CareQuality Commission

Good 🟢

Nottinghamshire Healthcare NHS Trust
Services for older people
Quality Report

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Date of inspection visit: 29 April – 1 May 2014
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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)
Bassetlaw Hospital	RHAAA	Ward B1	S81 0BD
City Hospital	RHALB	Daybrook and Bestwood wards	NG5 1PB
Millbrook Mental Health Unit	RHABW	Amber and Kingsley wards	NG17 4JL
Duncan Macmillan House (Trust Headquarters)	RHAPA	Community mental health teams	NG3 6AA
Highbury Hospital	RHANM	Cherry and Silver Birch wards	NG6 9DR

This report describes our judgement of the quality of care provided within this core service by Nottinghamshire 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 Nottinghamshire 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 Services for older people (Mental Health)	Good	●
Are Services for older people (Mental Health) safe?	**Good**	●
Are Services for older people (Mental Health) caring?	**Outstanding**	☆
Are Services for older people (Mental Health) effective?	**Good**	●
Are Services for older people (Mental Health) responsive?	**Good**	●
Are Services for older people (Mental Health) 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

Nottinghamshire Healthcare Mental Health services for older people provide both inpatient and community services for people over 65 with functional mental illness, and people of all ages with organic mental health illness.

These services for older people were good. They had a clear vision and staff where positive about working towards this. The quality of the service delivered was monitored on an ongoing basis using a range of measures. Where areas for development were identified, clear action plans were in place and progress monitored.

Staff were supported in their roles and received regular supervision. People using the service and their carers and relatives told us, and we observed, that most staff were very caring.

We found that there were a number of areas where the service should make improvements. The medical staff felt they were not empowered and did not always have enough time for direct clinical care with people using the service. The communication between the community and inpatient teams was not always working effectively to ensure that information was shared at all times. Do not attempt resuscitation documentation was not consistent.

Summary of findings

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

Are services safe?
Overall, the service provided a safe service for older adults. The service has a good track record on safety and there were clear structures and processes in place to ensure that services were delivered in a safe and responsive manner. The inpatient services all displayed the patient safety thermometer and strategic targets. All services were demonstrating a good level of compliance against critical targets and essential legislation.

Good ●

Are services effective?
Clear policies and structures for assessments were in place and they were delivering against the requirements of the service. Care was responsive and reflected the individual needs of people using the service and their carers. The service took current best practice into account in relation to critical physical care and reported monthly on key targets to ensure efficiency. There was a good governance structure in place within the service.

Good ●

Are services caring?
All of the staff we had contact with demonstrated outstanding levels of care and responsiveness to people using the service and their carers, and were skilled and sensitive in the delivery of care.

Outstanding ☆

Are services responsive to people's needs?
Services were generally responsive to people's needs. They were close to where people lived and had clear protocols for when people should be seen. However, communication between inpatient and community services could be improved, the duty roster system made more consistent, and consultant time on wards increased in order to improve support for people using the service.

Good ●

Are services well-led?
The service had a vision for how it would develop and had good systems in place for monitoring the quality of the service it provides. It had clear structures to support the management of the teams. Feedback from nurses was generally positive. Medical teams felt less supported and felt pressed for time.

Good ●

Summary of findings

Background to the service

Nottinghamshire Healthcare Mental Health services for older people (MHSOP) provide both inpatient and community services for people over 65 with functional mental illness, and people of all ages with organic mental health illness.

MHSOP wards were based on four hospital sites:

- Highbury hospital (Cherry ward, for women with functional conditions, and Silver Birch ward, the dementia intensive care unit)
- Bassetlaw hospital (ward B1, for people with functional and organic conditions in separate spaces)
- Millbrook Mental Health Unit (Kingsley ward, for people with functional conditions, and Amber ward, for people with organic conditions)
- City hospital St Francis unit (Daybrook ward, for people with functional conditions, and Bestwood ward, for people with organic conditions).

The service has eight community mental health teams (CMHT), which were spread across the city and county. The service also provides a memory assessment service, dementia outreach team (to provide guidance to other providers of care services), and a working age dementia service. Day services were also provided at a number of sites, including Millbrook Mental Health unit and City Hospital St Francis Unit. The Intensive Recovery Intervention Service offered intermediate care support to people, with the intention of supporting them to live successfully in a community setting.

CQC inspected Highbury hospital in October 2013. We identified non-compliance with the regulations related to people's care and welfare, consent, and medicines and issued compliance actions. This new inspection assessed whether the changes had been made to ensure the trust was meeting the required standards.

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Lelliott, Deputy Chief Inspector, Care Quality Commission.

Team Leader: Jenny Wilkes, Care Quality Commission

The team included CQC inspectors and a variety of specialists: A specialist registrar in old age psychiatry, a specialist mental health nurse, a social worker, a Mental Health Act Commissioner, CQC inspectors and two Experts by Experience who had experience of care.

