatory. Trust records showed six staff across all the assertive outreach and recovery teams had completed training in the Mental Health Act up until September 2015. One manager said places on the training were limited. One manager did not know if their staff were trained in the Mental Health Act or not. However, managers were confident in their staffs' knowledge of the Mental Health Act because it had been covered in their professional training. The trust informed us that basic awareness training in the Mental Health Act (MHA) and the Mental Capacity Act were included in Clinical Risk and Care Planning training and also in Think Family training, but we did not review this ourselves. There were limited opportunities for training in the MHA to be updated. . We asked staff about their confidence in understanding the Mental Health Act. Many felt they had good knowledge but one nurse said they needed more training in the revised Mental Health Act code of practice and in community treatment orders. One manager and one nurse were not aware of the revisions to the Mental Health Act code of practice. Another nurse said they needed more general training in the Mental Health Act. There was a trust mental health office where staff could ask for support and advice on the Mental Health Act.
- There were 61 patients on community treatment orders (CTOs) being treated across all the trust's assertive outreach and recovery teams. One manager told us patients should be reminded of their rights under the Mental Health Act every three months but they were not sure if this was happening. A psychiatrist said people were being told their rights every few months according to an individual plan. The manager for the assertive outreach team for Gloucestershire said patients were being read their rights under CTOs and that this is checked at the team meeting and captured on RiO. The Gloucester recovery team were giving patients on CTO their rights routinely every two months. Managers received a report to show when this had not been completed and would remind the care co-ordinator in supervision to ensure it was being done. Herefordshire assertive outreach team staff said patients also had their rights explained in a letter from the Mental Health Act office. A carer from the recovery team in Gloucester, confirmed the legal implications of the CTO had been explained to them.
- Patients had access to IMHA services and staff knew how to refer to them. The service was described as accessible and prompt. One nurse from Cheltenham and North Cotswold recovery team said patients were routinely asked at their 3 monthly review if they had received information about advocacy.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Training in the Mental Capacity Act was completed once by all staff but updates were not mandatory. Trust records showed 23 staff across all the assertive outreach and recovery teams had completed training in the Mental Capacity Act up to September 2015. One member of the Herefordshire recovery teams had recently had a refresher training in the Mental Capacity Act with the trust which they found helped them feel more competent and confident. One unqualified employee said they relied on the psychiatrist for capacity issues.
- We asked staff if they felt they had a good understanding of the Mental Capacity Act 2005. Staff confidence in their understanding varied. All staff knew who to go to for support if they needed it. Managers were confident that issues were being brought to team meetings and that advice was being given but some staff we spoke to said they needed more training. There was an item on the standard agenda to consider patients with mental capacity issues. The five statutory principles of the act were on screen savers on trust computers which helped to raise staff awareness.
- The teams were using a form with patients for them to consent to sharing information about their care. The form also explained how information would be shared and gave patients choices about the kinds of

information they preferred not to share. The person completing the form was required to say whether the patient had capacity in relation to the sharing of information and to document the best interests decision where applicable.

- Assessment forms were available on RiO for staff to use to complete capacity assessments if their patients needed them. There was heavy reliance on psychiatrists to complete mental capacity assessments. Staff understood that capacity was assessed on a decision–specific basis only and that they should always assume capacity unless there was evidence to the contrary. Managers were confident staff could identify who might need an assessment but not in their ability to complete the assessment. If a patient lacked capacity, a carer, advocate or the court of protection were sometimes included to support the patient.
- Most staff were not aware of any arrangements in place to monitor adherence to the Mental Capacity Act in the trust. Only a psychiatrist and a nurse from Stroud Recovery team were aware of this.

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

Our findings

Safe and clean environment

- All the team bases we visited had appropriate alarm systems. At St Owen street where the Hereford teams were based, interview rooms had alarms which were tested monthly. At Stroud and at Albion chambers where the Gloucester teams were based, all staff carried hand-held alarms which could activate an alarm in the building.
- The building at Stroud had recently been refurbished and provided clean, light, spacious surroundings.The building where the Gloucestershire teams were based was clean and well maintained.The clinic room was well equipped and the equipment had been checked weekly. The interview rooms were spacious and were furnished to a good standard There was a dedicated physiotherapy room. The building where the Herefordshire teams were based was dusty in some high up places such as shelves and we saw a dusty desk. The clinic room where the Herefordshire teams were based was dirty and in a poor state of repair.The scales were dusty and there were no cleaning stickers on them. The examination couch was unclean. The blood pressure monitor, thermometer and glucometer were stored in a washing up bowl. They were found to be in a pool of water which had leaked from a refrigerator which was no longer in use. The team manager confirmed equipment was not being checked or cleaned. One patient being treated in the Hereford base said the clinic room was dirty and another said it was dusty. The interview rooms were also unclean although furniture was in reasonable order. A member of staff complained the rooms at Hereford were poorly decorated, damp and unpleasant.Cleaning records consisted of generic cleaning schedules for each of the trust's sites. These showed the clinic room at St Owen street was coded for cleaning of 'toilets & kitchens'.

Safe staffing

- The staffing establishment levels funded 69 recovery and 21 assertive outreach whole time equivalent qualified staff. Unqualified establishment levels staff were for 22 staff in the recovery teams and 6 in assertive outreach teams.There were 7 whole time equivalent vacancies across the recovery and assertive outreach teams.Some of the teams had exceeded their funded staffing by agreement with the trust in order to meet increased demand.
- Staff turnover rate based on a 12 month period July 2014 to August 2015 for all the trust recovery teams, assertive outreach teams and early intervention teams was an average of 13%.
- In order to determine the required staffing levels, a 'caseload and confirm' audit had taken place which reviewed all the caseloads in the service to ensure staff were seeing an appropriate volume of the patients that matched the remit of the service. The staffing levels were based on staff doing four visits to patients per day. In Herefordshire where there were three recovery teams for north, south and east, the manager said the establishment for each team was the same but that the demands were not equal so there was flexibility to assign patients to a care-coordinator from a different team. Managers could request to exceed the staffing establishment levels and had done so in Gloucester where increases in the population size and in referrals were increasing demand on the service. Assertive outreach teams had one nurse and two other staff on duty during weekdays. At weekends when the teams only undertook essential work, there was one qualified and two unqualified or two qualified staff on duty. Gloucester and Cheltenham and North Cotswold assertive outreach teams provided cover at weekends. In Herefordshire and Stroud the assertive outreach teams did not work at weekends and cover was provided by crisis teams and the on call consultant psychiatrist.
- Patients were booked in with a clinician for an initial assessment but they were not allocated a care coordinator until they had been assessed and the referral accepted. This meant there were 239 recovery patients and 7 early intervention patients without a current care coordinator across all the teams, including those we did not visit. All assertive outreach patients had a care coordinator. There were 50 patients in

Requires improvement

Are services safe?

