

Gloucestershire Partnership NHS Trust

February 2005





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Clinical governance review

Gloucestershire Partnership NHS Trust

February 2005

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The Healthcare Commission

The Healthcare Commission exists to promote improvement in the quality of NHS and independent healthcare across England and Wales. It is a new organisation, which started work on April 1st 2004. The Healthcare Commission's full name is the Commission for Healthcare Audit and Inspection.

The Healthcare Commission was created under the Health and Social Care (Community Health and Standards) Act 2003. The organisation has a range of new functions and takes over some responsibilities from other commissions. It:

- replaces the work of the Commission for Health Improvement (CHI), which closed on March 31st 2004
- takes over the private and voluntary healthcare functions of the National Care Standards Commission, which also ceased to exist on March 31st 2004
- picks up the elements of the Audit Commission's work, which relate to efficiency, effectiveness and economy of healthcare

In taking over the functions of CHI, the Healthcare Commission now has responsibility for the programme of clinical governance reviews initiated by CHI.

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Introduction

Gloucestershire Partnership NHS Trust (the trust) was established in April 2002. It offers mental health and learning disability services, previously provided by Severn NHS Trust, East Gloucestershire NHS Trust, Gloucestershire County Council and Gloucester Health Authority. It serves a population of 560,000 people, across an area of 1,000 square miles, and shares the same boundaries as Gloucestershire County Council. The area includes the city of Gloucester and the large town of Cheltenham, as well as some small towns and rural areas. There is a significantly higher than average white British population, with a number of small minority ethnic communities. There is also a higher number of people aged over 65 years when compared with the national average. The area is generally prosperous, although there are pockets of urban and rural deprivation throughout the county.

The trust provides integrated mental health and social care services, including substance misuse and low secure services, for all adults of working age in Gloucestershire. It also provides mental health services for children, adolescents and older people, and services for people with learning disabilities. The trust works in partnership with all the relevant professionals for court diversion and prison in reach services. The trust is also working towards integrated health and social care for older people.

Gloucestershire Partnership NHS Trust organises its services according to five care groups: adults of working age, children and adolescents, older people, substance misuse, and learning disabilities. These care groups have the same boundaries as the three primary care trusts (PCTs) in Gloucestershire – Cheltenham and Tewkesbury PCT, Cotswold and Vale PCT, and West Gloucestershire PCT.

The trust is operating within its £76 million budget. It employs 2,500 staff, including staff at a number of residential homes which are run by voluntary organisations for people with learning disabilities. It provides 311 inpatient beds at Wotton Lawn Hospital, Montpellier low secure unit and Holly House in Gloucester; Charlton Lane Hospital in Cheltenham; Colliers' Court in Cinderford; Weaver's Croft in Stroud; a number of rehabilitation hostels for adults of working age; and four inpatient units for people with a learning disability in Cheltenham, Gloucester, Stroud and Standish.

The trust also provides a range of community mental health services, including county wide assertive outreach community teams, a crisis and home treatment team in Stroud, an early intervention in psychosis team in Cheltenham, an in reach prison service for HMP Gloucester, a black mental health team and community learning disability teams.

Some community services are provided in partnership with other organisations. The primary care mental health service operates in partnership with the three PCTs and an intensive domiciliary care service for older people is run with Cheltenham and Tewkesbury PCT, Cotswold and Vale PCT and Gloucestershire Social Services.

The trust provides a shared patient advice and liaison service (PALS) and a shared information management and technology support service for its services and the three PCTs.

The trust gained three stars in the 2004 NHS performance ratings and its drug support project at Ryecroft Approved Premises Hostel won an award for providing a high quality service.

This report by the Healthcare Commission gives an independent assessment of clinical governance in the trust. For this report, the Healthcare Commission looked at mental health services for adults of working age in Stroud, mental health services for older people in the Forest of Dean, and substance misuse services throughout Gloucestershire.

Clinical governance is the system of steps and procedures adopted by the NHS to ensure that service users receive the highest possible quality of care, ensuring high standards, safety and improvement in patient services.

What is the purpose of the review?

The Healthcare Commission's clinical governance reviews set out to answer three questions:

- 1 What is it like to be a service user here?
- 2 How good are the trust's systems for safeguarding and improving the quality of care?
- 3 What is the capacity in the organisation for improving the service user's experiences?

What is covered by a Healthcare Commission review?

The Healthcare Commission's review assesses seven areas of clinical governance. The areas are:

- 1 service users' involvement
- 2 risk management
- 3 clinical audit
- 4 staffing and staff management
- 5 education and training
- 6 clinical effectiveness
- 7 use of information

Healthcare Commission's review also describes two further areas:

- 1 service users' experiences
- 2 the trust's strategic capacity for developing and implementing clinical governance

An explanation of the Healthcare Commission's assessments

On the basis of the evidence collected, the Healthcare Commission's reviewers assess each component of clinical governance against a four point scale:

- i Little or no progress at strategic and planning levels or at operational level.
- ii
 - a) Worthwhile progress and development at strategic and planning level but not at operational level, OR
 - b) Worthwhile progress and development at operational level but not at strategic and planning level, OR
 - c) Worthwhile progress and development at strategic and planning and at operational level, but not across the whole organisation
- iii Good strategic grasp and substantial implementation. Alignment of activity and development across the strategic and planning levels and operational level of the trust.
- iv Excellence – coordinated activity and development across the organisation and with partner organisations in the local health economy that is demonstrably leading to improvement. Clarity about the next stage of clinical governance development.

What are the Healthcare Commission's main findings in their review of Gloucestershire Partnership NHS Trust?

What was the overall impression of the trust?

Gloucestershire Partnership NHS Trust is well regarded by its external partners and is recognised as the local champion for mental health services. The trust actively supports a model of mental health care that promotes recovery. However, services are not provided equally across the trust. This was inherited from its predecessor organisations, Severn NHS Trust and East Gloucestershire NHS Trust, and from Gloucestershire County Council and Gloucester Health Authority. The trust's commissioners have not agreed a mental health commissioning strategy, so there is a lack of clarity about the future configuration of some mental health services in Gloucestershire. This is hindering the full development of services.