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?

To answer these questions before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 29 and 30 April and 1 May 2014. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors and therapists. We observed how people were cared for and reviewed care or treatment records of

Summary of findings

people who use services. We talked with people who use services, and to their carers and / or family members, to understand their views and experiences of the core service.

What people who use the provider's services say

Before our inspection we used focus groups to speak with people who used the services.

During the inspection, we spoke with people on the wards and using the services, and their relatives. Most people were positive about their experience of care at the trust. People told us they found staff to be very caring and supportive towards them. They told us they were involved in decisions about their care. Some people told us they would like staff to share information with them more effectively.

Good practice

- The supervision structure for staff on the inpatient wards was excellent. It enabled lessons learnt to be shared with staff effectively and allowed staff to feel well supported.
- Ward leadership was strong on all older people's wards. Ward managers were visible and had clear plans to encourage leadership training for all grades of staff in their teams.
- Ward managers were able to meet the 'Releasing Time to Care' agenda with the support of the environment co-ordinators.
- People using the service told us, and we observed, that staff were very caring towards them.

Areas for improvement

Action the provider MUST or SHOULD take to improve
Action the provider should take to improve:

- The trust should ensure that 'Do not attempt resuscitation' documentation in older people's services is completed consistently.

Nottinghamshire Healthcare NHS Trust
Services for older people
Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Bassetlaw Hospital	Ward B1
City Hospital St Francis Unit	Daybrook and Bestwood wards
Millbrook mental health Unit	Amber and Kingsley wards
Duncan Macmillan House (Trust Headquarters)	Community mental health teams
Highbury Hospital	Cherry and Silver Birch wards

Mental Health Act responsibilities

The use of the Mental Health Act was generally good in the older people's inpatient wards. Mental health documentation reviewed was generally found to be compliant with the Act and the Code of Practice in the detained patients' files we examined. Care plans, risk assessments and patient involvement were generally documented.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) were used effectively in the areas we visited. We saw examples of DoLS procedures being followed in a timely and correct manner following staff identifying a concern. The capacity of the individual to make a decision had been assessed and there was a best interest assessment.

People using the service's capacity was discussed as routine in ward reviews and in nursing discharge planning meetings. Staff demonstrated a clear understanding of the Mental Capacity Act and documentation was completed by the multidisciplinary team.

Are services safe?

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

Good 🟢

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

Summary of findings

Overall, the service provided a safe service for older adults. The service has a good track record on safety and there were clear structures and processes in place to ensure that services were delivered in a safe and responsive manner. The inpatient services all displayed the patient safety thermometer and strategic targets. All services were demonstrating a good level of compliance against critical targets and essential legislation.

Our findings

Older people mental health inpatient services
Track record on safety

The service had a clear system for reporting incidents. When we spoke with staff they explained to us the process they used to report incidents through the electronic reporting system. They told us they felt confident in being able to report incidents and many told us they felt incidents were taken seriously and investigated.

Information on safety was collected from a range of sources to monitor performance in each of the wards. All wards we visited were displaying 'safety thermometer' crosses, which recorded the days on which a fall had happened or pressure ulcer developed. The performance of each ward was monitored through a 'balanced scorecard'. Each ward collected a range of performance indicators monthly, which was reported centrally. Indicators collected included the number of falls where a care pathway had not been followed, whether a ligature and health and safety audit had been completed in the last 12 months, and the number of people without a documented health improvement plan, where required. We saw that these had been completed and most indicators were green to indicate they were being met. In December, January and February 2013/14 the older people's wards recorded no acquired avoidable pressure ulcers stage 3 or 4. There were three avoidable pressure ulcers of all grades acquired.

Learning from incidents and improving safety standards

Learning points from incidents were identified and plans put in place to improve safety. Feedback from recent incidents was shared with staff in one-to-one supervision sessions, team meetings and through a monthly safety bulletin. Staff were able to give us examples of how they had learnt from incidents. For example, when we visited Bestwood ward staff explained they had reduced the number of falls by a range of means, including hourly rounding to check people were safe (for example by checking their footwear), and review of medication likely to increase falls risk. On Amber ward the level of physiotherapy input had been increased in response to falls.

At a previous inspection conducted by CQC in October 2013 at Highbury Hospital, the service had failed to meet some of the standards. This was because the trust did not always act in accordance with the legal requirements with regard to a person's capacity to consent, care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare, and the trust did not have appropriate arrangements in place to manage medicines. In response to this, the trust had developed an action plan to improve the safety of the service and ensure they were meeting the standards. We found that the learning from this had been shared across the service. For example, one area of concern had been the quality of risk assessment and physical health note keeping. In response, a regular monthly notes audit was now being undertaken by ward managers in each of the wards. As well as sharing the results centrally, individual feedback was given to staff through supervision sessions.

