Requires improvement

2gether NHS Foundation Trust

Community-based mental health services for older people

Quality Report

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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)
RTQ01	Charlton Lane Centre	Managing memory team for Gloucestershire	GL53 9DZ
RTQ01	Charlton Lane Centre	Later life mental health community team for Gloucestershire	GL20 8SJ
RTQ01	Stonebow Unit	Community mental health services for older people in Herefordshire.	HR1 2BG

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.

Summary of findings

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	Requires improvement 
Are services safe?	**Good** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

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 community-based mental health services for older people as requires improvement because:

- 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.
- We found the environment at Lexham Lodge, a temporary facility used by the managing memory team in Gloucestershire whilst their facilities were being rebuilt, was unsafe and unsuitable for older people accessing the building. The trust responded immediately to our concerns and arranged for all patients to be supported inappointments as home visits rather than outpatient appointments at Lexham Lodge.
- Patients told us they did not know how to complain and they had not been given the opportunity to feedback about their services.
- Staff did not record all relevant information in electronic patient records (RiO). This included staff not recording risk alerts and medication reviews in care plans. Some progress notes were detailed. However, most information was either not located in the correct sections or was missing altogether. Crisis plans, health of the nation outcome scales and consent to care documentation was missing from most of the patient records we examined. Staff working in the later life team who were supporting some people with end of life care had not recorded advanced decisions in RiO records.
- Sickness levels were high in Herefordshire with one team at 9%. There was a lack of managerial and clinical supervision in the Herefordshire teams and managers in the community teams in Gloucestershire had only received three managerial supervisions in one year. Staff in Herefordshire told us that the combination of losing three manager posts and the withdrawal of the social services component (social workers, carer assessment workers and their caseloads) from their teams had made them feel stressed at work. Staff felt unsupported and were unsupervised.
- Senior staff felt they were not consulted with or listened to by the senior executive team about changes and developments to their services. Some said there had been a lack of transparency in regards to service development and changes.

However:

- Staff in the community mental health teams had manageable caseloads, averaging 30 patients per full time worker. Wait times for initial assessments were mostly within the four week wait target time and any breaches were well managed. Staff offered patients flexible appointment times and locations. There were short wait times for access to psychological therapies in the later life team in Gloucestershire. Staff told us they reviewed antipsychotic and anti-dementia medication regularly, although they could have documented this more in RiO notes. Patients had good access to advocacy.
- Teams in Gloucestershire were well staffed and any vacancies were well managed. Managers here used long-term bank staff and did not use agency staff. Sickness and turnover rates were low. Teams held regular multidisciplinary meetings and teams in Gloucestershire had developed strong links with other services both internally and externally. Lone working policies were robust and reliable throughout all services.
- Managers shared good learning from incidents and complaints, cascaded to all staff in team meetings and learning events.
- The dementia education team at Sherbourne House worked innovatively to develop community awareness about dementia. Leaflets were displayed in waiting areas for patients to find information about advocacy, their rights and how to access services. Managers in all but the later life team utilised key performance indicators to monitor performance on team performance.
- The staff we spoke to were motivated, passionate, caring and dedicated. They promoted choice and were respectful of their patients. They were very proud of the job they did.
- Patients were complimentary of their staff teams. Patients had good access to advocacy.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- managing memory services were fully staffed, had low sickness absence rates, low turnover of staff and did not need to use agency staff. Managers of other services with vacancies managed them well by employing their part time staff and regular bank staff to cover any gaps
- caseloads within community teams were low, averaging 30 patients per full time worker
- a psychiatrist could be accessed within 24 hours when required
- lone working procedures were robust and reviewed in staff meetings
- staff demonstrated sound knowledge in safeguarding and had Gloucestershire services had established effective links and communication with local safeguarding teams
- managers cascaded learning from incidents to all staff during staff meetings. Managers organised learning events for staff following serious incidents
- mandatory training compliance was high, averaging 95% compliance. Staff talked positively about the opportunities available for ongoing learning and training within the trust

However:

- We found the environment at Lexham Lodge, a temporary facility used by the managing memory team in Gloucestershire whilst their facilities were being rebuilt, to be unsafe for older people accessing the building. There was a trip hazard on the ramp entering the building and resuscitation equipment was out of date. The trust responded immediately to our concerns and arranged for all patients to be supported inappointments as home visits rather than outpatient appointments at Lexham Lodge. If a home visit was inappropriate for any reason, an outpatientappointment would be offered fromthe Charlton Lane site main hospital or at the patient's GP Practice as most appropriate.
- staff did not often document risk assessments, medication reviews and crisis plans in the appropriate section of patients' electronic care records
- high caseloads in the managing memory services meant that nurses were no longer able to review anti-dementia medication every six months and were struggling to review all patients annually. Staff had not reviewed 11% of managing memory patients at the time of the inspection

Summary of findings

- teams in Herefordshire struggled with just one psychologist covering three teams
- sickness levels were high in Herefordshire with one team at 9%

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- information was out of date in some care records, not recorded in others and generally not stored within the appropriate sections of the care plan. There was a lack of recording of outcome ratings such as HoNOS. Staff had not uploaded Mental Health Act information about patients onto RiO. Records of physical healthcare checks were missing or not recorded in the correct section from 14 out of 23 records viewed.
- Staff described difficulties around the completion and monitoring of RiO, travelling long distances to see patients and the impact this had on their administrative time.
- 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 (including medical secretaries) had not been completed within the past 12 months. 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.

However:

- the managing memory services had recorded up to date information about patient appointments and visits within progress notes
- nurse prescribers carried out physical healthcare checks, although in community teams, RiO records did not reflect this
- multidisciplinary meetings took place every week
- monthly supervisions and peer supervisions were taking place for all staff in the managing memory services and for most in the later life team
- all staff in the managing memory services had training in the Mental Capacity Act and they had access to a reablement manager on site.

Are services caring?

Good

We rated caring as good because:

- patients and carers gave positive feedback about staff. Patients knew their staff team by name

Summary of findings

- 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
- we saw that patients were asked for their consent at each stage of assessment
- patients knew how to access advocacy
- managers used information from the service experience teams to develop and improve their services

However:

- consent to care was sometimes not well documented on RiO
- patients told us they had not been asked for their feedback about services.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- services mostly met the four week wait time target for referral to assessment
- managers identified any breaches in these wait times and put additional resources in place to address any problem areas
- there was a short wait time for access to psychological therapy within Gloucestershire; only three weeks in later life teams
- there was no one on the waiting list to access services in the later life team
- patients were given choices about the location and the times of their visits
- managers actioned the complaints log at the managing memory services. Staff knew the complaints procedure
- there was a good emergency (duty) response cover within all teams. All staff knew the duty response procedure
- there were accessible leaflets and posters displayed in all reception areas

However:

- therapy rooms at Lexham Lodge were not sound proofed, meaning people passing by could hear conversations taking place within the rooms and the windows looked out onto brick walls. The trust immediately rectified these issues by offering home appointments or appointments at Charlton Lane Hospital for those patients affected.
- there was a lengthy wait of up to six months for psychology in Herefordshire
- patients we spoke to did not know how to complain and said staff had not given them opportunities to feedback about their services.

