

Nottinghamshire Healthcare NHS Trust

Rapid response liaison psychiatry

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
Duncan Macmillan House (Trust Headquarters)	RHAPA	Rapid Response Liaison Psychiatry	Queen's Medical Centre NG7 2UH

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

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

Where applicable, we have reported on each core service provided by Nottingham Healthcare NHS Trust and these are brought together to inform our overall judgement of Nottinghamshire Healthcare NHS 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 Rapid Response Liaison Psychiatry

Good 

Are Rapid Response Liaison Psychiatry safe?

Good 

Are Rapid Response Liaison Psychiatry caring?

Good 

Are Rapid Response Liaison Psychiatry effective?

Good 

Are Rapid Response Liaison Psychiatry responsive?

Good 

Are Rapid Response Liaison Psychiatry well-led?

Good 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

The Rapid Response Liaison Psychiatry team is based in the Queen's Medical Centre at Nottingham University Hospital. The team assess people who walk in to the service for help and those that are referred by the community crisis resolution services.

We found that team members were compassionate and skilful when assessing people experiencing mental health problems. They worked closely with hospital staff and were proactive in dealing with referrals, prioritising them on a need and risk basis. The team also had good risk management strategies in place to make sure people were safe.

People's wellbeing and safety was central to making decisions about care. The team worked closely with staff in the emergency department (ED) to manage any delays. When there were delays in transferring people to inpatient beds, facilities were used resourcefully as they are not purpose built. This was jointly managed by the team and ED staff, as they remain responsible for people while waiting on hospital premises.

Staff understood the trust's policies and procedures for safeguarding adults and children, but had difficulty using the trust's recording systems as both paper and electronic records were used. This made finding information about previous risks, as well as more up-to-date information, difficult and could cause delays for people being referred to the team.

We found that there was not much feedback from people using the service. This was because of the nature of the teams' work, which was often a one-time contact when people were experiencing high levels of emotional and psychological distress. The team was working with an external organisation to address this, as they were keen to develop the service according to local need and discuss areas for improvement.

Staff told us that they enjoyed working in the service and that they felt well supported by their manager. Information including wider trust issues, as well as visions for the organisation, was regularly shared with staff in team meetings and via email.

Summary of findings

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

Are services safe?

Staff knew how to report incidents and raise safeguarding issues. There were also good risk management strategies in place for people awaiting assessment and throughout the assessment process. Staff managed waiting times proactively and used resources effectively.

During our unannounced follow-up visit, we saw that staff from the hospital's A&E department had dealt quickly with concerns raised about the condition of interview rooms.

Good



Are services effective?

Staff told us that they had received training in the Mental Capacity Act, Mental Health Act and Deprivation of Liberty Safeguards. They were supervised regularly and new staff were given a comprehensive induction. The team shared their expertise with hospital staff through training, for example about managing people with a mental health problem in a hospital setting. ED staff spoke highly of the team's work and described them as proactive. The paper based systems used by the community teams made getting up to date information about people's needs, risks and care plans difficult to attain in a timely manner.

Good



Are services caring?

The team was working with an external organisation to develop a feedback tool for service users. The staff were highly skilled and we saw them using evidence-based approaches in their assessments. They also considered people's ability to give informed consent as part of the assessments.

Good



Are services responsive to people's needs?

The team worked with hospital staff to protect people's safety when there were delays in transferring them to an inpatient bed. The rooms and facilities available for people waiting for transfer were adequate. However, staff described them as "not ideal" as they were away from the main ED area and had no private washing or toilet facilities. Staff worked hard to meet the national target for meeting with people who were referred to the service within an hour of arriving at the ED. They had also worked with ED staff to develop a flowchart, which was reducing waiting times.

Good



Are services well-led?