Staff at all levels in the organisation are committed to the delivery of good patient care. The trust supports its staff and middle managers, although there are some gaps in medical clinical leadership and there are staffing pressures and recruitment difficulties. The trust is introducing extended roles for nurses. This is progressing well, but robust workforce planning is difficult without a commissioning strategy. Nonetheless, the trust provides some high quality services, particularly in substance misuse and services for adults of working age.

The trust is working to ensure that service users are treated with dignity and respect. It is committed to engaging service users and carers, but this needs to be developed further at a strategic level. Adults of working age are involved in their own care and treatment. However, this occurs less among younger people and older people. There is good individual risk assessment for service users, as part of the Care Programme Approach, but a lack of systematic, trust wide ligature point and environmental risk audits.

Clinical governance processes are comprehensive, but complex, and responsibilities and accountabilities lack clarity. The trust needs to develop its use of information. It also needs to develop its performance reporting capacity to enhance the ability of non-executive directors to monitor the progress of clinical governance, and to hold the executive team to account for the trust's performance.

What did we find that is impressive at Gloucestershire Partnership NHS Trust?

There is exemplary involvement of service users in early intervention in psychosis work, particularly in research and training. With the consent of service users, videos of sessions held with service users to promote the trust's recovery model of care are sold to help fund the ongoing involvement of service users in this work.

There are also a number of commendable therapeutic activities which provide more holistic care, particularly for adults of working age and service users dealing with substance misuse. Sports therapists and physiotherapists enhance the quality of patient care through physical fitness activities and treatment, while art therapists and occupational therapists improve the environment for patients and encourage creativity by displaying patients' work in several wards and units.

The Integrated Care Pathways Coordinator has developed a commendable approach to establishing evidence-based pathways of care through ongoing dialogue with key stakeholders.

There are a number of other commendable examples of practice throughout the trust, including an eating disorders service, which uses an evidence-based approach together with good user and carer involvement; the nine module course for carers of older people with mental health problems and the use of life trees in older people's wards to chart key relationships and life events for individual patients.

The trust provides or funds a range of services to support its staff, including a commendable dignity at work policy and a mediation service that is highly valued by staff at all levels in the organisation.

What are the key areas of action that the trust needs to address to improve its clinical governance systems?

The Healthcare Commission expects the trust to review all aspects of this report. Here we highlight areas where action is particularly important or urgent.

- Action is required to recruit, empower and support medical clinical leaders to ensure all doctors engage with the trust as a corporate body. This will enable the trust to drive forward best medical clinical practice in all care groups.
- The trust board should continue to work proactively to encourage its local health and social care partners to agree on the configuration of all mental health services in Gloucestershire and on commissioning priorities.
- The trust should ensure that it is reaching all local organisations that wish to be involved in its work.
- Action is required to ensure that service users and carers are more involved with strategic planning and decisions, relating to the delivery of services, at an early stage.
- The trust needs to develop and roll out a programme of environmental audits of risk, including trust wide assessment of ligature points, and support any necessary action identified by this programme.
- Action is required to develop a robust workforce plan in line with service requirements.
- The trust should implement its training plan and training report process as soon as possible to support delivery of the lifelong learning strategy.
- The trust needs to develop the way it uses information systems and reporting indicators to support clinical governance, including the identification and use of information to inform best clinical practice.

What is it like to be a service user in Gloucestershire Partnership NHS Trust?

In this section, we report what we observed and what service users said about their experiences, through surveys or directly to the Healthcare Commission. We also look at what the trust's figures can tell service users about access to services, how they are involved in their own care and the outcomes of their care.

Many things can impact on a service user's experience of their local NHS service. These may include how easy it was to access the care they needed, the outcome of their care, whether they and their relatives or carers were treated with respect, the information they were given about their care, and the choices they had in the care they received.

Are service users treated with dignity and respect?

The trust is benchmarking Essence of Care privacy and dignity standards and received a good result in the 2004 NHS annual performance ratings, also known as star ratings, for treating service users with dignity and respect. Overall, the Healthcare Commission's observations support this result.

Staff interact well with service users in some wards and units and some staff groups demonstrate a clear understanding of the needs of service users. 'Life trees' are used on older people's wards to chart key relationships and life events for individual patients. This is a commendable example of patient and staff interaction, and encourages patients to retain their self awareness and identity.

Can service users access the services they need?

There is good access to specialist learning disability services. However, the percentage of children and adolescents waiting longer than 13 weeks for their first consultant outpatient appointment is higher than expected. The trust is successfully reducing these waits.

Some service users requiring inpatient care for substance misuse wait longer than the national target time for admission, although they receive active treatment within the target time. After an initial assessment, adults of working age experience long waiting times for community access to psychological therapies.

There is no dedicated out of hours mental health service in Gloucestershire. In many areas, service users rely on the general Gloucestershire out of hours service for access to psychiatric advice and care in an emergency.

The trust has plans to develop specialist women's services.

How good are the standards of cleanliness and facilities?

The trust has a range of purpose built accommodation. However, some of its facilities are in older buildings and have an institutional appearance. The trust is working to improve these facilities. It is also currently assessing whether some of its rehabilitation premises are fit for purpose.

The trust has done an audit of its sites to check compliance with the Disability Discrimination Act. Where necessary, there are plans to ensure that all sites comply with the requirements of the Act within the specified time frame. Signposting around trust sites and inside trust facilities is generally good.

The trust has some mixed gender wards but all bedrooms and bed bays are single gender facilities. All bathroom and toilet facilities are single user facilities. A day room in Greyfriars Ward can be designated exclusively for women's use, when required.

With the exception of Wotton Lawn Hospital, the trust's premises are rated as good by the Clean Hospitals programme. The trust is working to address cleanliness issues at Wotton Lawn. It is also working with the King's Fund to enhance the healing environment at Charlton Lane. All sites visited by the Healthcare Commission are clean and tidy.

The quality of food provided by the trust varies. Staff and service users say that the quality and choice of food has improved significantly in some units, and the trust is working to deliver improvements across all sites.

Some service users feel that there are insufficient smoke free areas in some facilities, notably the substance misuse ward.

What do the figures show about outcomes at the trust?