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Herefordshire recovery teams without care co-ordinators and one of the psychiatrists said some patients did not need a care coordinator. Patients who had not yet had a face-to-face assessments and were waiting for a care coordinator were given the contact numbers for the team they were allocated to and the crisis team.

- Service managers told us staff in the recovery teams should not have a caseload of over 40. We reviewed the numbers of patients on staff's caseloads and found the highest was 47 which was a band 4 support worker who was responsible for creating care plans and risk assessments but notinitial assessments. Most staff told us their current caseloads were manageable and that they were lower than they had been previously. However, one assertive outreach nurse said they felt staffing levels were too low for the team caseload. Assertive outreach teams had lower caseloads. The average caseloads in the Herefordshire assertive outreach team was 9 patients and the average in Gloucester assertive outreach team was 12 patients. Although caseloads were not formally weighted, one of the managers told us they consider if someone has a complex patient when allocating new patients. Caseloads were reviewed during clinical and management supervision.
- Short staffing was generally caused by sickness or annual leave. One manager told us when they were short staffed, nurses sometimes were unable to accompany an approved mental health professional to do a Mental Health Act assessment. This may have been detrimental because the knowledge and information the care coordinator would have about the patient would not be available during the assessment.
- Services were using some bank and agency staff to cover vacancies while they were recruiting or to cover long term sickness or maternity leave. These staff were familiar with the work of the teams and had been in place long term in many cases. One agency worker had previously been an NHS manager.
- All the teams could access a psychiatrist urgently when needed. Psychiatrists were based in the teams and staff said this made access to them easy. Managers said the psychiatrists were flexible and would see patients from other teams if needed and teams set aside clinics for urgent appointments each week. A nurse from the North Cotswold and Cheltenham recovery team said that when psychiatrists could not offer urgent appointments they offered verbal advice and email support. In Gloucestershire there were two consultants on long term sick leave and there were locums covering.
- The average mandatory training compliance rate for staff was 86%. However, all the teams except South Ciren Recovery fell below 75% compliance for at least one of the following mandatory trainings: Breakaway Techniques, Basic Life Support, Medication Delivery, Introduction to Child Multi Agency Child Protection Protection Level 2, Vulnerable Adults, Clinical Risk Assessment, Dual Diagnosis, Vulnerable Adults, Infection Control, Fire Safety (2yr), Information Governance, Handling and Moving.
- A manager told us there were problems for staff in navigating the website for e-learning and with logging on and that people give up on accessing training. Managers also said the reports on mandatory training were inaccurate and were always a month out of date. We were therefore unable to accurately assess the extent of non-compliance to specific mandatory training courses.

Assessing and managing risk to patients and staff

- We reviewed 56 care records in total and checked to see if patients had up to date risk assessments. Risk assessments were generally comprehensive and up to date but there were some exceptions. All the Herefordshire recovery teams east patients had a risk assessment but three were not up to date.We reviewed eight records for the assertive outreach team in Herefordshire. All of the patients had a risk assessments but only four were up to date.Of the ten records we reviewed for the recovery team in Gloucester, eight had a risk assessment, two did not and of the eight risk assessments that were present two were not up to date.In one case although the risk assessment was up to date it was of a poor quality and risk was not clearly summarised.Of the six North Cotswold and Cheltenham recovery team risk assessments we reviewed, three risk assessments had not been recently updated. Some staff told us risk was reviewed depending on need but that there should always be a comment in the notes to show risk had been considered at each contact. The contact centre who triaged the referrals decided if the patient needed to be seen within 72 hours or 28 days based on

the referral information and additional correspondence with the GP if they felt they needed more information. One recovery team manager said risk assessments were undertaken at the initial stage for every patient under care programme approach and then reviewed every 3 months or if there was a change of circumstances.

- There were inconsistencies in the way crisis plans were written and agreed. Gloucestershire recovery team managers said all patients should have a written a crisis plan within 28 days but in practice the clinician may not know the patient well enough yet to complete it. For this reason they were aware from their exception report that there were a high number of patients without crisis plans. Some staff told us formal crisis plans and advance decisions were not made but detailed within care plans instead. In assertive outreach teams, risk was reviewed daily or if there was an incident or change in presentation. When urgent support that could not be responded to by the teams was needed, the crisis team could be contacted. All patients were being given numbers to telephone in a crisis.
- All patients were triaged by the contact centre upon referral. The trust standard set out in the operational policies for this service determined patients would then be seen within 72 hours if the referral was urgent or within 28 days if it was a routine referral. In order to make this decision the contact centre might make contact with the GP to ascertain the risk and would also review any previous records with the trust. Patients were seen before they were allocated a care coordinator. Although there were no waiting lists because patients were given an appointment, they did need to wait for that appointment for up to 28 days. In the meantime they were given the emergency telephone numbers and the telephone number for the team base.
- Staff were trained in safeguarding with 'think family' which was an adult and child protection course. Staff knew how to make a safeguarding alert and that they would do this when appropriate. Staff felt able to identify abuse. Safeguarding was a standard item on the multi-disciplinary team meeting agenda . This gave staff an opportunity to discuss any cases where they had safeguarding concerns and to seek advice from the team. There was a specific team within the trust that provided support in safeguarding. The safeguarding policy was available on the intranet. Managers within the North Cotswold and Cheltenham recovery team also attended a higher level of safeguarding training.
- The trust had a lone working policy and, in addition, the teams had developed their own local lone working procedures. We reviewed the procedures for all of the teams we visited. There were signing in and out boards at team bases and a coded phrase people could use when phoning the base to indicate they were in trouble without raising suspicion. If staff wanted to arrange for someone to receive a call from them during the day to say they were safe, they could arrange this on an individual basis but this was not routine. At the end of the day all staff were expected to either return to the base or make a phone call to the base or to a colleague to confirm they were safe. There were clear steps for people receiving calls to act upon if their colleague did not call in to confirm they were safe. Staff did not consistently update their electronic RiO diaries to show which patient they were visiting before they went out on a visit. This meant it could be difficult for the manager to identify where a missing member of staff had gone. Reception staff at Leckhampton Lodge, where the North Cotswold and Cheltenham teams were based, identified that staff did not always populate their RiO diaries so the reception staff did not always know where they were, and that staff did not always sign in and out of the building. The Herefordshire Assertive Outreach team were following the same protocol.. All staff carried mobile phones and visited patients in pairs if there was a known risk.
- Nurses said they were aware of the policies and procedures for good medicines management practice. Teams had different arrangements for ensuring patients' blood was tested regularly when they were taking medicines such as Clozaril, which require patients to be monitored regularly. Herefordshire recovery teams were doing some of their own blood testing and some was being undertaken by the GP. At Albion Chambers where the Gloucestershire teams were based, a pharmacist was checking the medication they stored every two weeks and was available in between times for advice. The North Cotswold and Cheltenham and Gloucester recovery team managers explained that when the team doctors change medication they include changes in the letter they send to the GP after every appointment.