There was a high level of morale in the team and staff respected each other. They told us that they received clinical and managerial supervision, and also undertook peer group supervision. Staff said

Good



Summary of findings

that their manager was supportive and acted on any concerns raised. The manager also made sure that any staffing or health and safety issues, which could affect the team's ability to provide or deliver effective care, were included in the trust's risk register.

Summary of findings

Background to the service

Nottinghamshire Healthcare's Rapid Response Liaison Psychiatry Team (RRLP) is based in the Queen's Medical Centre at Nottingham University Hospital. The team helps all patients who are experiencing mental health problems in a general hospital setting. They also provide assessment, support, education and advice to staff.

The service works closely with the trust's other inpatient and community mental health services.

Our inspection team

Our inspection team was led by:

Chair: Paul Lelliott, Care Quality Commission

Team Leader: Jenny Wilkes, Care Quality Commission

The team included CQC inspectors and a variety of specialists: consultant psychiatrist, consultant nurse, social worker and nurses on our announced visit on 1 May 2014. The unannounced follow-up on the 19 May 2014 was undertaken by two CQC inspectors.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health and community health inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, 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?

We visited the Rapid Response Liaison Psychiatry team of Nottinghamshire Healthcare NHS Trust on 1 May 2014. Before visiting, we reviewed a range of information we hold about the core service and asked other

organisations to share what they knew. We visited the team's base at the Queen's Medical Centre and also met with staff from the emergency department of Nottingham University Hospital.

During the visit, we spoke with a range of staff who worked within the service, including nurses and doctors, as well as acute hospital staff, who shared their views and experiences of the core service. We observed how people were being cared for and also reviewed the records of people who use services.

We carried out a second unannounced visit on 19 May 2014.

What people who use the provider's services say

During our visit, we observed staff talking with people who were referred to the service. We saw that staff were positive and that people received an excellent service. Staff in the ED were very complimentary about the team

Summary of findings

and the service they provided, and told us that the team was proactive in their approach. Due to the nature of the service, we were not able to speak directly with people who use it. The service is currently looking at how to get meaningful feedback from users of the service.

Good practice

- People assessed by the team, who had brief psychological therapies, were offered follow-up appointments.
- Hospital staff were given training on caring for people experiencing mental health problems.
- We saw that staff were effective in managing the risk and prioritising the needs of people referred.
- Staff worked well with ED colleagues, dealing with people quickly and maintaining their safety.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should consider how it should work with the acute trust and local clinical commissioning groups, to develop an environment in the emergency department that meets the needs of those people needing a service.

Nottinghamshire Healthcare NHS Trust

Rapid response liaison psychiatry

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Rapid Response Liaison Psychiatry (RRLP)	Duncan Macmillan House

Mental Health Act responsibilities

We found that staff in the RRLP team had received training specifically related to the Mental Health Act (1983). Discussions with staff indicated that there was an understanding of their responsibilities in relation to people

who were requiring assessment or detained under the Mental Health Act. We found that there was information displayed in waiting areas within the hospital regarding access to advocacy services.

Mental Capacity Act and Deprivation of Liberty Safeguards

We found that staff and managers had a good understanding of the issues around capacity and consent and had attended training to ensure that they had the required knowledge. Staff, from within the team, were

called upon for their expertise in the use of the Mental Capacity Act (MCA) by staff within the general hospital setting. MCA and Deprivation of Liberty Safeguards (DoLS) training were part of mandatory trust training for staff.

Are services safe?

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

Summary of findings

Staff knew how to report incidents and raise safeguarding issues. There were also good risk management strategies in place for people awaiting assessment and throughout the assessment process. Staff managed waiting times proactively and used resources effectively. During our unannounced follow-up visit, we saw that staff from the hospital's A&E department had dealt quickly with concerns raised about the condition of interview rooms.

Our findings

Rapid Response Liaison Psychiatry (RRLP) – Queen's Medical Centre Track record on safety

Staff were knowledgeable about their responsibilities in regard to safeguarding children and adults. Staff had received safeguarding training. Policies and procedures were available to view via the trust's intranet site. Staff did not routinely follow up any safeguarding referrals made by recording this into the trust's online incident reporting system. This meant the data collected would not be robust or be a true reflection of activity of this kind within teams.