Summary of findings

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- there had been a gap in leadership and management within the Herefordshire teams. Staff said they felt unsupported and were unsupervised
- managers in the later life team in Gloucestershire were not being regularly supervised
- staff were not using the systems and processes in place required to keep patient records up to date and accurate
- staff told us they would think twice about using the whistleblowing procedure.
- some senior staff told us they did not feel listened to by the senior management team and they were not given enough say in service development.

However:

- nurses and support staff described a visible senior management team who would visit locations and conduct walk arounds
- staff in the managing memory services praised their local management teams
- managers in all but the later life team utilised key performance indicators to monitor performance on team performance.
- the dementia training team had won awards for their achievements in promoting community awareness about dementia
- staff morale was high within Gloucestershire teams
- memory assessment services were accredited for their psychological interventions

Summary of findings

Information about the service

2gether NHS Foundation Trust older peoples' community services were delivered by 11 teams covering Gloucestershire and Herefordshire. The teams delivered two main types of service: the managing memory services and the community mental health services.

The managing memory services had three departments; memory assessment services, community dementia nursing services and information and education services.

The memory assessment services offered assessment, diagnosis and treatment of dementia for people living in Gloucestershire and Herefordshire aged 18 years and over.

Community nurses specialising in dementias provided support to GP practices in the diagnosis, management and treatment of dementia. They were responsible for monitoring dementia medications. The service also provided short-term support to people with dementia and their carers to address immediate care needs arising from their diagnosis.

The information and education service offered information and advice to people worried about memory, people with dementia and carers of people with dementia. The service also provided a countywide programme of information sessions to support people with dementia and their carers to understand the diagnosis and live as well as possible with dementia.

Community mental health services for older people worked with people of all ages with organic illness and people with functional illness over the age of 65. It offered specialist assessment and treatment in the community for people who had a mental illness such as depression or anxiety. It also offered a service to people with dementia. It provided three main services; a mental health liaison service provided educational and clinical support in the care and treatment of patients with dementia and related conditions; a care home support team, worked to improve the network of care and involvement of people who lived in care homes and the later life team who offered immediate care intensive support at home and employed community mental health nurses who worked as part of a social care team to prevent admission and facilitate hospital discharge for people with dementia. The later life team also provided an end of life care pathway, which supported people to die in a place of their choice and put packages together to support this.

Social services had recently withdrawn social workers and carer assessment workers from their previously integrated role within 2gether mental health teams in Herefordshire. Subsequently, 2gether mental health services in Herefordshire also lost the patients allocated to these workers meaning the teams we inspected had experienced significant staffing and service delivery changes within the past six months.

Our inspection team

The comprehensive inspection was led by:

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

Head of Inspection: Karen Bennett-Wilson, Care Quality Commission

The team that inspected this core service comprised one CQC inspector, three older people specialist mental health advisors and an expert by experience who joined us for one day of the inspection.

Why we carried out this inspection

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

Summary of findings

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 visiting, we reviewed information we held about the older people's community mental health services. We asked other organisations and local people to share what they knew about these services. We sought feedback from patients, families and carers via our comment card box and by telephone interviews. We held focus groups for staff, patients and carers to feedback about the service.

During the inspection visit, the inspection team:

- visited three community mental health services for older people, including memory assessment services. We visited the managing memory team for Gloucestershire based at Charlton Lane Hospital, the Gloucestershire community later life team based at Avon House in Tewkesbury and the community mental health services for south, north and east Herefordshire based at Monkmoor Court
- looked at the quality of clinical areas and observed how staff were caring for patients
- spoke directly with four patients
- spoke with seven carers of patients
- attended and observed seven episodes of care, including clinical appointments
- attended and observed three multidisciplinary meetings
- spoke with six managers of the services, including team leaders and divisional managers
- spoke with 19 staff, including doctors, nurses and other clinicians
- reviewed 23 treatment records of patients
- reviewed procedures and other documents relating to the running of the services
- asked other organisations and local people to share what they knew about the mental health services provided by the trust.

What people who use the provider's services say

Patients using the managing memory services described the staff as excellent, helpful and supportive. Carers of patients using the managing memory service told us they have had excellent support from the nurses who were very responsive and kind in their approach. Carers told us that the letters sent to patients were well written and explained everything clearly. However, one carer told us that there was a delay of three to four weeks in sharing information about medication between the GP and the memory service.

Patients using the community services told us they were satisfied with their care and spoke highly of staff. Some talked to us about the difference staff had made to their lives. Carers told us about the positive changes they had seen with their family members using the community services and wanted us to reflect their appreciation in this report. However, patients in Herefordshire said there had been a long wait to access a psychiatrist and psychological therapies of up to six months.

Four patients from both areas told us they did not know how to complain and although they did not feel the need to, would not know how to start the process. Patients we spoke to said staff had not given them the opportunity to feedback about their services.

Good practice

- The managing memory team ran a dementia training and education programme. They had recently won a community dementia link award after training 400 firefighters about aspects of supporting people with

Summary of findings

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.

- The dementia training and education team had originally been funded as a nine month project and was still running seven years later. Their success in evidencing outcomes secured their annual renewal.
- The medical secretary with the later life team had created a list of patients' activity and social schedules, which they referred to when offering appointments to ensure visits did not interfere with their social lives.
- The teams in Herefordshire were trialling voice activated digital transcribing for staff.

Areas for improvement

Action the provider MUST take to improve

- provide regular managerial and clinical supervision for staff in the Herefordshire teams and managers in the community Gloucestershire teams
- improve the accurate recording of patient information.

Action the provider SHOULD take to improve

- review caseloads in the memory services so there are enough staff to review patients annually and update their care records accurately following assessments
- consider how waiting times for psychological therapies in Herefordshire could be improved so patients have timely access to services to meet their needs
- improve communication and consider how to reform links with the recently departed social services departments in Herefordshire
- ensure patients know how to complain and feedback about their services
- 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%.
- consider how it could engage with and involve staff more in decisions about service development.

2gether NHS Foundation Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Managing memory team for Gloucestershire	Charlton Lane Centre
Later life mental health community team for Gloucestershire	Charlton Lane Centre
Community mental health services for older people in Herefordshire.	Stonebow Unit

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.

- 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. Approved Mental Health Practitioners within the team sent out links to the rest of the team about updates in the MHA.
- The trust had MHA administrators to manage the use of the MHA.
- Few patients were detained under the MHA. The team were aware of the MHA and were aware of requirements of Section 117 (a person's entitlement to aftercare following admission to hospital). Teams that supported patients on a Section 117 held a specific review every year for that patient. They were uploading this information on a manual database, so this was not available to review on RiO.
- At the time of the inspection there were no patients subject to a Community Treatment Order (CTO) (the

provision of supervised treatment following a stay in hospital), at the time of our inspection. Staff showed knowledge in this area as they had supported people in the past on a CTO.