Requires improvement

Are services safe?

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

Some medicines needed to be kept in a refrigerator. Medicines were being stored appropriately in most of the team bases. We checked to see how medicines were being stored and administered. At Albion Chambers, the refrigerator was locked and at the correct temperature and the temperature was being checked daily. At Stroud medicines were stored appropriately and in date and medicines charts were legible and in order. Herefordshire team medicines were stored appropriately and there was a system in place for signing medicines out.North Cotswold and Cheltenham teams had a separate locked cabinet on the wall for each team. Refrigerator temperatures were not being monitored until recently when the manager started a rota to check the room monthly. We advised the manager to check the frequency with which refrigerator temperatures should be monitored.They referred to the trust check list and found that it should be done daily and they agreed to put this in place following our visit that day. There had been a power cut at the base earlier in the day and they agreed to check the refrigerator temperature following this.

Track record on safety

- We reviewed the serious incidents for the 12 month period from October 2014 to October 2015 across all the trust's recovery and assertive outreach teams. There were 16 serious incidents involving patients from recovery teams and one involving an assertive outreach team patient. This included five attempted suicides and seven suspected suicides.

Reporting incidents and learning from when things go wrong

- The north Cotswold and Cheltenham team manager told us about an incident where someone was locked in the building at night and this had led to a review of lone working practices and some alterations. At the Herefordshire base there had been an incident involving the hatch in reception and this had been mitigated by putting wire bars up temporarily at the hatch while it was being permanently remodelled.
- There was a lack of clarity across the teams about incident reporting. Incidents were reported using a database called Datix and the report was made by the witness to the incident or their team manager. Staff knew how to report incidents and could give examples of the kinds of incidents to report. There were some inconsistencies in what staff said they would report. One nurse said they would report significant self-harm or violence but a manager said everything was reported including slips and trips and other health and safety incidents. A psychiatrist said there was over reporting because there was a low threshold for reporting. While we were visiting the North Cotswold and Cheltenham teams there was a power cut and managers said they would report that on Datix.Managers would review incidents on Datix and sign off actions taken. Appropriate staff in the trust were informed by the Datix system to enable it to be investigated and action taken as needed.
- Staff understood the need to be open and transparent with patients when something went wrong in line with the Duty of Candour. When we asked about this, staff showed no reluctance to contacting their patients, apologising and putting things right with the involvement of the patient where possible.
- Lessons learned from incidents were sent to managers who then disseminated learning in team meetings. One member of staff told us they regularly received learning from incidents in a paper format which they were required to read and sign. One manager said they were not highlighting recommendations to their team. Another manager said there was no learning across teams except from the serious incidents and a psychiatrist said they did not have sufficient time to reflect on adverse incidents.
- Staff were debriefed after adverse incidents. There was also a folder that the assertive outreach team in Gloucester were using to record the learning and outcomes from incidents. There was an example from the North Cotswold and Cheltenham recovery team manager where following the recent suicide of a patient, they had followed a specific process for informing and de-briefing people to ensure everyone involved was supported. Staff were routinely offered support, time off, counselling and reflective supervision after serious incidents.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- Assertive outreach patients were seen by two clinicians at the initial stage. The outcome of an initial assessment of the patient was discussed and a plan agreed. The outcome was minuted. The assertive outreach team patients under care programme approach (CPA) were reviewed every three months by a consultant psychiatrist and had a CPA review every six months. Formal care programme approach reviews for recovery team patients took place every six months and managers received reports to inform them of when this needed to be done.
- We reviewed 56 care records in total. 50 patients had good quality care planswhich were up to date, personalised, holistic, recovery orientated and included evidence of ongoing physical care, informed consent and appropriate consideration of mental capacity.
- Staff were recording patient information electronically on a trust wide system called RiO. Community treatment order (CTO) forms and Mental Health Act forms and any other items routinely completed on paper were scanned and uploaded to RiO. One manager told us staff did not have access to RiO when they were out on home visits. They had to come back to the office to update records or they could do so from home via a virtual private network. Staff had the facility to make patient record updates while they were out of the office and then upload them later when they were connected to the internet. Staff we spoke to were aware of the trust's protocols for the safe storage of information and confidentiality.

Best practice in treatment and care

- There were strategies in place to ensure care was consistent with National Institute for Health and Care Excellence (NICE) guidance. Managers described following NICE guidance regarding cognitive behavioural therapy with psychosis, family therapy, psychosocial interventions and poly-pharmacy prescribing. Herefordshire was running a regular teaching programme for medics.
- The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. They are agreed with commissioners of care. There was a forthcoming CQUIN target to improve perinatal mental health. The perinatal specialism would be led by a specialist doctor and manager and staff were going to be offered additional training in perinatal mental health. (outside this team). They will be running maternal mental health training and most of the staff are booked in.
- Psychological therapies were available and they were informed by NICE guidance. In Gloucestershire there were waiting times of 11 weeks for assertive outreach team patients, nine weeks for Cheltenham, Tewkesbury and North Cotswold patients, five weeks for Gloucester and forest patients and three weeks for Stroud and North Cotswold and Cheltenham patients for psychological therapy. Staff within the teams could also offer interventions such as motivational interviewing and mindfulness. In Gloucester, an acceptance and commitment group was scheduled for January to March 2016 for people who have experience of psychosis. The group would be open to recovery and assertive outreach patients in Gloucester and the Forest of Dean. In Herefordshire, following an initiative to improve availability of psychological interventions, there were no waiting times. The psychology teams could offer both long and short term therapy. They had made the service more equitable and were providing some form of psychological input to 35% of the whole patient load. One patient we spoke to, who was being treated by the Herefordshire recovery team, had been having counselling for three years and said it was excellent.
- Clozapine is a medication prescribed by psychiatrists and due to potential side effects, regular blood tests throughout treatment with clozapine are carried out. Prior to commencing medication the consultant would liaise with the GP for blood testing and any other recommended physical health checks. We attended two meetings between service users and their psychiatrists.We observed discussions about side effects of medication which included reference to NICE guidelines. Clozapine was being managed with blood being taken at several sites in rural areas. All the teams were using the Clozaril patient management service to ensure blood monitoring checks were up to date, as required for patients taking this medication. Some