Staff were aware of the incident reporting system and gave examples of issues they had reported. Staff told us that, at busy times, people may have had to wait to be fully assessed and on occasion people had absconded from the department prior to being seen. This information, although clearly risk managed effectively, was not routinely reported as an incident. We saw statistics compiled by the team that showed that since November 2013 a total of 123 referred people had left the ED before being assessed by the team. Statistics compiled did not record information in regard to time waiting in the department for a full assessment. This meant that possible risks to people's safety could not be proven or mitigated due to lack of detailed recording.

We saw that the acute hospital, and the RRLP team, used two separate recording systems to identify risks. This meant that staff in ED, or on the wards, could be placed at risk as alerts would not necessarily be identified on their system.

Learning from incidents and improving safety standards

People coming to the ED for assessment by the team were initially triaged by a nurse from the ED. An initial screening assessment was undertaken using a Red, Amber, and Green (RAG) rating system which outlined each level of observation required and actions to take if concerns arose. If close supervision was required, a document detailing a reason for this was completed, and security staff were identified by ED staff to perform the observation. RRLP staff attempt to undertake initial face to face contact with people within an hour of them arriving in the ED which is in line with best practice. Following the face to face contact an initial risk assessment and time frame for assessment was discussed with ED, staff along with further discussion around safe management of them whilst in the department. We saw documentation outlining levels of observation to be provided. People awaiting assessment by the RRLP team were the responsibility of acute hospital staff whilst they were in the hospital environment.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

Staff told us that acute hospital staff from the ED, and wards, would complete a referral to the service and fax this to their department. ED staff performed an initial triage of need and risk, when people arrived in the department, using a rating tool for levels of observation required whilst waiting for RRLP Team to assess them.

Safeguarding concerns were referred to a central point for consideration provided by the local authority. Staff described the process as a clear. Staff we met gave a detailed account of the process for incident reporting. Staff gave examples of issues routinely reported such as delayed discharges due to bed availability.

Records management was in the main a paperwork system, although an electronic system did have limited data that staff could access from other departments. Staff used multiple sources of information when referrals to the team were taken.

There was a lone working policy and procedure in place and staff were familiar with this. At night, nurses worked alone between their office and the ED, although an onsite duty doctor was available for assessments if required.

Are services safe?

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

When assessing people in rooms, which were out of sight of ED, staff made their whereabouts known and, if needed, used an alarm system that could alert ED staff of the need for assistance.

We saw excellent examples of positive risk management adopted by staff. They showed high levels of risk management and decision making skills in order to maintain patient safety and that of others.

Assessing and monitoring safety and risk

One member of nursing staff was available on the night shift and on occasions, when staffing allowed, two nurses. However staff told us there was no pattern or consistency around this level of staffing. An onsite duty Senior House Officer and Registrar were contactable, to join assessments, when the need for medical support or input was identified to reduce waiting times for people at busy times.

ED staff we spoke with told us that waiting times for assessment by the team could be long, particularly on nights, although this was variable. Staff told us that they had experienced occasions when seven people were awaiting assessment in the ED. We undertook an out of hours follow up visit on 19 May 2014 and at the time of our visit six people were awaiting for assessment in the ED.

We observed a handover meeting in which staff discussed people referred to them and prioritised responses according to risk. ED staff told us they worked closely with the team and had a good relationship, with effective communication, in regard to risk management.

The team had an identified lead member for issues regarding the use of the Mental Capacity Act and the Mental Health Act. The lead linked in with the trust and hospital safeguarding leads on a regular basis. Mental capacity issues, arising in regard to people receiving treatment on the ward, were the wards responsibility but the team at times covered any second opinion requests or to review a decision made.