The mortality rate for older people with mental health problems, who are admitted to hospital, is decreasing.

The rate of suicide is higher than the national average in Cheltenham and Tewkesbury, but lower than the national average in the Cotswold and Vale and the West Gloucestershire PCT areas.

In Cheltenham, Gloucester and Stroud, the hospital admission rate for schizophrenia and neuroses is higher than the national average. The trust is developing early intervention services to reduce this rate.

Not all service users receive discharge plans and some service users experience delays for discharge, particularly in older people's services.

What did the Healthcare Commission find out about how care is organised by the trust?

The trust needs to continue to develop rehabilitation and recovery models of care across the county.

Assertive community outreach teams are in place throughout Gloucestershire and the trust is working with its local partners to develop a full range of services as alternatives to hospital admission. However, there is no liaison psychiatry service in Gloucestershire.

The crisis and home treatment team in Stroud is well regarded by service users and there are plans to extend this service to cover all adults of working age in the trust's area. There is an early intervention service in Cheltenham and there are plans to open a new specialist rehabilitation and recovery centre in Cheltenham in 2005.

Services for older people are not available equally across the trust. Psychotherapy services are limited and the provision of occupational therapy and social work support varies. There is very limited respite care and no dedicated services for younger dementia patients or for older people with long term challenging behaviour.

Staff and service users express dissatisfaction with the lack of effective separation of organic and functional mental illness beds. The future configuration of all older people's services is currently the subject of local consultation, and the trust is working to improve care for these service users. The trust is moving towards a more holistic approach to assessing and treating older people with mental health needs.

An intensive domiciliary care service is provided in partnership with Cheltenham and Tewkesbury PCT, Cotswold and Vale PCT, and Gloucestershire social services. Three mental health liaison nurses work in the local acute hospitals, helping staff to provide good care for older service users with mental health problems and to facilitate early discharge. There is also a memory clinic in Cheltenham and plans to include memory assessment clinics in day hospitals in other areas.

The trust provides a primary care mental health service in partnership with the three Gloucestershire PCTs. Four mental health triage workers have been appointed by the trust to cover 10 GP surgeries, resulting in more appropriate referrals to community mental health teams. A mental health toolkit is available for primary and community care services, and is well used by GPs.

The trust has referral and assessment protocols for its services, and protocols for transferring service users between age related services, for example from child and adolescent to adult services. There are no inpatient or day care child and adolescent mental health services. Young people (16-18) requiring emergency admission to hospital are admitted to adult wards. There is no agreed policy within the Gloucestershire local health, social and education community about the future configuration of children's mental health services.

The trust has developed some services to improve access for members of minority communities. The black mental health team, which is staffed by members of minority communities, is successfully attracting referrals to its team.

There is a range of day care facilities, many of which are run in conjunction with local voluntary organisations. There are also a number of commendable therapeutic activities, which allow the trust to provide more holistic care, particularly for adults of working age. For example, sports therapists and physiotherapists enhance the quality of patient care through physical fitness activities and treatment. Arts therapists and occupational therapists help to improve the patient environment and encourage creativity by displaying patients' work in several wards and units.

The trust is developing its use of psychological therapies through managed clinical networks. There is a policy for the use of complementary therapies.

What areas of the service user experience should the trust consider?

- The trust should build on good interaction between service users and staff in some services to spread good practice throughout the organisation.
- The trust should continue work to reduce the higher than expected mortality rates in older people's services.
- The trust needs to continue to develop recovery models of care throughout Gloucestershire, including access to mental health specific out of hours advice and referral across the organisation.
- The trust should continue to make services for older people more equitable across Gloucestershire, and ensure that older people with mental health needs have access to all available services.
- The trust should discuss the provision of a liaison psychiatry service with its partners in the local health community.

What is the Healthcare Commission's assessment of the trust's systems for service user, carer and public involvement?

This section describes how service users can have a say in their own treatment and how they, and service user and carer organisations, can have a say in the way that services are provided.

What is the Healthcare Commission's main assessment?

The trust has established a framework for service user, carer and public involvement at the care group and the corporate level. There is good individual service user involvement in services for adults of working age. However, activity is mainly focused on the involvement of individuals in their care, and on user and carer groups at care group and clinical team level. The trust is beginning to develop service user, carer and public involvement in strategic direction and planning. There is no operational manager to coordinate activity across the trust.

Assessment = ii (c)

What are the key findings?

The service user and carer group reports to the clinical governance committee, which in turn provides quarterly reports to the board on service experience, including service user, carer and public activity. The board lead for service user, carer and public involvement is the Director of Social Care. Each care group has an identified lead for service user and carer involvement. There is no operational post with responsibility for coordinating activity across the trust.

There is a strategy for improving service user, carer and public involvement and the service user and carer group has responsibility for publishing an annual action plan. The trust has signed a local compact (local agreement) with its statutory and voluntary sector partners.

The trust employs two participation workers for service user and carer involvement and has recently appointed an information officer to develop information for service users and carers. In addition, the Care Programme Approach Coordinator and the modern matrons leading the Essence of Care work are responsible for service user and carer involvement in their work.

In services for adults of working age, there is evidence of individual service user involvement in decisions about their own care and treatment. There are examples of change to services as a result of this involvement, such as the provision of more talking therapies. The majority of patients within adult services are given copies of their care plans, although some are unaware that they have a care plan. There are plans to develop an expert patient programme for clients with personality disorders.

A number of user and carer groups and service users are involved in monitoring and developing services for adults of working age and older people, including representation on the acute care forum. However, there is less involvement of young people in monitoring services. The trust is developing services to support and involve carers more widely throughout the organisation. It has established a joint agency

carers' network and introduced pocket sized cards to remind staff of the needs of young carers. Both service users and carers are participating in the development of some integrated care pathways. The trust makes limited use of volunteers.

There is less service user and public involvement at corporate level, particularly at the early strategic planning stage. The trust has published a guide to its structures, its role in the local community and the NHS to assist service users, carers and members of the public who wish to become involved in its business. The black mental health team encourages members of minority communities to participate. An Asian group is also being developed. The trust offers reimbursements to people willing to be involved in planning and monitoring services.