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teams offered blood screening for patients on Clozaril and others were monitored by the patient's GP. The Gloucester recovery team provided the initial daily monitoring for patients when they were first prescribed the drug and then the GP took over the ongoing monitoring but gave the teams the results. When blood was taken at the GP surgery, the prescription for Clozaril or lithium was signed off by the consultant. Teams had systems for ensuring blood tests were completed regularly and the results received and reviewed. For example, the manager for the Cheltenham recovery team said they checked a list of people on Clozaril to ensure their blood results were in date. The consultant psychiatrist for Gloucester assertive outreach team said they were monitoring all lithium and Clorazil blood results. Stroud assertive outreach team were conducting similar monitoring using a weekly spreadsheet which the manager monitored.

- In Herefordshire the section 75 agreement that had previously been in place between the trust and the local authority had been withdrawn.This meant that social care staff were no longer situated in the team. Some staff expressed concern that the division of health and social care provision may impact upon how effectively patients' social care needs were assessed and met. However, there were a number of resources in place to support staff and patients to access housing and benefits advice, for example, the citizens advice bureau. There was a vocational service provided by the trust that provided advice and support around employment.
- However, patients were continuing to be supported with their social care needs by the teams. One patient from the Herefordshire east team told us they had had support from their care coordinator to obtain social care input and another carer had obtained carer's leave through the support from the team. One nurse told us they recognised patients benefitted from being able to work and said they provided employment advice to their patients. Another nurse told us there was a vocational service provided by trust which they were enabling their patients to access. One nurse said they work closely with the citizens advice bureau.A nurse from the North Cotswold and Cheltenham recovery team said they would discuss housing and social issues at every home visit. In the Assertive outreach team at Herefordshire, one of the health care assistants had a specialist interest in benefits, work placements and housing.
- Physical healthcare needs were taken into consideration in all of the teams we visited although there was varying provision. Patients physical health checks were undertaken by their GPs and some teams would remind the GPs to do this. To complement the role of the GP, there was a band four support worker in the Gloucester recovery team who provided physical health, smoking cessation and general health advice. In Herefordshire assertive outreach team a former GP had been appointed and they were monitoring physical health jointly with the team consultant psychiatrist. Cheltenham assertive outreach team had a sports therapist who offered weight management and smoking cessation support. We saw an example of a letter from a consultant to a GP where the patient's asthma was taken into consideration and a test for diabetes was recommended. In North Cotswold and Cheltenham, the recovery team had a clinic room with a blood pressure monitor and scales but staff told us they were not routinely used. One psychiatrist was not sure who was responsible for undertaking physical health checks. Teams could support patients with their physical health needs if necessary by accompanying them to appointments. One assertive outreach team clinician was supporting a pregnant patient with antenatal appointments.
- Teams were using outcome measurement scales to inform diagnosis and treatment but they were not routinely monitoring outcomes of treatment for patients. Teams were using the health of the nation outcome scale to cluster their patients using mental health clustering. This was a way of determining a treatment path depending on the diagnosis and severity of symptoms. The assertive outreach team for Gloucester also used the Becks depression inventory. Cheltenham and North Cotswolds assertive outreach team were using the Hamilton depression scale, thePsychiatric Assessment Schedules for Adults with Developmental Disabilities and the Wechsler Adult Intelligence Scale.
- Staff participated in a range of clinical audits. For example, the Stroud team manager was taking part in

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an audit of patients with a first presentation of psychosis. Another manager was involved in a trust-wide audit of records. One manager was involved in auditing data quality and ensuring care programme approach reviews were being completed. The manager for North Cotswold and Cheltenham recovery team was completing a quarterly suicide audit where they reviewed 5 service users records to ensure everything was in place such as risk assessments and crisis plans. The Herefordshire manager was reviewing patients' clusters and their length of time with the service to ensure treatment pathways were being completed and reviewed. The trust was able to provide us with a good selection of completed audits but they did not involve members of the teams we visited. However, nurses and psychiatrists consistently told us they were not involved in clinical audits. Managers completed overarching service monitoring activity.

Skilled staff to deliver care

- All the teams we visited had a good range of staff working in them, including nurses, psychologists, psychiatrists, occupational therapists, support workers, social workers (in Gloucestershire only) and physiotherapists. Managers were actively recruiting to vacant posts and using suitably experienced bank or agency staff as needed. In Stroud recovery team they also had an art therapist. Staff in the teams were suitably experienced and qualified.
- New staff were provided with corporate and local inductions. For example, the North Cotswold and Cheltenham recovery team gave staff a four week induction during which time the new staff member could spend time with each of their team members and with other teams and organisations they refer to. There was an extensive list of competencies to signed off for new staff working within the Stroud assertive outreach team.
- Clinical supervision was taking place on a regular basis and was provided by the team managers with optional access to additional clinical supervision.Line managers were providing supervision at a frequency of between every six and 12 weeks depending on the team. We reviewed some line manager delivered clinical supervision records from the Gloucester recovery team. We saw active discussions documented about developing practice through additional training. There was a template for recording clinical supervision which some managers used. The form guided them to review all of the cases on the employee's case load as well as their performance, training needs, leave and IT needs. All but one of the managers were keeping formal electronic supervision records and sharing them with their supervisees. Clinicians were responsible for arranging their own supervision to suit their own needs. The supervision arrangements for the assertive outreach team in Herefordshire were unclear. The manager informed us that it was the responsibility of staff to make their own supervision arrangements. They could not confirm that they knew what these arrangements were, or whether staff did receive regular supervision. However, two staff members within this team told us that they did receive supervision from their line manager and optional clinical supervision. Staff told us they could also seek informal supervision from the team or from their manager as needed. Some of the optional supervision was in group formats. The Herefordshire recovery teams were having a monthly formulation supervision group facilitated by one of the psychology team. The occupational therapist from one of the Herefordshire teams was having monthly specialist peer group meetings. Psychiatrists had weekly peer supervision.
- The percentage of non-medical staff that had had an appraisal in the last 12 months was 79% inJuly 2015. The method of reporting appraisals had changed in May 2015 and was now being revised quarterly to enable managers to have reports that were more up to date and needed less data validation. Some staff had not been appraised because they were new to the team, changing jobs or on sick leave. Staff were being appraised annually using a standard appraisal tool.Some staff completed a standard employee self-assessment form prior to their appraisal meeting. We reviewed some appraisals for staff in the Gloucester recovery teams. Managers had written supportive and positive overall comments on them. Objectives had been set but there were no success criteria on one of the appraisals to enable the employee and manager to determine if the objective had been met. One of the Gloucester team described the appraisal as a paper exercise and said they didn't feel they could progress any more in their job.