- Staff we spoke with told us they would refer to Independent Mental Health Advocates (IMHAs) when required. Issues relating to advocacy were discussed in multidisciplinary meetings. We saw leaflets on advocacy in reception areas. Posters were displayed in waiting areas about how to access IMHA and Independent Mental Capacity Act services.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust stated that 51% of clinical staff had completed training about the Mental Capacity Act (MCA). However, training was not mandatory. Courses were available for staff on the MCA, which included training on the Deprivation of Liberty Safeguards (DoLS).
- Staff attended MCA forums to update their knowledge and we saw posters on the walls advertising these within community services. Mental capacity lead nurses within each service sent out up to date information on the MCA and DoLS. Community teams worked with care homes to complete DoLS assessments for patients subject to this requirement.
- Staff we spoke to were aware of the trust's policy on the MCA.
- We saw two good examples of when staff had recorded MCA information. However, only 10 out of 20 care records had mental capacity assessments, where applicable, detailed on RiO.
- We observed home visits where staff supported patients to make decisions. These took account of their history, personal wishes and cultural needs. Staff had been involved in best interest meetings following the outcome of mental capacity assessments.

Good

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

- Community mental health teams tended to visit patients in their own homes or arranged an appointment at the patient's local hospital. Only one out of the three locations we visited had facilities where they saw patients on site. Lexham Lodge, serving managing memory services for older people in the Gloucestershire region, was being used as a temporary site whilst their previous premises were being turned into research offices. Upon inspection, we had concerns over the safety and suitability of these premises. For example, portable appliance testing for equipment used for patient care was out of date, the ramp into the building caused a potential trip hazard, as it was elevated one inch off the ground, there was unrestricted access to the second floor where a sash window opened up fully and there were no emergency pull cords in the toilet. Inside the toilet, the exit was located behind the toilet, unlabelled and a different locked door stood in front of the toilet. There were no panic buttons in the rooms although an alarm was fitted onto the telephone in each room. There was no equipment available for physical examinations, the first aid box was under-equipped to meet the needs of the group of patients and the resuscitation mask was out of date. However, the trust immediately rectified this situation once we pointed out these concerns. They arrangedfor all patients to be supported inappointments as home visits rather than outpatient appointments at Lexham Lodge. Where a home visit was inappropriate for any reason, an outpatientappointment would be offered fromthe Charlton Lane site main hospital or at the patient's GP practice as most appropriate. Alternative outpatient bases would be considered in order that a return to outpatient clinics inan appropriate environment could be considered while the research centre facilities were completed. This included the use of the Charlton Lane Hospital facilities and/or another established outpatient's base in the Cheltenham locality. Should there have been a need for an interim increase in resources to support the team over this period of interim working, this wouldhave been made available.

Safe staffing

- The managing memory services had an established level of 23.3 staff members, which equated to 17.6 whole time equivalent posts. They carried a 0.3 vacancy and had one leaver in the past 12 months. The managing memory service had a sickness and absence level of 3.6% and the dementia nursing team had a sickness and absence rate of 5.1%, due to a staff bereavement.

The later life team at Avon House had an established staffing level of 11.5 full time equivalent staff, with four vacancies (equating to 2.5 whole time equivalent posts), three leavers in the past 12 months and a 4.2% sickness and absence rate. Part time staff and known bank staff (staff employed by the trust who covered temporary vacancies) covered vacancies within the team. They did not use any agency staff.

The community mental health services for older people in Hereford had an established staffing level of 16.5 whole time equivalent posts, three vacancies, five leavers in the past 12 months and a sickness absence level of 9% in the east, 4.4% in the north and 6.8% in the south. There was one psychologist supporting the three locality services in Herefordshire and three psychologists covering four teams within the Managing Memory services in Gloucestershire. The Herefordshire team supported a total population of 180,000 and the four teams within the managing memory services in Gloucestershire supported a total population of 620,000. Teams in Herefordshire were overseen by a senior operational manager but each had been without a manager since July. One had been appointed to oversee all three services and was going through induction at the time of our inspection. This team had undergone some significant staffing changes since the local authority had withdrawn social workers and their caseloads from their previously integrated team structure in April 2015. Each team lost approximately three staff who were allocated to social services, and a number of patients from their caseloads, meaning the three separate teams were no longer had enough staff to warrant an individual manager for each service. The services were subsequently combined into single service.

- Some managers noted the challenge of attracting bank staff to community teams when they would rather work

Good

Are services safe?

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

on inpatient wards. Managers were working on increasing the opportunities for induction into community teams and were looking at staff rotation within services.

- Managers worked out staffing levels based on the number of GPs in the area, the referral rates and the comorbidity (i.e. the presence of one or more additional disorders co-occurring with a primary disorder) of the patients in the area.
- Caseloads within the memory services averaged over 300 patients per full time worker. Staff told us they felt 'swamped' with referrals and there was not enough time to meet the demand for support from patients and their families. Staff told us they needed to see nine patients a week in order to ensure that all patients had an annual review, brief interventions and support with their diagnosis. Memory teams had recently changed the criteria for reviewing patients from every six months to every year but were still struggling to review patients annually. At the time of inspection, the managing memory team were at 89% compliance with annual reviews. Staff working within community teams in Gloucestershire had an average caseload of 29 patients per full time member of staff. Teams in Herefordshire averaged 31 patients per full time member of staff.
- Each service we inspected had psychiatrists allocated to their teams and staff told us they could access a psychiatrist within 24 hours when required.
- On call systems operated within all community services. On call cover consisted of one consultant psychiatrist, one junior doctor, an out-of-hours senior clinical manager, an out-of-hours non clinical manager, an executive director and members of the crisis services duty teams who worked across the 24 hour period in both Gloucestershire and Herefordshire.
- Ninety four percent of staff in the managing memory services and 95% of the dementia nursing staff had completed the required mandatory training. Ninety five percent of the community staff in Herefordshire and 90% of the community staff in the later life service had completed the required mandatory training. Mandatory training included: basic life support, breakaway techniques, clinical risk assessment, clinical supervision, conflict resolution, corporate induction, diversity, fire safety, food hygiene, handling and moving, HoNOS, infection control, information governance, introduction to child protection, positive behaviour management and vulnerable adults.

Assessing and managing risk to patients and staff

- Staff conducted initial risk assessments or risk screenings during the patient's first appointment. Staff monitored high-risk patients at least weekly in multidisciplinary team meetings. Staff told us all risk assessments were reviewed either six or 12 monthly and logged onto the RiO system. Teams worked in line with care clustering recommendations. Community dementia nurses told us the aim was to keep people at home, so risk assessments included capacity assessments, the involvement of carers, and the environment at home. There was evidence that although care plans, risk assessments and allocation of care level had been recorded within the electronic healthcare record (RiO), information had not been recorded appropriately in the relevant section in accordance with the trust's 'assessing and managing clinical risk and safety' policy and its associated guidance. Staff were therefore not following the trust's guidelines on risk assessments by failing to record changes to presenting risk in the risk section of RiO. Out of 23 records reviewed, four did not have a risk assessment in place at all. Out of 16 records with a care plan, staff had not highlighted risk assessment concerns in the main care plan.
- Staff told us they went through crisis plans and relapse contingency plans at a patient's initial assessment and updated these at their next contact appointment. Community dementia nurses at Sherbourne House told us that they talked to patients at post-diagnosis about advance decisions. However, they needed to get better at this aspect of assessment. The later life team told us they discussed advanced decisions and end of life care planning in annual reviews, which included family members, GPs and care homes. However, when we checked patient's RiO records we found that only 12 out of 23 records had crisis plans documented. We could not find any evidence that staff had recorded any advanced decisions for patients who were receiving end of life care.
- Staff told us that the patient's family, carer, GP or care home reported any deterioration in health during

Good

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contact visits. Staff were also able to identify this by observing a change in functioning of the patient's behaviour during contact visits. They brought any issues back to team meetings or contacted the psychiatrists within the team for advice when required. Staff told us that they updated any deterioration in a patient's health on RiO after every contact or on the same day (within 24 hours). The manager at the memory services told us any changes in health were reviewed at the post-diagnostic appointment or at the cognitive enhancing medication review. We saw some evidence of this within progress notes.