The trust provides considerable support for self help groups, such as the hearing voices group and the eating disorders group. The trust also supports a day service run by service users, called the 'clubhouse', which serves as a good example of how a statutory body can facilitate a user led and managed service.

The trust produces information and materials for a range of service users, including a strategy for communicating with people with learning disabilities. There are some good information booklets for inpatients across all service areas and in some units. For example, Colliers' Court produce their own newsletters with useful information for carers and service users. There is a general guide to local services for mental health service users produced by the local health community.

A series of events has been held by the trust to help service users and carers to understand their rights. There are policies for consent to treatment, access to records and resuscitation. However, the trust recognises the provision of information to service users and carers as an area for development.

The trust has a complaints manager and systems to deal with complaints. It is also working towards a joint approach to complaints with social services, when appropriate.

The trust hosts the patient advice and liaison service (PALS) for itself and the three Gloucestershire PCTs. Staff and service user knowledge of this service varies. Information on PALS and complaints is not on display at all trust premises.

The trust seeks feedback on its services through surveys of service users and service user groups. There are some examples of improvements in service quality and delivery as a result of this feedback. However, there are no systematic mechanisms to share learning from service user and carer involvement across the trust, including learning from complaints.

Advocacy services are available for detained patients and for adults suffering from a severe and enduring mental illness with funding from Gloucestershire Social Services. Local voluntary organisations also provide some ad hoc advocacy services to adults of working age and older people out of good will. The trust is supporting service users' plans to set up advocacy services for people dealing with substance misuse. Interpreter services and a chaplain service, with links to other faith communities, are also provided by the trust.

There is training in complaints handling and customer care for staff on induction. There is some training for staff in involving service users and carers in making treatment choices, and in monitoring service quality. The trust's appraisal process includes a section on how staff encourage patient and public involvement.

What areas of patient involvement should the trust consider?

- The trust should review responsibilities for service user, carer and public involvement to ensure activity is coordinated across the trust.
- The trust should build on good engagement of service users in adult services and in some older people's services to encourage greater involvement by older people and young people, including making greater use of volunteers.
- The trust needs to establish systematic processes for sharing learning from service user and carer feedback across the organisation.
- The trust should review the provision of advocacy services and discuss with its commissioners how these services can be extended to cover all service users.
- The trust should extend training for staff in involving service users and carers in treatment choices, and in monitoring the quality of services.

What is the Healthcare Commission's assessment of the trust's systems for risk management?

This section describes the trust's systems to understand, monitor and minimise the risks to patients and staff, and to learn from mistakes.

What is the Healthcare Commission's main assessment?

The trust has structures and accountabilities for the management of clinical and non-clinical risk. The clinical risk strategy is part of a comprehensive risk management strategy. Staff awareness of these processes varies at operational level. The trust works with its local partners in risk assessment and management. Training in risk management is available, and the trust is developing ways to identify specific training requirements and monitor attendance.

Assessment = ii (a)

What are the key findings?

The main risk committee is responsible for all clinical and non-clinical risk at the trust. It has sub committees for health and safety, controls assurance and infection control, and reports to the board. The Director of Social Care is responsible for coordinating the trust's approach to risk management and ensuring that policies for managing operational risk are in place. A number of other directors are also responsible for aspects of risk. However, there is no dedicated budget for risk management.

The Medical Director leads clinical risk management, with support from the Clinical Governance and Risk Manager. The clinical risk theme group, which includes service user representatives, reports to the clinical governance committee, but it can access the risk management committee directly for matters of urgency. There is no definition of urgency for this procedure and no formal link between the clinical risk group and the risk management committee. The health and safety committee and infection control committee report to the main risk management committee. These processes appear disjointed and the level of staff understanding of how risk management activities and risk assessment processes are coordinated varies.

There is a risk management strategy with a section on clinical risk, but there is no separate clinical risk strategy. The risk management strategy provides links to other clinical governance components, including clinical audit, and outlines the processes for considering risk in business planning decisions. It also prioritises risk activity, but there is no clear implementation plan.

The trust has a corporate risk register and is beginning to grade risks using one process across the trust. However, there are no local risk registers to inform this process.

The trust also has a system for reporting adverse incidents, although staff do not always report near misses. The trust has established mechanisms for sharing incident reports with local partners. It promotes a culture of fair blame but there is still a low rate of incident reporting in some service areas.

Gloucestershire Partnership NHS Trust has agreed common risk assessment procedures for adults with its local partners. These provide clear guidelines about sharing information and safeguarding patient confidentiality. There is limited service user involvement in risk activity.

The trust is developing pressure sore management with support from the county wide tissue viability committee, and is participating in the development of a county wide strategy for suicide and self harm. There is a recent major incident plan that is aligned with emergency planning policies in Gloucestershire.

There is a policy and toolkit to manage child protection, agreed with other Gloucestershire agencies in the area child protection committee. There is a named nurse and named doctor for child protection issues, and basic awareness training for all staff. Specialist training is available for appropriate staff, and take up is now being monitored. The trust has a policy for vulnerable adults, agreed with its local partners. Some multi-agency training in dealing with vulnerable adults is available.

The trust obtains its infection control services and training through the community infection control team and has its own infection control lead. Infection control training was reduced in 2004, due to vacancies in the team.

There is good individual risk assessment undertaken as part of the Care Programme Approach. However, there is limited evidence of systematic audit of environmental risk and ligature point risks. The Healthcare Commission has some concerns about the trust's approach to environmental risk and its ability to balance a normal environment with minimising all possible risks. The trust has responded promptly and positively to these concerns by initiating an independent audit of environmental risk and ligature points at its main sites.

The trust has policies for the safe and effective use of drugs, and has recently audited the number of falls in older people's services. Policies for lone working and for managing violence and aggression help to minimise risks to staff.

There are a number of methods for sharing learning from incidents at an operational level. The clinical risk theme group undertakes risk theme and root cause analysis, but there is little systematic sharing of learning across the trust. Some staff report a lack of feedback on individual incident reporting.

Risk assessment training is available for all staff and more specialist training is provided for managers. The trust is beginning to monitor attendance at these courses.