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- Some staff said they would like to do more specialist training for their roles. One nurse said they struggled to find specialist training and another said a great deal of training was on offer. Two nurses said it was difficult to undertake training because there was not enough cover in their teams to alleviate them from their duties. One psychiatrist from the assertive outreach service said they had specialist training in the assertive outreach model and they were having three meetings per year as ongoing updates. Another psychiatrist said the trust are good at encouraging training.
- We spoke to managers about how they performance manage their staff. Where this had been necessary, informal discussions had been held before the process became formal and the human resources department had been involved.

Multi-disciplinary and inter-agency team work

- All teams were holding weekly multi-disciplinary team meetings for the whole team. All Stafftold us these meetings were useful. Teams had a standard agenda to follow. The agenda provided prompts to consider important issues such as safeguarding concerns, medication changes, perinatal issues and accommodation issues. All team agendas included a section on complaints. Through reading minutes and attending three team meetings we saw consistent thorough discussions about patients and how best to meet their needs. Team meetings provided additional opportunities to seek supervision from peers . One member of staff described it as an opportunity to `bounce ideas off other members of the team`. We attended the Herefordshire east recovery teams meeting and found it to be effective . We observed careful consideration being given to individual patients' needs. A patient who was considered to be a potential candidate for psychological therapy was discussed and it was decided with the psychologist at the meeting for them to offer support to the case coordinator in formulating the patient's difficulties. The north Cotswold and Cheltenham recovery team manager said they sometimes invited external speakers to their meetings, including a dual diagnosis consultant who attends monthly.
- The trust had issued a guidance document on team interface decision making in September 2015. It challenged staff to ensure patients' needs were at the heart of decisions made about their care rather than on team needs or cluster allocations.There were effective handovers between teams within the organisation. We saw care being taken to ensure patients were placed in the correct service. During the Herefordshire recovery team's meeting, where it was unclear which service would work best with a patient, it was decided to offer a further assessment session. An assertive outreach team nurse said there were handover planning meetings every Monday in Herefordshire. This enabled the team to plan for the week ahead. One nurse from the North Cotswold and Cheltenham recovery team confirmed that referring patients to the assertive outreach team was straightforward. The Gloucester recovery team manager was attending a ward interface meeting every week and feeding back to the team on discussions had at the meeting about patients approaching discharge or admission. In Stroud the crisis team attended team meetings each week. A Cheltenham recovery team nurse said there were good links with the crisis team and with the inpatient unit. Teams said they tried to keep in contact with patients they were care co-ordinating if they went into hospital but told us that geography could sometimes be an obstacle. A psychiatrist reported there was good communication with the psychiatric liaison service at the local hospital. One carer from Gloucester complained that communication between the acute wards and community team was fragmented. When young people transferred from children and young people's mental health services to adult services, the aim was to begin a cross over with a young person at the age of 17 to enable them to transfer completely at the age of 18. The lead psychologist for Herefordshire was going to the children and young people's service once per week in order to improve transitions for children into adult services across Herefordshire. It had been identified that abrupt transfers or discharges had been made in the past and this had been detrimental to patients. There were good links with the primary care talking therapies service and in Herefordshire we heard of an example of joint working with them to ensure a patient was placed in the service that best met their needs. The assertive outreach teams would transfer patients to recovery teams over sufficient time and with careful consideration.

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- Staff were able to tell us about local services including housing and employment resources which they could signpost their patients to. There were good links with services external to the trust such as substance misuse services. However, in Stroud, staff relationships with primary care were described as positive. The assertive outreach team in Herefordshire said reported that they worked effectively with housing and social care services.

Adherence to the MHA and the MHA Code of Practice

- Training in the Mental Health Act was not mandatory. Trust records showed six staff across all the assertive outreach and recovery teams had completed training in the Mental Health Act up until September 2015. One manager said places on the training were limited. One manager did not know if their staff were trained in the Mental Health Act or not. However, managers were confident in their staffs' knowledge of the Mental Health Act because it had been covered in their professional training. The trust informed us that basic awareness training in the Mental Health Act (MHA) and the Mental Capacity Act were included in Clinical Risk and Care Planning training and also in Think Family training, but we did not review this ourselves. There were limited opportunities for training in the MHA to be updated. . We asked staff about their confidence in understanding the Mental Health Act. Many felt they had good knowledge but one nurse said they needed more training in the revised Mental Health Act code of practice and in community treatment orders. One manager and one nurse were not aware of the revisions to the Mental Health Act code of practice. Another nurse said they needed more general training in the Mental Health Act. There was a trust mental health office where staff could ask for support and advice on the Mental Health Act.

- Consent to general treatment was implied in most of the teams. The manager from Herefordshire recovery teams said staff would make a general note in the progress notes so say a patient had consented to their treatment. One of the assertive outreach team managers explained that consent to treatment was assumed unless a patient was sectioned under the Mental Health Act. One manager said that one way in which implicit consent was gained was by ticking the box on the electronic records system to show a patient had had a copy of their care plan. However, they were unable to run a report to see which patients did not have this box ticked. Psychiatrists were aware of the need to gain consent when giving injectable medicines. The manager for the assertive outreach team for Herefordshire said capacity to consent to medication was not being assessed, including for depot injections. A nurse and a psychiatrist from the assertive outreach team in Stroud said consent to treatment was attached to medication charts but we did not check this.