- Community dementia nurses at Sherbourne House told us the GP responsible for the patient's care or patient themselves would inform them of a change in health whilst on a waiting list. When the team received this information, the community dementia nurses would ensure that they treated that patient as a priority. Nurses told us that if a patient were at high risk, they would ask the community team duty worker to respond urgently. Staff made contact with a patient within four weeks of referral. They then assessed any change in risk over the phone. Other community teams did not have a waiting list so this was not an issue. Community teams had a response time of 72 hours if they needed to see a patient urgently.
- Staff told us they received three yearly training in safeguarding, which was statutory training run by the trust. The trust safeguarding policy was accessible to staff. Staff knew how to report to the local safeguarding team and social services, knew who their trust safeguarding lead was, and discussed any issues in team meetings, following which they raised any issues with social services. Staff told us that the local authority safeguarding teams would tell teams if a patient had safeguarding issues. The local authority teams no longer notified teams in Herefordshire about safeguarding alerts raised by social services. However, staff would be invited to safeguarding meetings if the concern was upheld. We observed a multidisciplinary meeting for the managing memory team where safeguarding was on the agenda and discussed during the meeting. We also saw that safeguarding was a standing item on other community staff meeting agendas, which demonstrated that safeguarding was managed effectively.
- Staff signed in and out of the buildings, kept their RiO and electronic diaries up to date and made sure their mobile number was available to all staff. Staff were aware of the trust's lone working policy as well as their local arrangements and managers told us staff followed the policy. When out of hours appointments occurred, a buddy system was place. There was an emergency contact number, which connected through to trust headquarters. Staff told us that they always checked that clinicians phoned in following their appointments and before they finished work. Staff working in Gloucestershire could also contact the on-call service manager at Wotton Lawn if there was an out of hours issue. We saw that the 'working alone guidelines for community teams' were read through in a recent managing memory staff meeting. Staff told us that if a patient has identified risk issues, they either offered them a clinic appointment so they could ensure the environment is safe, or they had the capacity to conduct a joint visit. Some staff reported issues with phone signal coverage in Herefordshire. In Herefordshire, there was one duty worker per day to cover a population proportionate to a duty worker in Gloucestershire.

Track record on safety

- There had been one serious self-harm incident reported in the last 12 months for older people community mental health teams. The incident had been shared within teams meetings and learning had been identified within the minutes. Staff confirmed they had received a debrief from the trust regarding this incident.
- Managers logged recent adverse events and shared them within team meetings at each of the services we inspected. This raised awareness of where services could have improved to decrease the risk of adverse incidents occurring.

Reporting incidents and learning from when things go wrong

- Staff would report a serious incident to their manager and record it on the trust's electronic incident reporting system, datix. Psychiatrists confirmed that they completed serious incident reports within 48 hours.
- The older people community teams reported 56 incidents between November 2014 and October 2015. Staff told us they would report all medication errors on datix and knew the difference between an incident and a serious incident.

Good

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- Staff spoke of their duty of candour to be open and honest when explaining an incident to a patient. Staff would seek advice from their manager before disclosing the incident to the patient.
- Staff received feedback from incidents during weekly team meetings and for teams in Gloucestershire, during monthly group supervision. Staff told us that managers shared episodes of incidents with all the team via email and discussed lessons learnt in their meetings.
- We saw an example of an incident detailed in the staff meeting minutes at Avon House. The team had detailed three learning outcomes and had evidenced that they had shared them with the patient. The incident showed how staff received support from the psychiatrist and they referred to the 'working well' department where staff could self-refer for additional support.

Are services effective?

Requires improvement

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

- Staff working in the managing memory completed assessments, which included a full history, physical, and memory assessments, a cognitive score, the patient's presentation, their capacity to consent, any safeguarding information, risks, diet, medication, any carer information, personal history, social history, changes in functioning and presentation. A letter to the patient copied to their GP and a post-diagnosis letter, which included a discharge plan, medication monitoring and a referral to community services if required, followed this. Other community teams included an assessment on a patient's mental state, their behaviour, their environment, mood, physical health, medication, social circumstances, support, risk factors and social history. Staff explained the details of the assessment with the patient prior to a possible diagnosis. Staff conducted mini mental or anticholinesterase inhibitors assessments (memory tests) during the initial assessment. During home visits, we observed that staff always asked for consent before starting these tests.
- Staff completed comprehensive assessments within 90 minutes, with information about the referral, scans when applicable and formal conversations recorded.
- For patients on a cognitive enhancing medication, trust guidelines stated they received an annual or six monthly review, information about the medication they were taking, information about dementia, signposting access to support services and a carer review all of which resulted in a care plan including how to contact their nurse. Other community patients also received information about their condition including how physical health could affect presentation of symptoms, support to maintain healthy living activities and strategies for managing difficulties arising from their diagnosis, including any risks. However, the managing memory team had missed 11% of their annual reviews at the time of inspection and in one service only one out of 12 records viewed had recorded the annual review.
- Psychological therapies were available for all patients and the wait times varied from three weeks in the Gloucestershire later life teams to up to six months in the Herefordshire community teams.
- Staff were expected to complete care plans within 28 days of the initial assessment. Trust guidelines stated that staff should record clinical activity onto the electronic patient system, RiO. The guidelines went on to state that each care plan should have included the patient's identified care coordinator, their completed core assessment, HoNOS information and cluster allocation, a diagnosis, a risk summary and assessment, care review and progress notes of clinical contacts. Out of 23 RiO records reviewed, seven did not have a care plan. Out of the 16 records with a care plan, staff had not completed some core assessments and formulation summaries and letters to the GP were basic. and staff had not highlighted risk assessment concerns in the main care plan. Only 14 care plans contained the patient's views, 13 were recovery orientated, nine contained a physical health evaluation, eight had evidence of informed consent, 10 had evidence of mental capacity assessments and only two had Mental Health Act documentation (where 10 were applicable). We saw 12 crisis plans, no recorded advanced decisions, five medication reviews and three HONOS score summaries. We did find some evidence detailed in progress notes but it was difficult to locate as it was not stored in the correct place on RiO.
- Staff told us that they reviewed medication at least annually in patient's care reviews. The manager of the dementia service told us that the team attended non-medical prescribing forum 3 times a year and the trust ran a forum to discuss protocol for outpatient services for non-medical prescribers. However, in one service, we reviewed 12 RiO records that showed patients were taking anti-dementia medication yet we could only find one review documented.
- At the time of the inspection, staff had to return to their work base to complete RiO records and did not have mobile data and recording systems in place, although some staff did have access to lap tops. Some staff said this was the reason they were unable to complete RiO records as visits could be 50 miles away and offices would be shut by the time they returned.