The trust has a controls assurance framework and has achieved compliance with level one of the NHS Litigation Authority risk management standard for NHS trusts.

What areas of risk management should the trust consider?

- The trust needs to develop and rollout a programme of environmental audits of risk, including a trust wide assessment of ligature points, and support any necessary action identified by this programme.
- The trust should ensure that all operational staff understand its risk assessment and management processes, and use these processes appropriately to develop a culture of clinical and environmental risk awareness throughout the organisation.
- The trust needs to develop local risk registers to provide more local ownership of risk issues.
- The trust should review the level of incident reporting and actively promote reporting of all incidents and near misses.
- The trust needs to further develop mechanisms to share learning from risk across the organisation.
- The trust should review all risk management training to ensure that all staff receive appropriate and targeted training.

What is the Healthcare Commission's assessment of the trust's systems for clinical audit?

This section describes how the trust ensures the continual evaluation, measurement and improvement by health professionals of their work and the standards they are achieving.

What is the Healthcare Commission's main assessment?

The trust has recently increased its capacity to undertake audit within a clear strategic framework. Staff who engage with the new audit team value their role. However, the team does not engage consistently with all staff across the trust. There is a lot of audit activity undertaken throughout the organisation, but this is not always informed by the audit strategy or undertaken through the audit department. Clinical audit work is beginning to be more closely linked with clinical effectiveness.

Assessment = ii (b)

What are the key findings?

The clinical audit committee is responsible for delivering and reporting on the audit programme agreed by the clinical governance committee. The board lead for audit is the Medical Director, with support from the Clinical Audit Manager and the clinical audit team.

The new strategy includes a clear implementation plan with targets and timescales. An annual audit plan is produced for the clinical governance committee and the board. Each care group has its own clinical audit group, although the child and adolescent group is not meeting due to staffing pressures.

The trust is beginning to link audit with other clinical governance components, particularly with clinical effectiveness and best practice work. There are systems to prioritise audit, but these do not effectively inform all audit activity across the trust. Some local audits are devised without reference to the trust wide strategy and audit plan, and without the involvement of the audit department. The audit team provides support to staff undertaking audit on request, but it does not proactively engage with all staff groups at present.

The trust participates in national audits and in national confidential enquiries. There is little other partnership work in clinical audit. Service users and carers are represented on the clinical audit committee, and service users are involved in devising some audit in the systematic needs assessment project.

There is good audit of prescribing protocols and some audit work is linked to compliance with the National Institute of Clinical Excellence (NICE) guidelines. A number of care pathways are being audited to ensure that service users are receiving agreed levels of care. The trust has a regular programme of auditing Essence of Care standards, and there is some audit of compliance with standards set by national service frameworks.

There is a database of audits and a variety of methods with which the trust shares audit findings across the organisation, including a clinical audit newsletter. The trust has recently held its first clinical audit forum. However, most information sharing takes place at care group level.

There are a few examples of changes to practice as a result of audit activity, for example, in dementia day care services. However, audit reports do not always contain clear recommendations for actions linking to practice improvement. Monitoring the implementation of findings and recommendations is limited, including plans for re-audit.

Clinical staff have protected time to participate in audit but not all staff feel able to take advantage of this time because of staffing pressures. There is limited clinical audit training across the trust.

What areas of clinical audit should the trust consider?

- The trust should further develop mechanisms to ensure that all audit activity across the trust is undertaken within the agreed audit strategy and framework.
- The trust needs to increase the level of partnership working in audit, particularly as it develops integrated care pathways with partner organisations.
- The trust should further develop systems to share audit results appropriately across the organisation.
- The trust needs to ensure that the audit department has sufficient capacity to proactively engage with all staff undertaking audit, and to ensure that all audit methodology contains a process for recommending changes to practice as a result of audit findings and for monitoring compliance with identified changes.
- The trust should implement a comprehensive training programme for all staff to support audit.

What is the Healthcare Commission's assessment of the trust's systems for clinical effectiveness?

This section is about the way the trust ensures that the approaches and treatments it uses are based on the best available evidence, for example, from research, literature or national or local guidance.

What is the Healthcare Commission's main assessment?

There is a structure and strategy in place to support and promote clinical effectiveness activity across the organisation, but there are no dedicated resources to direct strategy implementation at operational level. The trust is making good progress in developing integrated care pathways and is beginning to link clinical effectiveness work with audit activity. There are systems to disseminate National Institute of Clinical Effectiveness (NICE) guidance, but the trust needs to further develop systems to monitor compliance.

Assessment = ii (b)

What are the key findings?

The board lead for clinical effectiveness is the Medical Director. The trust has appointed an integrated care pathway development officer, but there are no other dedicated operational staff to support clinical effectiveness work across the organisation. Each care group has an identified clinical effectiveness lead and a work plan.

The clinical governance committee oversees the implementation of the clinical effectiveness strategy in the trust through three standing groups – the evidence based practice group, the research governance group and the clinical audit committee. The drugs and therapeutic committee supports best practice in prescribing and medicines management.

The trust has recently revised its systems for considering and disseminating NICE guidance. The Healthcare Commission looked specifically at processes to implement guidance on anti-psychotic prescribing. An implementation group develops an implementation plan for each piece of guidance, including arrangements to audit compliance, and signposts links with the risk register. The clinical governance committee and the trust board receive reports on the extent of compliance. However, the use of audit to promote and enhance compliance needs to be developed further. There is also a lack of clarity about mechanisms to ensure that all staff have received the appropriate guidance.

There are established processes for implementing and monitoring national service frameworks. The trust also monitors compliance with the Care Programme Approach and procedures for sectioning patients under the Mental Health Act.

The trust is making good progress on the development of integrated care pathways, including pathway development and shared care protocols with partner organisations such as guidance for dementia and depression. The Integrated Care Pathways Development Officer has developed a commendable approach to the establishment of evidence-based pathways based on ongoing dialogue with key stakeholders. There are well established protocols for the management of medicines.

Service users are involved in clinical effectiveness activity and are represented on the research governance group. Service user involvement in early intervention in psychosis work is exemplary. Service users are involved in research and training, and videos of sessions held with service users to promote a recovery model of care are sold, with their consent, to fund their ongoing involvement in this work.