- There were 61 patients on community treatment orders (CTOs) being treated across all the trust'sassertive outreach and recovery teams. One manager told us patients should be reminded of their rights under the Mental Health Act every three months but they were not sure if this was happening. A psychiatrist said people were being told their rights every few months according to an individual plan. The manager for the assertive outreach team for Gloucestershire said patients were being read their rights under CTOs and that this is checked at the team meeting and captured on RiO. The Gloucester recovery team were giving patients on CTO their rights routinely every two months.Managers received a report to show when this had not been completed and would remind the care co-ordinator in supervision to ensure it was being done. Herefordshire assertive outreach team staff said patients also had their rights explained in a letter from the Mental Health Act office.A carer from the recovery team in Gloucester, confirmed the legal implicationsof the CTO had been explained to them.

- Patients had access to IMHA services and staff knew how to refer to them. The service was described as accessible and prompt. One nurse from Cheltenham and North Cotswold recovery team said patients were routinely asked at their 3 monthly review if they had received information about advocacy.

Good practice in applying the MCA

- Training in the Mental Capacity Act was completed once by all staff but updates were not mandatory. Trust records showed 23 staff across all the assertive outreach and recovery teams had completed training in the Mental Capacity Act up to September 2015. One member of the Herefordshire recovery teams had recently had a refresher training in the Mental Capacity

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Act with the trust which they found helped them feel more competent and confident.One unqualified employee said they relied on the psychiatrist for capacity issues.

- We asked staff if they felt they had a good understanding of the Mental Capacity Act 2005. Staff confidence in their understanding varied. All staff knew who to go to for support if they needed it. Managers were confident that issues were being brought to team meetings and that advice was being given but some staff we spoke to said they needed more training. There was an item on the standard agenda to consider patients with mental capacity issues. The five statutory principles of the act were on screen savers on trust computers which helped to raise staff awareness.
- The teams were using a form with patients for them to consent to sharing information about their care. The form also explained how information would be shared and gave patients choices about the kinds of information they preferred not to share. The person completing the form was required to say whether the patient had capacity in relation to the sharing of information and to document the best interests decision where applicable.
- Assessment forms were available on RiO for staff to use to complete capacity assessments if their patients needed them. There was heavy reliance on psychiatrists to complete mental capacity assessments. Staff understood that capacity was assessed on a decision–specific basis only and that they should always assume capacity unless there was evidence to the contrary. Managers were confident staff could identify who might need an assessment but not in their ability to complete the assessment. If a patient lacked capacity, a carer, advocate or the court of protection were sometimes included to support the patient.
- Most staff were not aware of any arrangements in place to monitor adherence to the Mental Capacity Act in the trust. Only a psychiatrist and a nurse from Stroud Recovery team were aware of this.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- During our inspection we observed three outpatient appointments and went out on a one home visit with ahealthcare provider to see a patient. We observed staff being respectful and compassionate. They listened patiently and offered practical advice.
- The majority of feedback about the service and the staff was overwhelmingly positive.Patients used words such as kind, responsive, polite, respectful, supportive, caring and encouraging to describe staff. One patient said the staff go “above and beyond” and that they were very caring. One patient said staff made them feel safe. There were three negative comments, one carer said there was a lack of warmth and empathy from the team. One comment card from a patient said their support worker made them feel worthless. There were comments from two patients about feeling unsupported when staff left the service because they lost regular support. Two carers complained of the inconsistency of psychiatrists in Gloucester where there had been locums covering two posts due to long term sickness.
- During the Herefordshire east recovery team’s meeting staff talked about patients’ needs and how best to support them. All the staff in attendance spoke empathically about patients and with insight and knowledge.
- Staff took confidentiality seriously. At Albion Chambers where the Gloucestershire teams were based, the staff were aware of the poor sound proofing in the building and were keen to move to more suitable premises because of concerns about potential breaches of confidentiality.The Herefordshire east recovery teams arranged an interpreter for a patient who needed one even though they had a family member who could translate. This was in order to preserve the patient’s confidentiality.

The involvement of people in the care they receive

- Apart from two patients, most of the patients we spoke to said they had copies of their care plans and that they had been involved in their care. It was not always clear from their records whether patients had been given a copy of their care plan. For example, of the seven care plans we reviewed for the assertive outreach team in Herefordshire, four of the patients had no care plans at all and none had been given a copy.
- Patients could discuss their medication and side effects with their psychiatrist. Staff provided patients with information about medication and mental health conditions. We observed patients being given choices about their care in an outpatient appointment where a psychiatrist and care coordinator discussed social and biological aspects of the patient’s life with them including daily activities, finances, accommodation, diet and emotional wellbeing.The patient was given time to speak and was treated respectfully and with compassion throughout the review meeting. A plan was made to change medication at the request of the patient.
- Consent to general treatment was implied unless a patient was sectioned under the Mental Health Act. Psychiatrists were aware of the need to gain consent when giving injectable medicines and we were told consent to treatment forms were attached to medication charts.
- Some teams had leaflets available at their base and others printed information from the intranet as required and directed patients to internet resources. Patients told us they had been given information about groups and external services. Patients told us they were encouraged to learn new skills and take part in community projects.
- Carers were involved in patients care as far as the patient wanted them to be. One patient had allowed their family to have independent access to clinicians. Another did not want their family involved and both had had their choices respected. The trust provided a booklet of information for carers of people using the service. It provided useful information including what to do in an emergency and was available at all the locations we visited. A patient from the Herefordshire recovery teams said carer support and information had been offered. We saw evidence of a carer being involved in a patient’s care during a home visit we attended. One carer said they had been encouraged to be involved in the care being provided including taking part in care plan reviews and being supported in assisting the patient with living skills at home. Carers assessments were available and could be arranged by staff.

Good

Are services caring?