Are services effective?

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- All patient information was stored securely on the electronic system, RiO. Any paperwork such as old prescription cards and original section papers were stored in locked filing cabinets.

Best practice in treatment and care

- Staff followed the national institute for health and care excellence (NICE) guidance for prescribing and administering cognitive medications; for example, monitoring regular health checks and arranging reviews. However, despite following the guidelines, 11% of annual reviews had been missed at the time of our inspection. Community dementia nurses at Sherbourne House reviewed any changes in health at post diagnostic appointments or at ACI reviews (a cognitive enhancing medication review). Other community teams reviewed medication every six months or annually, although again they did not necessarily document this in the patient's RiO records. In Herefordshire, staff told us they reviewed patients on antipsychotic medication every three months, patients on Memantine every six months and patients on ACIs annually. The operational manager for this area told us that this was monitored during caseload supervision; however, we found that records showed gaps in regular supervision. We saw that medication charts were stored in locked cabinets at the service base.
- The teams offered a variety of therapies including, skill based cognitive behavioural therapy, anxiety management and remanence therapy. Staff used 'doll therapy', a therapy recognised by the Alzheimer's Society used to alleviate stress and anxiety, when working with patients in care homes who had progressive dementia. Staff told us had a soothing effect on patients. Memory assessment services (MAS) were involved in a MAS accreditation programme, which was in progress at the time of the inspection. They were also accredited for psychological interventions. Memory assessments were structured in line with the requirements of NICE guidelines. Staff were aware of NICE guidance and provided several good examples of how they adhered to them when we observed a multidisciplinary team meeting.
- When carrying out annual health checks community dementia nurses checked bloods, pulse and blood pressure with patients and recorded a score, which they flagged to the GP if outside what would be expected. Nurses told us that when GPs provided reports about patients they included physical healthcare information within the report. Staff carried out physical healthcare checks routinely for all patients who were prescribed anti-dementia medication. Older people community teams told us they monitored patients taking anti-psychotic medication every three months. Psychiatrists told us this was because patients used these for a shorter amount of time. Patients who were prescribed lithium were reviewed regularly by their GP but under the advice of a consultant psychiatrist who would review blood test results. However, when we reviewed RiO records, records of physical healthcare checks were missing or not recorded in the correct section from 14 out of 23 records viewed.
- Staff told us they used HoNOS outcome measures and cluster care packages to rate severity and outcomes, as well as patient experience feedback cards at the initial memory assessment appointment, diagnosis appointment, post diagnosis appointment and ACI monitoring appointment. However, information was again lacking in RiO records when we checked the evidence of this. Only two out of 23 records checked had recorded information about HoNOS.
- Staff told us that their managers involved them in clinical audits and that they were involved in the trust audit process. All junior doctors completed audits as part of their training and annual audit programmes were organised. The teams in Herefordshire had recently taken part in a caseload assessment tool, benchmarked against other organisations. The trust provided two examples of clinical audits carried out in the past 12 months that demonstrated that treatment practice was in line with NICE guidelines. One detailed that services followed NICE guidance the treatment of Alzheimer's disease. Compliance against all criteria across the whole trust was high at 90%, with Gloucestershire achieving 98% and Herefordshire achieving 82% compliance. Another audit within the memory assessment services showed that services followed NICE recommendations on treating patients with dementia. The older people teams were also involved in other trust audits, such as 'improving personalised discharge planning', to reduce the risk of harm for patients leaving inpatient units.

Skilled staff to deliver care

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- Memory assessment services comprised psychiatrists, psychologists, nurses, speech and language therapists and occupational therapists. Community teams comprised occupational therapists, community psychiatric nurses, support workers, psychologists, support workers, administrative staff, speech and language therapists, physiotherapists, physiotherapists and consultant psychiatrists. Social workers were no longer integrated into the Herefordshire teams following the withdrawal by the local authority. Teams in Herefordshire had to request support of a social worker using a lengthy referral form. They told us social workers were responsive if there was an emergency but otherwise this process could take months to get a response. This team no longer had carer assessment workers integrated into their teams as they went back to social services, so they again had to refer back to request their support. Within the community dementia team at Sherbourne House, there were three non-medical prescribers who were part of the MAS.
- New staff had to complete a corporate and local induction before they were given a caseload. Staff at the managing memory services received workload supervision every month as well as a monthly peer group supervision. Managerial supervision occurred less regularly in the later life team for some staff who had gaps in their supervision records. For example, three staff had not received regular managerial supervisions in the past 12 months. One manager had only received three supervisions in the past 12 months and the other manager had received four. However, other staff within the same team had received regular supervision and told us they had this every four to six weeks. The manager was unable to show us records that detailed staff clinical supervision. However, staff told us that a psychologist facilitated clinical supervisions for them every month. Staff told us that they had learning opportunities within their clinical supervisions. Staff in Herefordshire told us that supervision had been infrequent since their managers had left earlier in the year. Their supervision records showed that 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 (including medical secretaries) appraisals had not been completed within the past 12 months. Staff told us they felt stressed and unsupported as a result. The operational manager was aware of this issue and had organised for other community managers to come in and deliver supervisions to the team. However, there were no plans in place to address the lack of clinical supervision.
- Mandatory training was linked in with annual appraisals. Community dementia nurses had good access to specialist training; for example, nurses we spoke to had recently attended a five-step dementia programme. Nurse prescribers had regular teaching and training sessions. Staff working in the community teams in Hereford recently completed motivational interviewing training and military post-traumatic stress disorder training.
- We only heard of one issue around poor performance with a previous manager in Herefordshire, which had been addressed following the trust's performance policy.
- The average percentage of staff who had received an appraisal in the last 12 months was 84%. Outstanding appraisals were in Herefordshire where a lack of management had affected their ability to conduct all appraisals in time. At the time of inspection, 10 outstanding had been booked in.

Multi-disciplinary and inter-agency team work

- Multidisciplinary team meetings took place weekly within all older people community services. Managers alternated the day to ensure all participants could attend. All disciplines would attend these weekly meetings including memory assessment nurses, occupational therapists, psychologists, specialist and trainee doctors, consultants and student nurses. We observed one multidisciplinary meeting for the managing memory service during which doctors looked at scans and blood counts for individual patients. There were opportunities for each member of staff to contribute to the discussion and abbreviations were explained so all staff understood the terminology. Care co-ordinators attended the meeting and fed back about their recent appointments and assessments to the group.
- Within the later life team at Avon House, representatives from the crisis team attended weekly multidisciplinary team meetings as well as a link person from the intermediate care team. The crisis team would not

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respond to patients with an organic presentation; this was the responsibility of the on call duty worker for the community mental health team. Managers from different services met quarterly. The operational manager in Herefordshire told us about a serious incident where the case review had highlighted an issue around communication between the community and memory teams. The lead psychiatrist had debriefed the staff team shortly after the incident and a learning event had been organised for all staff involved. Everyone involved had contributed to the internal review. Staff told us this had been a supportive and informative way of learning from a serious incident.