There is an identified trust lead for research and a trust research governance committee. However, trust research activity is currently driven by individual interest. The trust is part of the Gloucestershire research and development consortium to implement a research governance framework for the county. The trust has access to advice and support from the Research and Development Coordinator for the Gloucestershire research and development support unit.

There is a research register, which is used to improve clinical practice, for example, in early intervention work. There are also a number of examples of evidence-based practice being used to evaluate and develop services, for instance, in electro-convulsive therapy and psychological therapies. The eating disorders service is a commendable example of service development using an evidence-based approach and user and carer involvement.

A number of methods are used to share information on evidence-based practice and local research, including peer group meetings and journal clubs. Some care groups have evidence-based practice newsletters and some clinical teams hold best practice meetings. However, these processes are not in place across the whole organisation and do not monitor the extent of compliance. The trust has held some research feedback days.

Most staff within the trust have access to the internet, intranet and a library service to support evidence-based practice and research. All clinicians have access to clinical evidence bases. However, there are limited training opportunities for evidence-based practice and critical appraisal skills.

What areas of clinical effectiveness should the trust consider?

- The trust should review operational arrangements for coordinating clinical effectiveness, research activity and audits of best practice across the organisation.
- The trust needs to further develop systems to ensure that all staff receive appropriate NICE guidance, and to promote compliance with guidance.
- The trust needs to develop more systematic processes to share evidence-based learning throughout the organisation, and to check staff compliance at operational level.
- The trust should provide more training opportunities for clinical effectiveness activity.

What is the Healthcare Commission's assessment of the trust's systems for staffing and staff management?

This section covers the recruitment, management and development of staff. It also includes the promotion of good working conditions and effective methods of working.

What is the Healthcare Commission's main assessment?

The trust board has direct responsibility for staffing and staff management and for the implementation of its human resources (HR) strategy. The board and all care groups receive regular reports on a range of key staffing indicators. There is little robust workforce planning, although the trust has developed a number of extended roles for nurses. There are some staffing pressures and recruitment difficulties, forcing some services to rely heavily on bank and agency staff. The trust has some gaps in medical clinical leadership.

Assessment = ii (c)

What are the key findings?

The trust does not have a dedicated committee for staffing and staff management. Responsibilities and accountabilities for HR are based on a number of committees, which report directly to the board. There are groups responsible for implementing Improving Working Lives, junior doctors' hours, Agenda for Change, race equalities and a joint negotiating and consultative committee. Staff are represented in all these groups. The board lead for staffing and staff management is the Director of HR.

The board and care group teams receive quarterly reports on staff numbers, use of agency staff and sickness trends. In addition, the board receives a yearly performance report on the staff gender and ethnicity profile, as well as other indicators.

The trust has an HR strategy and an implementation plan that links with the requirements of national service frameworks (NSFs). The trust is beginning to make progress with the Agenda for Change employment initiative, but it currently has no detailed workforce plan and no systematic workforce planning or reporting. The trust recognises this as an area for development and is in the process of appointing a position to take workforce planning forward.

There have been some skill mix reviews in services for adults of working age and in learning disability services. The trust has developed extended roles for nurses and has appointed five modern matrons and three nurse consultants. The psychiatric intensive care units are led by qualified nurse prescribers. There is also a consultant post for occupational therapy. The trust has plans to develop a career pathway for staff without professional qualifications by establishing assistant practitioner posts.

There are policies to promote diversity and to address bullying and harassment at work. The trust has good systems to monitor the ethnicity of its staff.

The trust has an induction programme that combines corporate and local programmes. The corporate programme includes a self directed workbook, but some staff report a delay in attending the induction workshop. There are some good examples of local induction packages, for example, at Colliers' Court.

Systems are in place for managing supervision and poor performance. There is a whistle-blowing policy, which most staff are aware of and feel confident using. There are systems to check the registration of health and social care professionals.

There is considerable evidence of good team working, within and between teams, across the trust. Teams are multidisciplinary and team members have a clear understanding of each other's roles. The trust provides good support for its middle managers.

Not all staff groups have regular appraisals, although most staff who spoke to the Healthcare Commission have had a recent appraisal or have a date set for an appraisal. The trust is developing a programme to ensure it meets its declared target to provide annual appraisals for all staff.

The trust has some significant staffing pressures and difficulties with recruitment and retention in some areas. There is a risk that these issues may affect patient care. Child and adolescent services, learning disability services and, to a slightly lesser extent, older people's services are particularly under staffed at consultant psychiatrist level. There are also nursing and allied health professional staffing pressures in some services. The trust has a recruitment and retention strategy, but it does not have a comprehensive system to monitor vacancies or for reporting and action planning. The trust recognises the need for further development of this work.

The trust uses a number of methods to communicate with staff, including a trust wide staff newsletter and the intranet. There is a senior manager and clinicians forum. The intranet and e-mail system are used to provide updates on policies and alerts, but not all staff access these facilities.

The trust has achieved compliance with maximum working times for junior doctors, but compliance with the European working time directive is only achieved in some areas by using the opt out clause. The trust recognises the need to resolve this situation quickly.

There are a number of schemes to support the employment of service users, including schemes to provide work on a trial basis and to support people returning to full time employment.

The trust provides or funds a range of services to support its staff, including a commendable dignity at work policy and a mediation service that is highly valued by staff at all levels of the organisation. There is a childcare policy and policies for flexible working and retirement. The trust hosts the occupational health service on behalf of the whole Gloucestershire health community.

Some areas of the trust experience high staff turnover, sickness and absence rates. This is being addressed in the short term but there is no long term strategy to identify and address the underlying reasons the high rates.

The trust has practice status for Improving Working Lives.

What areas of staffing and staff management should the trust consider?

- The trust should review its structures and accountabilities for coordinating staffing and staff management processes in order to provide a dedicated focus for this work.
- Action is required to accelerate workforce planning and to develop a robust workforce plan linked with service requirements.
- The trust needs to establish a system for monitoring vacancies, together with action plans to tackle significant staff vacancies as soon as possible.
- The trust should ensure that it is fully compliant with working time directives, without using the opt out clause, as soon as possible.
- The trust needs to establish robust, long term processes to deal with some high levels of sickness among staff.
- The trust should review its mechanisms for ensuring that all staff are using up to date policies and are aware of alerts.