Understanding and management of foreseeable risks

We saw the interview rooms that were used for assessment by the team. When we visited the door at one end of the room it was locked and the narrow corridor behind this locked door was blocked by a wheel chair. This in turn was blocking an exit that staff may need in an emergency. Staff informed us that at times mattresses had been in the corridor which blocked a potential exit route. On our follow up visit on the evening of 19 May 2014 we saw a schedule for cleaning the interview rooms, ensuring the alternative exit door was unlocked and corridor clear. This had been implemented, following our previous visit, by ED managers. ED staff were responsible for this and we saw evidence in the room, and on the cleaning schedules, that the room was now being checked four times a day.

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

Are services effective?

Good 

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

Summary of findings

Staff told us that they had received training in the Mental Capacity Act, Mental Health Act and Deprivation of Liberty Safeguards. They were supervised regularly and new staff were given a comprehensive induction. The team shared their expertise with hospital staff through training, for example about managing people with a mental health problem in a hospital setting. ED staff spoke highly of the team's work and described them as proactive. The paper based systems used by the community teams made getting up to date information about people's needs, risks and care plans difficult to attain in a timely manner.

Our findings

Rapid Response Liaison Psychiatry (RRLP) – Queen's Medical Centre

Assessment and delivery of care and treatment

RRLP staff provided a liaison service to ward staff and the ED. This included management of behaviours advice and guidance, signposting and assessment. Staff provided a rolling programme of training regarding management of mental health for staff in the hospital setting. They described a good working relationship with staff in other departments. Staff we spoke to in the ED were complimentary about the work undertaken by the team. Any physical health needs identified by staff, that may need investigation, were discussed further with ED staff.

Staff were able to discuss issues around consent and capacity and how to undertake or organise an assessment for people as necessary. Mental Capacity Act and Deprivation of Liberty Safeguards are part of the mandatory training programme.

Outcomes for people using services

Levels of activity and referrals into the service, and their source, were collated within the department. Feedback about performance was shared with managers.

Staff, equipment and facilities

Staff told us they were supported to undertake training outside of mandatory training. We saw a robust supervision process in place. Staff told us they received management supervision on a monthly basis. Training needs, case reflection and improving performance were imbedded in this process. We met with newly appointed staff who had recently joined the team. They were being provided with a comprehensive induction program.

Multidisciplinary working

Staff we spoke with told us obtaining verbal or paper based information about people receiving a service from Community Mental Health Teams (CMHT) was difficult due to paper notes not being readily available and community staff not always free to provide verbal information. Staff identified that the duty worker in CMHT operated from midday until 5pm, which meant that mornings were a particularly difficult time to access community staff by phone. As their worker in the community was the person who knew people best, their timely response was important to avoid delays in people being assessed. Paper based systems complicated this further as RRLP staff had no instant access to agreed crisis or contingency information. This meant that a full picture in terms of risk may not be readily available to the team and impacted upon effective multi disciplinary working between services.

Mental Health Act (MHA)

Staff were familiar with their responsibilities in regard to the MHA. Staff told us that people attending the ED who needed assessment under the Act were sought by the team via the local authorities Emergency Duty Team (EDT). Staff told us that people could face a significant wait in the department, whilst an assessment was organised, but that this was managed safely by ED staff.

Are services caring?

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

Summary of findings

The team was working with an external organisation to develop a feedback tool for service users. The staff were highly skilled and we saw them using evidence-based approaches in their assessments. They also considered people's ability to give informed consent as part of the assessments.

Our findings

Rapid Response Liaison Psychiatry (RRLP) - Queens Medical Centre

Kindness, dignity and respect

Staff were compassionate and respectful towards people. We observed examples of staff offering patient choices about their care. Patient confidentiality was observed with the use of private interview rooms for assessment.

People using services involvement

RRLP staff and management recognised there was a lack of feedback received from users of the service. They were liaising with "Harmless", which is a national self-harm support network, to develop service user involvement. Plans were being developed to create a service user group. An occupational therapist was supporting development of this project.