Another area of concern had been in relation to the management of covert medication. In response, staff had received training in covert medications and pharmacy input had been increased. When we visited Bestwood ward, at City Hospital St Francis Unit, we found that this learning had been shared here as well.

The provider had clear safety-related goals that the wards were working towards. Each ward was completing a

Are services safe?

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balanced scorecard, which recorded their performance against a range of indicators. Where performance did not meet the expected standard it was risk flagged and the reason was investigated.

When safety alerts were issued by the central alerting system these were shared with staff through the monthly safety bulletin. They would also be e-mailed to the ward managers who had responsibility to share the information with staff through their supervisions and team meetings.

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

Information on how to report safeguarding was clearly displayed on the wards and when we spoke with staff their knowledge of how to report incidents was good. Staff had received training in safeguarding vulnerable adults and were able to describe to us how they would report concerns. Ward managers told us they felt well supported by the trust's safeguarding team and that they were available should they require any advice.

We found that the wards had reliable systems in place to mitigate the risks to people using the service. All of the wards were clean and tidy when we visited them. Cleaning schedules were in place to ensure cleaning was undertaken and monthly infection control audits were being undertaken in each of the wards to monitor the management of infection control. We saw that personal protective equipment, such as gloves and gowns, was available for staff to use and observed them using it where appropriate. Staff were able to explain to us how they would respond should someone develop an infectious condition.

The wards were generally well maintained and safe. Corridors were clear and not used for storage. Where outdoor space was available, such as on Silver Birch ward, trip hazards had been minimised.

Appropriate equipment was available on the wards to help keep people safe. For example, when we visited Cherry ward staff told us they had a store of pressure relieving mattresses they could use if required. Some of the wards we visited had full resuscitation trolleys and some had grab bags. These had been regularly checked by staff to ensure they were complete.

When we checked medicines we found they were managed in a safe manner. For example, on Silver Birch ward medicines were stored in a locked clinic room and all

medicine cupboards and refrigerators were locked. The keys were kept by a nurse. Clinic room and fridge temperatures were monitored and were within the guidelines for the dates we checked.

Assessing and monitoring safety and risk

Staff were aware of the needs of people using the service and were able to explain how they were supporting people. Appropriate nursing handover took place at the beginning of shifts. We observed these on a number of the wards, including Bestwood and Silver Birch. These included a discussion of risk factors for the people on the ward and how to support people.

When a person was admitted to a ward a comprehensive assessment was completed. This included undertaking a number of risk assessments. Where a risk was identified, plans were put in place to support the person. For example, when a person was identified as at risk of developing a pressure ulcer, the wards were using a SSKIN bundle to support them. This is a set of support plans covering a person's nutrition, movement and skin integrity. The service had also recently introduced the national early warning score (NEWS) as a method of identifying, assessing and responding to any signs of deteriorating physical health. When we looked at the care notes for people we saw this was completed.

Nurse staffing levels on the wards were clear and reviewed according to the current needs of people on the ward. Most staff we spoke with felt there was enough staff to meet the needs of the people using the service. On each of the wards we visited the ward managers were evident in the unit and led the team meetings.

The Deprivation of Liberty Safeguards (DoLS) were used effectively in the areas we visited. For example, on Cherry ward we saw that a DoLS procedure had been followed promptly and correctly following staff identifying a concern. The capacity of the individual to make a decision had been assessed and there was a 'best interests' assessment. Most staff had undertaken training and demonstrated a high level of understanding of the Mental Capacity Act. For example, on Kingsley ward staff were assessing capacity in their care preparation and planning for people going on leave from the unit

Are services safe?

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Good ●

Understanding and management of foreseeable risks

Staff managed foreseeable risks to care through their assessments and knowledge of people and felt able to respond to local staffing and emergency situations.

When staffing shortages needed to be filled, this was generally done through using bank staff. This was mostly well managed in the wards, with the use of regular staff who were familiar with the ward. On Daybrook ward, which the trust plans to close, longer term temporary staff were being used to fill vacancies. This meant they would have knowledge of the ward and the people using it.

Clear plans were in place, and staff were able to explain how they would respond, should there be an infection outbreak, such as norovirus.

Older people mental health community services
Track record on safety
The service has a clear system for the reporting of incidents. When we spoke with staff they explained to us the process they used to report incidents through the electronic reporting system. They told us they felt confident in being able to report incidents. Where investigations had been required these had been undertaken.

Learning from incidents and improving safety standards
Learning points from incidents were identified and plans put in place to improve safety. Feedback from recent incidents was being shared with staff in one-to-one supervision sessions, team meetings and through a monthly safety bulletin.