What is the Healthcare Commission's assessment of the trust's systems for education, training and continuing personal and professional development?

This section covers the support available to enable staff to be competent in doing their jobs, while developing their skills and the degree to which staff are up to date with developments in their field.

What is the Healthcare Commission's main assessment?

The trust supports its staff with a range of training and education opportunities, which are often delivered in partnership with other organisations. However, there is no central coordination of training needs and limited monitoring or evaluation of training. The trust is now establishing an infrastructure and corporate strategy for education and training, and is developing a comprehensive training plan and reporting process. The trust works with local partners and with service users in training.

Assessment = ii (b)

What are the key findings?

The board lead is the Director of HR, with support from the Head of Training and Education and lead trainers for mental health and learning disabilities. The trust has an internal training team and provides a training service to Cotswold and Vale PCT. The training, education and continuing professional development steering group reports to the clinical governance committee and oversees education and training in the trust.

The trust has a lifelong learning strategy, which provides links to workforce development. It is also developing an education and training plan, with links to risk issues and clinical effectiveness issues, and a training report process.

There are good links with the workforce development directorate, external training organisations and local academic institutions to support a range of education and training. The trust receives funding from the workforce development directorate for nurse training and to support staff studying for higher educational qualifications.

The trust works in partnership with the local health community for national vocational qualifications training but a shortage of work-based assessors is deterring staff from taking up these courses. The new training plan will address this by establishing a team of assessors to support national vocational qualifications training. Gloucestershire Social Services gives some funds for joint training of integrated teams, and the trust provides some training to voluntary organisations as part of this programme. The trust is also beginning to provide some training for other local partners, such as the probation service and GP staff.

There are some links between workforce modernisation and training needs. The local certificate in community mental health enhances skills for staff without any formal qualifications. The trust has funded training for a number of nurse prescribers and leadership training for clinicians. There is good clinical training for junior doctors.

There is some involvement of service users and carers in the training of trust staff. The Thorn course, one of a number of national initiatives to support psychosocial interventions in psychosis, has been developed with service user involvement and is

delivered by practitioners, service users and carers. Service users and carers also contribute to the certificate in community mental health. There is some formal training available to assist service users and carers in these roles.

Not all staff have an agreed personal development plan at present and individual training needs are not linked with organisational requirements. Through its training plan and training report, the trust is beginning to develop systems to analyse training needs in line with corporate objectives and business planning.

The trust provides mandatory training but attendance levels are low for some staff groups. Implementation of the training plan will enable more targeted training and monitoring of uptake. The trust's intranet has a directory of training available.

There are some specific educational programmes for service users. The nine module course for carers of older people with mental health problems is undertaking commendable partnership work in education to enhance care for a vulnerable group of service users.

The trust has some processes for sharing learning across the organisation, including newsletters and care group meetings. However, these are not in place throughout the organisation.

There is some protected learning time in services for adults of working age, but a few staff told the Healthcare Commission that they are reluctant to undertake training due to staffing pressures.

What areas of education and training should the trust consider?

- The trust needs to implement its training plan and training report processes as soon as possible to provide the infrastructure to deliver its lifelong learning strategy.
- The trust should develop systems, including annual appraisal, to identify individual training needs which are linked to service developments, workforce modernisation and organisational needs.
- The trust needs to ensure that all staff requiring mandatory training receive this training at appropriate intervals.
- The trust should continue to develop formal training to support service user and carer involvement in trust training programmes.
- The trust needs to develop robust processes for sharing learning across the organisation.

What is the Healthcare Commission's assessment of the trust's systems for using information?

This section describes the systems the trust has in place to collect and interpret clinical information and to use it to monitor, plan and improve the quality of patient care.

What is the Healthcare Commission's main assessment?

There is a strategy and structures in place to support the development of information management and technology (IM&T). However, there is limited use of information to support clinical governance or to inform improvements in the quality of clinical care. The trust is reporting some performance information to the board and to care groups and is working actively to improve its clinical systems. There are structures and processes in place to ensure confidentiality and information governance requirements are met.

Assessment = ii (a)

What are the key findings?

The board lead for IM&T is the acting Director of Finance and Information, with support from the Head of Information Management Services. The IM&T steering group reports to the board on an annual basis. A health and social care records group reports to the clinical governance committee, but no other information groups have formal reporting links with the committee.

Four working groups, covering operational client based systems, consumer information, information governance and data quality, have work plans to deliver short term strategic objectives. There are two project managers working on data protection and integrating clinical systems. The trust is working with its local partners to develop the local infrastructure for rolling out electronic patient records.

Regular performance management reports are provided at both corporate and care group levels. Performance reports to care groups include complaints and critical incident information as well as activity data, but each group uses this information differently. The trust recognises the need to improve these systems and is developing a data warehouse with this in mind.

Each care group has a designated information analyst, while the information team responds to ad hoc requests for clinical information. However, there is limited use of information to inform clinical governance or to support clinical quality, and little evidence of clinicians identifying information needs. The trust has recently appointed an information officer to take forward the information requirements of users and carers.

The trust shares its Caldicott (confidentiality) guardian with Gloucestershire Hospitals Foundation NHS Trust. All staff who spoke to the Healthcare Commission are aware of confidentiality requirements and data protection issues, but some staff do not know the identity of the Caldicott guardian. The trust has recently approved a data protection policy and is currently using an information governance self assessment process to develop action plans to improve information governance.

There are some systems to share information with local partners. Trust information systems allow electronic communication with GPs through a county wide health network which is linked to the social services network. The trust has good information sharing protocols.

There are integrated multiprofessional records across inpatient and community services, but there are some duplicate and subsidiary notes. There is a records management strategy and a health and social care records policy.

There are still a number of different clinical systems in use throughout the trust and some staff continue to use paper systems. The trust is working towards a single, paperless system.

The trust has inherited poor data quality systems. There is some inconsistency in data coding and some staff do not record contacts. The trust is working to improve data quality throughout the organisation. The trust complies with the mental health minimum data set.