We observed an assessment being undertaken by staff. The person was observed to engage well in the consultation, with rapport established quickly, and this appeared due to the compassionate and attentive approach of the nurse. We saw that a cognitive behavioural therapy approach was used in conversation with the person.

Emotional support for care and treatment

We observed staff to be skilled, compassionate and highly motivated in the work they undertook. Language used by staff reflected a strong team approach and a caring attitude. Staff demonstrated a proactive approach to incoming referrals. Staff we met with told us that carers were involved in people's assessment, with the person's permission. Staff provided information in written form for carers to access support. For people that required referral on to other services within the trust, staff would highlight any unmet needs of carers on the assessment document or verbally if appropriate. This meant the needs of those involved in people's care were routinely given consideration.

We saw that staff used evidence based practice and positive risk management techniques in formulating their assessment. Consideration in regard to capacity and consent were demonstrated. Advice regarding issues of informed consent was provided to wards within the general hospital setting. This meant specialist knowledge was available to acute staff to ensure best practice was adopted in people's care.

Are services responsive to people's needs?

Good 

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

Summary of findings

The team worked with hospital staff to protect people's safety when there were delays in transferring them to an inpatient bed. The rooms and facilities available for people waiting for transfer were adequate. However, staff described them as "not ideal" as they were away from the main ED area and had no private washing or toilet facilities. Staff worked hard to meet the national target for meeting with people who were referred to the service within an hour of arriving at the ED. They had also worked with ED staff to develop a flowchart, which was reducing waiting times.

Our findings

Rapid Response Liaison Psychiatry (RRLP) – Queen's Medical Centre

Planning and delivering services

The team provided mental health assessment to the acute hospital wards, ED and offered short term follow up clinics. Hospital staff utilised the service for advice, regarding management of people experiencing physical health problems in the ward setting, alongside mental health problems.

The team's operational policy remained in draft due to the ongoing development of the team. The clinical lead and medical staff met monthly to review and update this. One staff member told us "We offer a flexible need driven response outside of the service." This meant that the team were not rigid in their approach to care and were responsive to people's unmet needs.

Right care at the right time

During our visit we observed one person waiting in the ED, who had been assessed by the team 12 hours previously, as requiring an inpatient mental health bed. In total the person had been in the ED for 21 hours at the time of our visit. This meant that people experienced extended waits following assessment due to lack of availability of inpatient beds.

We spoke with both the ED and RRLP staff about the issue of bed availability. Feedback given was that it was not uncommon for delayed transfers to happen. One staff member told us, "It's a common occurrence particularly at

night and weekends". This meant that the needs of people in vulnerable circumstances were not being met in a timely manner. We saw that the person had been risk assessed by RRLP and a level of monitoring agreed with ED staff. Security staff provided the agreed level of observation. Availability of facilities and equipment for people delayed in ED were not meant for use over extended periods, such as overnight. We observed a person sleeping across two chairs in the interview rooms provided. No washing or toilet facilities were available within the room. ED staff provided food and drink to people routinely whilst they waited and checked on their welfare periodically. RRLP staff relied upon the availability of rooms for the purposes of assessment. Staff told us that at times both rooms were occupied and this caused further unnecessary delays for people waiting. Overall the facilities were adequate but not designed for the purpose they were being used for by people delayed due to lack of beds.

Staff had identified recent peaks in people attending the ED who were known to community mental health teams. Data we were provided with clearly demonstrated this issue. The ED was used as the default service for people experiencing a mental health crisis, requiring a face to face assessment out of hours, as no provision was available in the community or people's own home. This was confirmed with staff from the community teams we visited. This meant that provision of assessment, in or close to people's homes if this was their preference, was not available out of hours. Travel to the ED was up to 20 miles for people in certain areas of the county.