- The managing memory team worked collaboratively with a wide range of agencies to ensure that patients and carers received optimum care and support. This included primary care, other care groups within 2gether trust such as substance misuse, working age adult mental health services, learning disability teams and voluntary sector organisation such as neighbourhood projects, Alzheimer's disease society, dementia care trust, age concern, Barnwood trust, Gloucestershire drug and alcohol services, Gloucestershire association for mental health and the independent sector providers such as care homes and home care services. The managing memory service also provided lessons about dementia to pupils in Tewkesbury School. Other staff reported good working links with primary care with whom they completed joint assessments as required. Community teams had good working links with Age UK. One manager told us the links with outpatient teams were particularly good and dementia services told us they had good working relationships with their GPs who sent regular referrals via a secure inbox. Some managers told us they directly transferred entries onto the social services system from RiO to make sure all risk had been identified with the relevant departments. Teams in Gloucestershire linked with social services in the case of a safeguarding event or a best interests meeting and staff reported they still maintained social care links.

Adherence to the MHA and the MHA Code of Practice

- 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. The trust had MHA administrators to manage the use of the MHA. MHA awareness training was integrated into other training courses including clinical risk and care planning (all clinical qualified staff were required to update this training annually) and in 'think family' training, which was required every three years.
- The psychiatrist in the later life team (Avon House) told us that they had very few patients detained under the MHA. The team were aware of the MHA and were aware of requirements of Section 117 (a person's entitlement to aftercare following admission to hospital). Approved Mental Health Practitioners within the team sent out links to the rest of the team about updates in the MHA. The teams in Herefordshire had recently received some training from the MHA lead in the trust following a suicide, about 'asking the right questions'.
- Teams that supported patients on a Section 117 held a specific review every year for that patient. Teams in Herefordshire had struggled to get social services involved in these meetings following their departure from the team earlier this year. Teams in Herefordshire who supported people on Section 117 were uploading this information on a manual database, so this was not available to review on RiO.
- At the time of the inspection there were no patients subject to a Community Treatment Order (CTO) (the provision of supervised treatment following a stay in hospital), at the time of our inspection. Staff showed knowledge in this area as they had supported people in the past on a CTO.
- One person in the later life team was supported on Section 17 leave (where the patient is granted leave by their clinician from hospital). However when we checked their RiO records, this information had not been recorded. The manager sought to instantly rectify this.
- Staff we spoke with told us they would refer to Independent Mental Health Advocates (IMHAs) when required. Issues relating to advocacy were discusses in multidisciplinary meetings. We saw leaflets on advocacy in reception areas. Posters were displayed in waiting areas about how to access IMHA and Independent Mental Capacity Act services.

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Good practice in applying the MCA

- The trust stated that 51% of clinical staff had completed training about the Mental Capacity Act (MCA). However, training was not mandatory. Courses were available for staff on the MCA, which included training on the Deprivation of Liberty Safeguards (DoLS). There were also courses available in Herefordshire on advanced mental capacity; this involved training in the legalities of the Act and was delivered by the local authority.
- Staff attended MCA forums to update their knowledge and we saw posters on the walls advertising these within community services. In the later life team, the senior community mental health nurse, who was the lead for the Mental Capacity Act, sent out up to date information on the MCA and DoLS. Community teams worked with care homes to complete DoLS assessments for patients subject to this requirement.
- Staff we spoke to were aware of the trust's policy on the MCA. There was a MCA lead within each team and within the trust who were available for advice when needed.
- We saw two examples when staff had recorded MCA information where a patient had gone through a capacity assessment and staff had completed the five statutory questions. We saw another good example of sensitive support and management of a patient who was subject to DoLS in a care home.
- We observed home visits where staff supported patients to make decisions. These took account of their history, personal wishes and cultural needs. Staff had been involved in best interest meetings following the outcome of mental capacity assessments.
- However, when we reviewed care records, only 10 out of 20 care records had mental capacity assessments, where applicable, detailed on RiO.

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

- We observed a multidisciplinary team meeting for the managing memory services and found that staff were respectful and caring in the way they described patients. Staff showed empathy when talking about patients and we saw evidence of caring letters written by the consultant. During home visits we observed staff to be sensitive and respectful, they used a person centred approach and developing a positive rapport with the patient. Staff acted with respect and kindness during the home visits we observed. Staff made patients feel relaxed and at ease, explaining each step of the process as they went along. Staff communicated appropriately with patients, using direct and clear sentences. Staff used an empowering approach with patients. For example, a patient asked a nurse to help them to bed during a home visit and the nurse provided just enough support so the patient used their own physical abilities to make the manoeuver. The nurse then withdrew from the room once the patient indicated they had had enough of talking.
- Patients we spoke to told us that they would recommend the nurses providing support to them. Patients said the teams were very good at what they do. For example, one patient told us that their nurse was very knowledgeable about anxiety and depression. Another told us that the older people community teams helped them overcome their problems with isolation by supporting the development of their links to the outside world. Patients told us staff were very polite and helpful. For example, one patient told us their nurses spoke very slowly because they were hard of hearing, which showed their patience, when they had to repeat things repeatedly. Following an assessment with a psychologist in the later life team, another patient told us they felt the process was 'stress-less', they were satisfied with the service and felt it was a 'rounded' service. A carer we spoke to was very pleased with the support they received from the community teams. They described the responsiveness of the staff and their availability when they had a concern or a query. Carers told us that staff had provided them with clear and useful information and assisted them to access the support they needed.
- IPads were trialled with patients using the older people services but patients told the team they preferred paper forms. The medical secretary with the later life team had created a list of patients' activity and social schedules, which they referred to when offering appointments to ensure visits did not interfere with their social lives. The team took time to reassure anxious carers, staff told us they treated patients and carers how they would like to be treated. We observed that staff had in depth knowledge of the patients they visited at home and knew how to communicate, behave and approach patients in their own homes.

The involvement of people in the care they receive

- Staff arranged appointments in advance and contacted patients or carers about them ahead of time. One patient we spoke to said they were not aware of their care plan but had confidence their carer was very much involved. Patients said either they did have a copy of their care plan or they thought their carer had a copy. One patient told us that their doctor sent them a copy of any letters that concerned their health. One nurse told us that they worked with care homes to ensure patient-focussed work was carried on at the care home. They researched patients' interests and hobbies, life history, activities and work and tailored therapy accordingly.
- Following the withdrawal of social work staff from the previously integrated teams in Herefordshire, community teams no longer ran carers' groups within the community teams. Carers were referred to the Herefordshire Carers organisation who facilititated carers groups. The teams had been involved the trust's annual "remember me" event. During this event, the trust stall was themed around person centred care and the importance of remembering the person. The later life team had a document displayed in offices called 'a staff guide to supporting carers in Gloucester'. In December 2014, a tea party had been held at Charlton Lane for people with dementia and their carers. Staff shared information about the carer peer support groups in the area. 'Dance and dementia' and 'singing for the brain' sessions were also included. In the same year the trust committed to becoming members of the 'carers trust triangle of care' (a carers included scheme.) The trust set up the 'carers' charter' in 2011 which was co-produced with carers and carer organisations. It was

Good

Are services caring?