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- Patients were informed about advocacy services. One service user had accessed the service and found this easy.
- One service user had been invited to give a talk about their experiences to junior doctors and student nurses during their training. Other patients said they had been given questionnaires. Three patients from Herefordshire had been on interview panels for the service.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- Gloucestershire teams referrals were triaged upon referral by a central contact centre. Administrators gathered information about the patient and then the referral was screened by a qualified mental health clinician. The contact centre aimed to contact crisis referrals within one hour, urgent referrals within one working day and routine referrals within 48 hours. If these standards could not be met the matter was escalated to a senior manager. The team booked appointments directly into an appropriate clinician's RiO diary. If the appointment booked breached the waiting time target then the team manager was informed at the time the appointment was booked. In Herefordshire there was no central referral system and referrals were directed to the recovery teams who reviewed and allocated referrals to clinicians within their teams.
- There was a target for Gloucestershire patients to be seen within 28 days if the referral was routine or within 72 hours if the referral was urgent. In Herefordshire the target was to see all routine patients within 21 days and urgent referrals were seen by the crisis assessment home treatment team within 24 hours. Managers said these targets were generally only breached if patients failed to engage with the service. Assertive outreach teams did not accept urgent referrals for patients in crisis because during a crisis was not a good time to approach patients who were struggling to engage. Team managers and the service manager at Gloucester were unable to say how often and for how long patients had waited longer than for 28 days for their first routine appointment. The service manager had been working with the data department to create bespoke reports to improve the quality of the data the teams were receiving.
- The trust provided its latest waiting times: 56% (33 patients) were seen within two weeks for assessment within the Gloucestershire recovery teams. 15% waited two to four weeks (9 patients), 10% waited four to six weeks (six patients), two percent six to eight weeks (one patient), five percent eight to 13 weeks (three patients) and twelve percent more than 17 weeks (7 patients).In the Herefordshire teams 55% (24 patients) were seen within two weeks of referral, 23% (10 patients) waited two to four weeks, 9% (four patients) waited four to six weeks, two percent six to eight weeks (one patient), five percent eight to 13 weeks (two patients) and seven percent more than 17 weeks (3 patients).
- The Gloucestershire team base had a duty system where a clinician was on duty to take calls from patients. At Herefordshire this duty was operated by the administrative team who passed the enquiry on to the relevant clinician.
- Gloucestershire and Herefordshire had separate operational policies which set out the criteria for the service. There was flexibility, for example, if a patient reached the age of 65 and did not have specialist needs best met by an older persons service such as a dementia diagnosis, then they could remain in the adult service. The remit of the assertive outreach teams was to engage patients with psychosis who were struggling to engage with services. However, the team was not diagnosis led and if appropriate they would work with a range of people who may not engage well with services.
- Teams tried to engage with people who had difficulties or who were reluctant to engage with mental health services. During the Herefordshire east team meeting, we saw examples of staff making particular efforts to engage patients who were struggling to attend appointments such as seeing them at home or at a GP surgery.There were efforts to ensure patients who were more suitable for other services were engaged in another service rather than simply declining the referral.
- When patients did not attend their appointment they were sent a letter which asked them to make contact with the service. If patients did not reply to a letter sent to them after they failed to attend, they were discharged. Some staff said that this approach seemed strict for new patients and that they could do more to engage them, such as sending text reminders. When patients were discharged because they disengaged or failed to engage with the service, their GP was informed. When there was an identified risk, there were further steps taken to check the patients' safety. Sometimes staff would go to a patient's house to check they were ok if they were concerned about risk.
- All the teams tried to accommodate patient's needs in offering flexibility in appointment times to suit the

Are services responsive to people's needs?

Good

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

patient. The assertive outreach team at Gloucester were able to see patients between the hours of 8.00am to 8.00pm if required although their routine hours were 9.00am to 5.00pm.

- Appointments were not cancelled unless it was unavoidable, such as due to sickness. One patient complained their care coordinator had often cancelled her appointments. In this patient's care records it was noted that a previous care co-ordinator had often rescheduled appointments at short notice and that this had not suited the patient and they had been assigned a new care coordinator. Managers told us appointments usually ran on time. In the Herefordshire assertive outreach team patients were seen by different members of the team, not necessarily their care coordinator. This enabled them to visit patients up to four times per day if needed. The whole team aimed to be familiar with the team caseload.

The facilities promote recovery, comfort, dignity and confidentiality

- All of the team bases we visited had a full range of rooms and equipment to support treatment and care. Staff said access to rooms was adequate. Patients were happy with the buildings although they said it was difficult to park at Gloucester.
- The soundproofing at St Owen street, where the Herefordshire teams were based, was poor and conversations inside interview rooms could be heard from outside them. Staff complained to us about the sound proofing and one member of staff told us the building was unfit for purpose. One of the patients we interviewed also voiced concerns about some of the rooms not being sound proofed.
- Patients were provided with written information to keep them informed about their treatment choices. At Stroud there was lots of information about local services, mental illnesses, advocacy and the patient advocacy and liaison service on display. Leaflets and feedback forms were on display at Owen street. One patient said they had been given information in the form of leaflets and fact sheets.Patients were given information about their medication including information about side effects. Patients were also directed to websites. information leaflets and feedback forms were provided in the reception area at Albion chambers where the Gloucester teams were based. At North Cotswold and Cheltenham recovery team base and at Hereford there was very little information on display but information about was being printed for patients as they needed it. Herefordshire patients said they had information about local services and about mental and physical health issues.One Herefordshire patient said they had not been given any written information to help them with their care and treatment but that they were able to discuss it.A patient being treated by the assertive outreach team in Herefordshire said they had been given lots of information in written form and that they had also been offered IMHA Services.

Meeting the needs of all people who use the service

- All of the team buildings could be accessed by people with disabilities. Albion chambers where the Gloucestershire teams were based had a ramp into the building and an interview room with wide access. All buildings had disabled toilets. Patients said parking was difficult at the Gloucester and Hereford bases. A patient from the North Cotswold and Cheltenham recovery team said the reception staff helped them with their mobility issues.
- Information in foreign languages was not readily available in any of the buildings but staff told us they could access them. The populations of Herefordshire and Gloucestershire were predominantly white British. 95% of the population were white British in Gloucestershire and 94% in Herefordshire. This meant translation services did not need to be used very often. A patient discussed in the Herefordshire east recovery team meeting was going to be seen in the GP surgery with an interpreter. Teams would use interpreters rather than family members to preserve patient confidentiality. Interpreters could be booked easily by email or telephone.

Listening to and learning from concerns and complaints

- 39 complaints had been received in the 12 months previous to our inspection for all the trust's assertive outreach and recovery teams.One of these complaints was upheld and 17 were partially upheld, 13 were not upheld and 3 were withdrawn. The remaining five were still open.One complaint had been referred to the ombudsman but the outcome was still awaited.

Are services responsive to people's needs?