Care Pathway

We saw that the team had clear pathways to meet the needs of people using the service. ED staff showed us the flowchart and fast track system that had been developed jointly with the RRLP. This had helped manage the incoming workload, especially when people requiring assessment are medically fit for discharge and ready for assessment around the same time, which impacted upon capacity issues of both RRLP and the ED. ED staff told us that the fast track system has improved waiting times.

Staff we spoke with described clearly how to access interpreters within the acute setting and described mandatory training and additional online learning in relation to black minority and ethnic people.

Are services responsive to people's needs?

Good 

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

Learning from concerns and complaints

Staff were aware of the trust's complaints policy. Complaints were received directly and passed to the team manager or from the Patient Advocacy Liaison service (PALS). Staff were confident on how to advise people with concerns, complaints or compliments. We saw a number of posters, in the ED reception areas used by people, on how to make a complaint. Information leaflets about the service

included this information as well. Staff told us that people who had made complaints were kept up to date as to its progress. Investigations of complaints were investigated by the service manager where appropriate.

Evidence of trust wide learning from complaints and incidents was demonstrated through the team manager sharing with staff and globally through updates via the trust email system. This information was included and discussed in regular team meetings.

Are services well-led?

Good 

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

Summary of findings

There was a high level of morale in the team and staff respected each other. They told us that they received clinical and managerial supervision, and also undertook peer group supervision. Staff said that their manager was supportive and acted on any concerns raised. The manager also made sure that any staffing or health and safety issues, which could affect the team's ability to provide or deliver effective care, were included in the trust's risk register.

Our findings

Rapid Response Liaison Psychiatry (RRLP) – Queen's Medical Centre Vision and strategy

Staff we spoke with told us they were well supported by their managers. They all spoke positively about their role and demonstrated their dedication to providing quality patient care. They told us that senior managers and the board members had engaged with them, provided information and regularly consulted with them in a variety of formats.

We saw, and staff confirmed, that the team was cohesive with high staff morale. Key messages about the trust were communicated to managers at monthly senior management meetings and this was in turn cascaded to staff in team meetings or via email.

Responsible governance

Staff told us that they received clinical, managerial, and undertook, peer group supervision. Staff attended monthly team meetings. Clinical handovers were undertaken at the beginning of each shift. We saw that staff attendance on training was monitored by managers and shared with staff.

Staff had a broad understanding of the trust visions and values and received regular emails in regard to this. Staff told us monthly business meetings were good for feedback in regard to audits undertaken within, and outside of, the team. Staff confirmed that they had received governance training.

Senior managers raised any issues that needed inclusion in the trust wide risk register and the manager told us that this was generally an effective tool for capturing ongoing concerns.

Monthly audits of records were undertaken by the manager and submitted to the governance department. Managers received bi-monthly reports which monitored their performance. Alongside this collation of data was undertaken routinely in the team and shared with governance.

Leadership and culture

A supportive and cohesive team was evident. Staff were able to discuss a broad understanding of the current and future needs of the organisation. Staff we met with were passionate about their work and showed a genuine compassion for people. We saw a sense of collective responsibility in meetings and in case discussions and interactions between staff. Staff demonstrated their understanding of their role, objectives and communication processes within the team and the wider trust.

One staff member told us about the care and support they had received during a period of ill health. They described the managers and staff as having a genuine concern for their well-being.

Engagement

Staff told us that they were aware of the trust's whistleblowing policy and felt able to report incidents, raise concerns and that they would be listened to. Staff confirmed that their manager was supportive and acted upon any concerns raised.

Staff were aware on how to access advocacy services for people and leaflets, given to people about the team, also contained information about relevant local advocacy contacts.

Performance improvement

Staff we met with understood their aims and objectives in regard to improvement and learning, through regular formal supervision. Staff told us they valued the supervision they received and that it was structured and meaningful.

We saw that service developments were being monitored for risks. Monthly team meetings covered developments in the team, their objectives and managing risks to the service.