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created through listening events and launched with partner organisations. The trust built the development of the 'triangle of care' on this foundation, which formed an important part of their service experience strategy.

- Patients could access an advocate through the patient advice and liaison service (PALS), by reading leaflets or by using the trust intranet to look for recommended advocacy organisations.
- Staff received compliments from care homes and relatives. Staff also used the friends and family test and gave out questionnaires to carers.
- The community teams received feedback from the trust's service experience report, which provided information about patients' reported experience of older people services. It also provided examples of the learning that had been achieved through service experience reporting and updated on activity to enhance service experience. The information that emerged from reporting included complaints, concerns, comments and compliments and survey information. Information was also gathered from Healthwatch Herefordshire and Gloucestershire, 2gether's patient advice and liaison service report, compliments, comments and concerns Information, narrative reports made by members of the service experience committee, feedback from 'carers Gloucestershire', Herefordshire carers support and Gloucestershire young carers and meetings with patients.
- We did not see any evidence of patients being directly involved in decisions about their service such as helping to recruit staff. Patients we spoke to told us that staff had not asked them to provide any feedback about their service. However, the trust told us that a patient had been individual involved in recruitment of a clinical psychologist in June 2015 and in the recruitment of a consultant in dementia in July 2015.

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

- Memory assessment services were able to see most patients within the trust's set target of four weeks. However, there were some breaches recorded. The highest was in Gloucester where 14 patients had to wait up to 13 weeks and three up to 17 weeks. Five patients using the Forest of Dean services had to wait up to 13 weeks from referral to assessment. The manager had acknowledged the issue had been the ratio between staff to the number of referrals. However, this had been addressed providing an additional band six member of staff member to work over in Gloucester and the Forest of Dean teams. This would increase the number of staff so waiting times would reduce. Memory services contacted patients by telephone within 2-4 weeks from receipt of referral and seek agreement to assessment, check that the appointment was convenient, answer any questions or queries regarding the assessment, respond to any identified risks and respond to any issues related to mental capacity regarding the assessment. Older people teams in Cheltenham, Tewkesbury and the North Cotswolds saw most people within two weeks and the Herefordshire older people community teams reported four breaches where two patients had to wait up to 17 weeks for an assessment and two others up to 13 weeks. Herefordshire received a maximum of 15 referrals per week per team.
- The later life team only had a three week wait time from assessment to a psychological therapy. Patients using the Herefordshire community services had a much longer wait, up to six months at the time of inspection. This was due to only one psychologist in place to cover three areas teams.
- Any delayed discharges from the community services were due to awaiting care packages from social services. There was limited access to other providers delivering domiciliary care packages for some areas of Gloucestershire and Herefordshire where the volume of demand made it challenging for providers to have any critical mass of services within the area and to make the package cost effective because of the travel times which were often involved. In such cases, services had to seek agreement to spot purchase care, which added to the timescales involved. Managers were working with commissioners to try and expand the portfolio of domiciliary care providers available across Gloucestershire and Herefordshire along with the range and options of community support available.
- Each team provided a duty worker to cover emergency calls every day. If the duty worker were called out, the on call service manager would then cover their responsibilities. If a patient had an emergency after hours, the crisis team responded to functional patients or if the patient had organic presentation, the GP would contact the on call consultant.
- Managing memory older people teams offered 'ageless services', meaning that if a person under the age of 65 presented with the early onset of dementia, they would be accepted as a referral.
- Teams offered flexible appointments to people so they would find it easier to engage with services. One community dementia nurse at Sherbourne House told us that they worked together with care home staff to engage people who were finding it difficult to use mental health services.
- If staff were aware a patient had not attended an appointment they would initiate safety checks to ensure the patient was safe. If they were worried about the patient who would not engage with the service, they would contact their GP or social services.
- Staff would ring up and apologise to the patient if a staff member was off sick and could not meet them. They would then offer the patient an alternative appointment.

The facilities promote recovery, comfort, dignity and confidentiality

- The environment at Lexham Lodge, a temporary facility used to see older people within the memory assessment team, was unsafe and not well maintained. There was no equipment available at Lexham Lodge for physical examinations, the first aid box was underequipped to meet the needs of the group of patients and the resuscitation mask was out of date. Interview rooms were not sound proofed. However, the trust rectified this issue immediately so this was no longer a problem.
- Staff gave leaflets to patients using the memory assessment service, which included options for

Are services responsive to people's needs?

Good

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

treatment. Staff confirmed they talked through these leaflets with patients before they decided upon their treatment options. In Herefordshire, staff offered taster sessions at day care centres then referred the patient over to social services if they were interested. Other leaflets were available in reception areas detailing advocacy, patient rights, how to complain and local services and events available to patients.

Meeting the needs of all people who use the service

- The ramp leading into Lexham Lodge had a one-inch trip hazard at the bottom of it. There was no lift to the second floor. Again these issues were immediately addressed by the trust who moved patient services to other venues in the county, patients' homes or the Charlton Lane centre. The one-inch trip hazard had been made safe while remedial actions were completed to remove the trip hazard.
- The trust provided interpreters for patients who did not have English as their first language. Interpreters for D/deaf patients were accessed centrally through the trust.

Listening to and learning from concerns and complaints

- There had been eight complaints about older people community mental health services in the past 12 months, three of which were upheld. The three upheld complaints were around out of date assessments, lack of family involvement in decision-making and staff attitude. The services had responded to these complaints through developing an action plans which identified how it would improve communication with families, record information in clinical records accurately and to support staff reflective practise.
- There were leaflets displayed in community team reception areas about how to complain. Patients we spoke to told us they did not know how to complain because they had never had to complain. However, one patient from Herefordshire told us that they would have complained about how long it took to get counselling sessions started.
- Staff we spoke to said they would assist the patient to initially make a complaint, and if needed would inform their manager as in their complaints policy. Managers explained that they would personally meet the patient or carer making the complaint, then if they could not resolve the issue informally, would allocate an investigator to look into the issue. If the complaint was upheld, a letter would also go out to the person from the chief executive. Managers shared learning points from complaints in team meetings. We saw that staff responded to patients concerns directly when out on home visits; for example, when a patient complained about taking medication, the staff member listened patiently and then explained the importance of the medication in a way the patient understood.
- One manager showed us a summary from the service experience group called 'complaints, outcomes and learning' which included the complaint reference number, the date of complaint, the complaint description, any learning and whether the complaint was upheld or not upheld. Staff also learnt from the outcome of complaints via critical incident reviews and aggregated learning from these feedback sessions.

Are services well-led?