Good

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

- The trust ran a centralised complaints process for patients to make formal complaints. Complaints were managed by the patient advice and liaison service and there was a poster, leaflet and complaint form available in the bases. None of the teams advised patients directly how to complain unless they were aware the patient wished to complain. However, most of the patients we spoke to said they knew how to complain. One patient we spoke to from Herefordshire said they would not feel confident making a complaint because they did not know the process and would fear the consequences. Another patient being treated by Herefordshire assertive outreach team said they would talk to somebody from the team in the first instance and that they would feel confident making a complaint. When we asked Gloucester carers if they knew how to complain, one said they knew how to complain and three did not.

  Patients told us they would be confident in complaining on the whole and that they would approach their care co-ordinator in the first instance. None of the patients we spoke to had made recent complaints.

- 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. Complaints was a standard agenda item at team meetings. A psychiatrist said they reflected on complaints and considered how they would do things differently.

Are services well-led?

Good

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

Our findings

Vision and values

- Staff were aware of the organisation's values. Managers knew the acronym 'SERVICE' and one was able to recite what the letters stood for. Another manager talked about the trust's vision for a well led, high quality and equitable access. One manager said providing patient centred care was particularly strongly embedded in their team.
- Staff knew who the senior managers in the organisation were. One manager said that although the senior team were visible, they were not sure they fully understand the pressures in the recovery teams. A new team manager said they had felt particularly well supported and encouraged by their service manager. Staff were aware that the executive team visited services, although some staff and managers did not always feel that the executive team understood the challenges faced by the services.

Good governance

- Managers had key performance indicators to reach in order to ensure their services were running to a high standard. The trust expected patients to be seen within the timeframes set out in the operational policies for the service. If a patient waited longer, then this was considered a breach and managers were informed with an exception report. Patients had to have their care programme approach reviewed every 12 months and this was reported on and checked by managers. There was also data on appraisals which had to be completed annually and mandatory training had to be completed on a rolling basis. Patients all had to have cluster allocations and care plans and this was also reported on. This enabled managers to prompt their staff to complete these if they were not completed. Data had to be validated by managers and they said data was often out of date or inaccurate. Managers complained of spending a great deal of time checking the accuracy of quality and performance reports and having them corrected and reissued. Reports the managers received were complex and had to be interpreted, this could be time consuming and some managers found it reduced time spent on other aspects of their role, for example, staff support. The service manager for Gloucester was working collaboratively with the data management team who issue the reports to improve them.
- With the exception of a manager who was unclear of the supervision arrangements for their staff, managers ensured staff were being appraised and supervised appropriately and that they were up to date with their mandatory training. Staff attended weekly team meetings and these were well structured.
- Clinical audits were scheduled by the trust, these were identified centrally which meant there were limited opportunities for front line staff to lead and participate in audits.
- Staff knew how to make safeguarding alerts and were supported in considering safeguarding issues through team meetings and through the trust safeguarding team. Some staff felt they lacked knowledge of the Mental Capacity Act and were relying on psychiatrists and social workers to undertake assessments which meant patients could have their capacity assessed by someone who did not know them well.
- Incidents were being reported and investigated. There were some inconsistencies in what staff said they would report because of a lack of clarity across the teams about what should be reported. One member of staff said they would report significant self-harm or violence whereas a manager from a different team said everything including slips, trips and falls was reported. Appropriate staff in the trust were informed by the Datix system to enable it to be investigated and actions taken as needed.
- Team managers felt they had sufficient authority and said they had good access to administrative support.
- We reviewed the risk registers for the Gloucestershire and Herefordshire. Entries to the trust risk register were made indirectly via the service manager who could then escalate the concern if necessary. Managers across the teams were unclear about the process. One said they would approach the quality assurance lead directly, and one manager did not know how to submit items at all. Three managers said they would refer concerns to their service manager. Another manager said they would make entries to the trust risk register via Datix.

Are services well-led?

Good

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

Leadership, morale and staff engagement

- We reviewed the staff sickness rates for each recovery and assertive outreach team. The average of the monthly team sickness rates 8% in the 12 month period from October 2014 to August 2015.
- Staff told us there were no issues with bullying and harassment in the service.
- Staff told us they knew how to whistle blow and most would do so if they needed to. One manager told us it was their professional duty to do so. Some staff were aware of a new initiative which meant staff could whistle blow anonymously online and they thought this was a good idea. One person said they had complained to their team manager about a member of staff but that they haven't felt supported or that the complaint had been adequately followed up. Two members of staff said they would fear the repercussions of whistleblowing. One of the managers told us it would depend on the issue as to whether they would feel victimised. The rest of the staff we spoke to said they felt they could raise concerns without fear of victimisation.
- Generally staff enjoyed their jobs and felt well supported despite the pressures. Staff said relationships between team members were supportive and that although there was stress it was at an acceptable level. People told us staff got on well, worked together and could be relied upon for support. Morale was generally high in all the teams although one of the North Cotswold and Cheltenham recovery team and one of the Gloucester recovery team said they thought morale in their teams was challenged by high caseloads. One member of staff said they felt they were making a difference to people in their job. One manager said staff pull together when there are challenges. Teams worked well together. Staff said their managers were supportive. One recovery team member told us relationships between staff were strong and this helped them to work in a demanding job.
- Some of the staff we met had had leadership training in the trust. Managers said they were encouraged to develop. However, one manager felt there were insufficient opportunities for leadership training and that training was sometimes withdrawn. One of the medical staff had just completed the King's fund clinical directors programme and had been promoted to clinical director.
- Staff generally said they could voice concerns or ideas about the service and they could give feedback and input. One nurse said there were opportunities to give feedback online and through staff surveys. A minority of staff we spoke with felt that feedback from staff was not always acted on by the trust.

Commitment to quality improvement and innovation

- The service was taking part in a national study on DNA polymorphisms(genetic factors) in mental illness. The consultant psychiatrist from the Gloucester teams was actively recruiting patients to take part in the study. The research was aiming to build knowledge to improve and tailor treatments based on a patient's genetic make up to increase effectiveness and reduce side effects.
- The trust had set up a recovery college for patients who were recovering from mental health difficulties to enable them to learn and socialise. Participants could access training in mindfulness and learn about developing their self-confidence. They could have psycho-educational training in understanding mental health difficulties. They could also go on to learn to be trainers themselves.

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
	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 (1)(a)(e) HCSA 2008 (Regulated Activities) Regulations 2014 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 regulations 15(1)(a) and 15 (1)(e)