Most teams have access to electronic systems capable of recording Care Programme Approach information. The trust is currently working to provide 24 hour electronic availability of care plan documents at all its sites. The trust is working with partner agencies to integrate the Care Programme Approach within the Single Assessment Process. However, more training is required to ensure that all staff understand and use this process.

The trust provides staff with access to a personal computer and an e-mail address but these are not accessed by all staff. The trust's intranet is a comprehensive information system for staff, with dedicated sections for clinical governance as well as care group and clinical team information.

Support for IM&T for the trust and the three PCTs in Gloucestershire is provided by a shared service. Training in IT and the use of clinical systems is available, but training in the use of information is limited.

What areas of using information should the trust consider?

- The trust should continue work with its local partners to develop the infrastructure for the eventual roll out of electronic patient records.
- The trust needs to further develop processes to support clinicians and clinical teams in identifying information needs and using information.
- The trust should extend training in the use of information to all staff.
- The trust needs to ensure that staff understand and are using the integrated single care assessment process for older people.
- Action is required to develop use of information systems and reporting indicators to support clinical governance, including the identification and use of information to inform best clinical practice.

What is the trust's strategic capacity for improvement?

This section describes the ability within the trust to monitor and improve the quality of patient care.

What is the Healthcare Commission's main assessment?

The trust's current structures and reporting arrangements for clinical governance are somewhat complex and disjointed. The trust works with its local partners, but the absence of an agreed mental health commissioning strategy is hindering service development for older people and for children and adolescents. The trust is committed to engaging service users and carers at a strategic level, although progress in this area is taking time.

What are the key findings?

The Chief Executive is regarded by the trust's staff and external stakeholders as visible and approachable. Most staff are positive about the trust, but some doctors are disengaged from the trust as a corporate identity. There are some tensions between psychiatrists in child and adolescent services that the trust has not yet resolved, and there are some gaps in medical clinical leadership. This is resulting in a lack of clarity about how the trust is driving forward medical clinical practice to support its overall vision and values. There is an associate director for allied health professionals and the trust recently appointed an associate medical director in services for adults of working age to provide more clinical leadership.

The board lead for clinical governance is the Medical Director, with support from the Clinical Governance and Risk Manager. Each care group has a clinical board and clinical governance lead. The trust has a number of non-executive leads for clinical governance activities, but not for all components. Non-executives are also linked with care groups. Directors have multiple roles across clinical governance components. In fact, there are few directors with sole overall responsibility for a clinical governance component.

There is a clinical governance strategy and an annual clinical governance development plan containing actions and timescales, covering all aspects of clinical governance. There are links between the clinical governance strategy and the trust's business plan, although these are not always explicit.

The clinical governance committee oversees the implementation of the clinical governance strategy and reports to the board every quarter. Care group clinical boards also report quarterly to the trust board, and the board receives updates from each theme group on an annual basis. The reporting structure does not cover all clinical governance components. There are eight theme groups reporting to the main clinical governance committee, but there are no theme groups for the use of information or for staffing. These arrangements are disjointed and do not allow the board to monitor progress in clinical governance in a coordinated manner.

The trust is encouraging debate on future service configuration to support its new approach around the recovery model of care and its preferred move to providing specialist mental health and learning disability services. Slow progress on this, and the absence of a mental health commissioning strategy, is adversely affecting business

planning and organisational development in the trust. However, the trust is clear about how it will meet its objectives in the local delivery plan and is actively working to improve and develop services within these constraints.

There is an urgent need for agreement between all key partners about the future provision of older people's services and child and adolescent services. It is difficult for the trust to fully meet the needs of these client groups without this agreement.

The trust has a wide range of partnerships. Integrated partnership arrangements in services for adults of working age and for substance misuse services are working well, with social work professionals supported within the trust. There is also partnership working with criminal justice organisations, PCTs and Gloucestershire Hospitals NHS Trust. The trust employs a mental health promotion coordinator who provides a coordinating point for the county wide mental wellbeing strategy.

There are also a number of partnerships with local voluntary organisations. The trust met with these organisations as part of its consultation on the future configuration of its services. There are a number of contracts with local voluntary organisations to provide day care for adults of working age, which are currently under review. However, some smaller local organisations feel that the trust does not engage with them.

The trust is committed to developing involvement of service users and carers at strategic level. There is service user and carer representation on some of the committees that report to the clinical governance committee. The trust has recently established the Speak Out group to encourage more strategic involvement of service users. This is at an early stage of development. A service user involvement day was recently held, supported by the trust, to move the group forward. The trust's last annual meeting included a series of workshops to extend knowledge of service developments in the trust and to help create choices in mental health care. Feedback from this event is being used to inform the trust's future strategic direction.

The board receives a range of information about progress in clinical governance and the trust's overall performance, but non-executives need more support to use this information to hold the executive team to account for its performance. The trust has robust arrangements to monitor service level agreements and contracts with external organisations.

What areas of strategic capacity should the trust consider?

- Action is required to recruit, empower and support medical clinical leaders to establish the engagement of all doctors with the trust as a corporate body, and to drive forward best medical clinical practice in all care groups
- The trust should review its clinical governance structures, accountabilities and reporting arrangements to ensure that they are clear and enable the board to monitor progress in clinical governance more closely and in a more coordinated way.
- The trust board should continue to work proactively to encourage agreement with its local health and social care partners on the configuration of mental health services in Gloucestershire and commissioning priorities.
- The trust needs to ensure that it is reaching all local organisations that wish to become involved in its work.
- Action is required to ensure that there is greater involvement of service users and carers in strategic planning and service delivery decision making.
- Action is required to further develop the trust's capacity to ensure non-executive directors hold the executive team to account for its performance.

Further information

The Healthcare Commission clinical governance review took place between June 2004 and February 2005.

This report sets out the main findings and areas for action from the review. The trust has been given a detailed summary of the evidence on which these findings are based.

The trust will produce an action plan that will be available from:

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or from the Healthcare Commission website. The trust's implementation of the action plan will be monitored.

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The Healthcare Commission should like to make clear that responsibility for the content of the report and its conclusions is the Commission's alone.

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