Requires improvement

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 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.
- Staff said the senior management team were visible via their annual walk arounds, which they felt were very valuable. Staff told us that the trust were very responsive to patient safety concerns and gave us an example of how staffing ratios had been changed with benefits to patient safety. Senior management teams sent global emails to cascade key trust messages. All staff had access to these although some complained the intranet was slow and difficult to locate things.
- There was mixed feedback about how well supported staff felt in the Herefordshire teams due to a lack of supervision.
- Other senior staff told us that the trust had reorganised services without listening to front line staff and they did not feel part of any consultation processes.

Good governance

- The General Medical Council had reported that the trust was 'better than expected' for induction of trainee doctors in old age psychiatry. An average of 95% of staff had completed mandatory training. Managers within the manging memory services reported on their training compliance figures every three months. Staff reported that the trust were excellent at providing on-going training and learning.
- There were substantial gaps in managerial, peer and clinical supervision in Herefordshire, which had experienced gaps in managerial support. Managers in community teams within Gloucestershire were not being regularly supervised.
- Staff were good at focussing their shift time on direct care activities rather than administrative tasks. We observed outstanding care and support during home visits, although we then found gaps in recording patient information. Staff told us they struggled to find the time to input data onto RiO and did not appreciate being performance managed on the quantity of data they inputted as opposed to the quality of their direct patient care.
- Incidents were well reported onto Datix and serious incidents were case reviewed. We saw examples of learning events following serious incidents and staff knew how to report onto Datix. Complaints were well logged and any learning was shared within staff meetings. Managers shared information gathered from the trust's service experience report in team meetings.
- Staff were involved in clinical audits, either ran by the trust or within their teams.
- Safeguarding, MHA and MCA procedures were followed but not well documented. MCA assessments were present in 10 out of 23 records of patients where this was relevant.
- The managers in the later life team did not complete key performance indicators. Information summarising their team performance came from the trust via electronic staff records then the manager cross-referenced this. Community dementia services reviewed their targets through an expert reference group and data for all community services was held on an IT SharePoint reporting system. The manager had completed an assessment on the demand on the service's capacity looking at waiting times and delays in pathway when the completion of a core plan assessment was not in place by the four-week target. The operational manager at the Herefordshire locality older person's community mental health teams monitored whether CPA reviews were completed within 12 months, whether patients were seen within 48 hours following discharge, training compliance, sickness and absence rates and performance.
- Managers held their own local risk register and were able to submit items to the trust's risk register via the community services manager. In Herefordshire, issues with local authority were logged on the local risk register and were reviewed monthly.

Leadership, morale and staff engagement

- Staff told us that their immediate line managers, where present, were supportive.
- Managers in the later life team reported some leadership issues due to them managing both older people and recovery teams, having expertise in one area but not necessarily in the other.

Are services well-led?

Requires improvement

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.

- Sickness and absence rates were generally low, with the exception of two of the Herefordshire teams at 9% and 6.8%. Staff in these teams told us they felt stressed following the departure of social services components from their teams and due to the lack of management support.
- Staff felt that they treated each other well and with respect. We heard about one bullying and harassment case in Herefordshire, which was related to a previous manager who was no longer working within the team.
- Staff told us they would know how to use the whistleblowing process if they needed to, although some senior clinicians said they would have to think twice about using the whistleblowing process.
- Staff told us they felt able to raise concerns without fear of victimisation, but this would sometimes depend on the concern.
- We received mixed feedback about job satisfaction within the services that we inspected. Some staff we spoke to told us they loved their job and were optimistic about the future. They told us they were happy within their teams and felt there were opportunities to develop within their role. However, staff described difficulties around the completion and monitoring of RiO, travelling long distances to see patients and the impact this had on their administrative time and lack of supervision and managerial support in Herefordshire. For example, staff felt frustrated with RiO as they felt they were monitored on their completion of this rather than the actual care they provided. One staff member told us they felt worthless after coming out of supervision, as there was a focus on the outstanding tasks not completed on RiO. Staff in the later life teams told us they felt tired from driving so many miles to see patients. They found it a struggle to keep on top of paperwork, as they had to come back to base following an appointment, which could sometimes be a 100 mile round trip. Some staff felt that people who did not understand the needs of the community teams wrote the pool car policy. Some staff in Herefordshire reported stress as a result of recent managerial changes within the team but did reflect that the team supported each other well through this change. Some staff in Herefordshire described a lack of clinical supervision, gaps in managerial supervision and morale being low as a result of social services recently retracting services. Some senior staff told us that morale had been fluctuating since the departure of social services and that the gap in leadership affected the team's sense of security.
- Staff working in Herefordshire had opportunities to take part in the Elizabeth Garrett Anderson and the Elizabeth Seacole leadership programmes. All managers took part in the trust leadership courses. The trust ran a leadership forum every quarter for band eight and above staff, whom the executive team mentored.
- Community dementia teams spoke positively about the support they offered and received from one another and their managers. Staff told us that their relationships with each other were excellent and team members were supportive of each other. Managers attended monthly meetings, called 'team talk', where a member of the executive team was always present. Some staff who had moved over from Gloucester to Tewkesbury told us they felt removed from other teams and found it difficult to maintain links with other departments. One member of the community team told us they felt the need for improved transparency and active listening to all members of the team during meetings.
- Nurses in the managing memory services told us they were actively encouraged to feedback about service delivery during their monthly supervision meetings. They said that peer supervision was a good forum for feedback about service development issues. Staff at the community dementia services used an expert reference group to feedback about their dementia pathways service. However, staff working in Hereford did not feel they had the same opportunity due to a lack of managerial supervision.

Commitment to quality improvement and innovation

- The Gloucestershire memory service had been accredited with the 'memory services national accreditation programme up until 2016. The community dementia and memory services provided a strengths based model on dementia training and an education pathway. Community dementia services had achieved a community dementia link award when they trained 400 firefighters and others in the community. They had also achieved a dementia leadership award and had written an intergenerational play, using links with the schools they had provided training at. The care home support team held an annual awareness day for care homes in

Are services well-led?

Requires improvement

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.

the whole of Gloucestershire involving external speakers. Community services were involved in care planning audits to improve the quality of inputting. This was due to identified breaches in care plans being out of date and staff not correctly inputting information onto RiO. The teams in Herefordshire had just started a programme to open up specialist training in older people specialisms for staff. This was led by the lead occupational therapist looking at caseloads and tweaking the support given to individual patients.

- The trust was building a research facility in Gloucester focussing on dementia study, whilst also supporting research across all clinical areas and services provided by the trust. One occupational therapist in the later life team was taking part in a 'valid' research project (valuing active life in dementia) with patients coming out of the memory assessment services into community services. The project hoped to show a cost effective approach to working with patients and carers. The managing memory teams had developed a dementia awareness tool called 'stand by me'. This had been developed alongside the university of Worcester capturing videos of people living with dementia. This tool was now being widely used within the NHS.

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 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated activities) Regulations 2014 Staffing Staff working in the Herefordshire teams and managers in the Gloucestershire community teams were not receiving regular supervision. This was a breach of Regulation 18: Staffing 18. – (2) (a) Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they employed to perform.

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 Regulation 17 HSCA 2008 (Regulated activities) Regulations 2014 Good governance

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Requirement notices

Staff 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) (2) (c):

Systems and 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.