For example, when we spoke with staff in the Gedling community mental health team (CMHT) they described how learning from a recent incident had been put in place. They told us they felt supported during these periods when they have had to write and attend Coroner's court by both team managers and the trust.

When safety alerts were issued by the central alerting system these were shared with staff through the monthly safety bulletin. They would also be e-mailed to the team managers who had the responsibility to share they information with staff through their supervisions and team meetings.

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

Information on how to report safeguarding was clearly displayed in team base rooms and when we spoke with staff their knowledge of how to report incidents was good. Staff had received training in safeguarding vulnerable adults and were able to describe to us how they would report concerns. Safeguarding was included in team and individual supervisions. For example, at the St Francis day hospital, feedback from the statutory safe practice forum was included on the team agenda.

The community teams had systems in place to manage caseloads. There was a single point of access to all community services and specialist team members based within the team. In some teams a daily duty system picked up all referrals and allocated according to need and priority. However, this was not consistently in place at all times in all of the teams. For example, The Newark and Sherwood CMHT only had a duty roster system for three days a week. For the City North CMHT new referrals may only be reviewed initially by non-clinical staff and not seen by clinicians until the following day.

Protocols were in place for transferring people from working age to older adults' services, and admission and discharge criteria were in place. Staff were using case load management systems and their caseloads were being audited to check they were appropriate.

There were a number of systems in place to ensure people using the service were safe. The day hospital at St Francis had a register to record if people had attended. If people did not attend they would follow up with the person to check they were safe.

Locked cases were available should they be required for medications, although staff told us it was rare they carried medications.

Systems were in place to maintain staff safety. The service had robust lone working practices in the form of a buddy system and effective across all day service provisions in the service.

Assessing and monitoring safety and risk
Staff were aware of the needs of people using the service and were able to explain to us how they were supporting people. Briefing meetings were undertaken in the community teams each shift. We observed one of these meetings and saw that risks were assessed appropriately.

Are services safe?

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When people were allocated to the team a full assessment was completed. This included undertaking a number of risk assessments.

The service has just implemented a revised care plan that assesses people's capacity where the clinician has doubts about their capacity. In the plans we reviewed risks were generally identified and weighed-up, with an appropriate management plan in place that was reviewed regularly.

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

Clear policies and structures for assessments were in place and they were delivering against the requirements of the service. Care was responsive and reflected the individual needs of people using the service and their carers. The service took current best practice into account in relation to critical physical care and reported monthly on key targets to ensure efficiency. There was a good governance structure in place within the service.

Our findings

Older people mental health inpatient services
Assessment and delivery of care and treatment

Clear care bundles for assessments were in place and were implemented and monitored in line with key national targets. The assessment packages were consistent across services and were monitored and reviewed monthly. Standard risk assessment tools, such as the MUST (malnutrition universal screening tool) were used as appropriate. Physical healthcare checks were completed in the first 72 hours. Where appropriate, referrals could be made to specialist teams. For example, on ward B1 liaison and links with the physical healthcare teams was described as excellent and responsive, especially in the management of diabetes and emergency responses. This was felt to enhance care for people using the service and to support the team with ensuring best practice in regards to treatment plans.

The clinical effectiveness group assessed guidance information and shared this with ward managers and teams. This was then shared with staff in team meetings and supervisions. E-mails were also sent. We spoke with nursing and medical staff who displayed a good understanding of clinical guidelines, for example, NICE (National Institute for Health and Clinical Excellence) guidelines regarding the use of psychotropic medication for people with dementia.

Whether a person had consented to care or treatment was recorded in most people's notes. We saw this was usually completed appropriately. An example of this was that consent for photographs being used for medication management and newsletters.

The wards we visited were following best practice guidelines on managing risks and improving the wards. For example, approaches such as Essence of Care and Releasing Time to Care were being used.

Outcomes for people using services

The service was using a number of ways to measure the effectiveness of its service. A set of targets had been developed and were monitored through the balanced scorecard on wards.

Health of the nation outcome scales (HoNOS) were used to assess people. This meant that the service was aiming to admit people only when their level of need reached a level that would benefit from inpatient admission. The level of usage of HoNOS was monitored and reported.

The number of inpatients without a documented health improvement care plan, where required, was also monitored to ensure that plans were in place appropriately.

The length of stay in inpatient areas was monitored and plans were in place to reduce this where appropriate. Each ward had a target it was working towards and this data was monitored centrally. On ward B1 there was a clear focus on brief inpatient assessment and treatment in the service with an emphasis on people returning to the community as soon as possible. This was because the trust was aiming to manage people in the community as much as possible.

Information on inpatient safety risk indicators was reported through the national safety thermometer. Data from the trust showed that it was generally performing better than the national average.

Staff, equipment and facilities

Most staff we spoke with told us that they felt supported in their roles and had good access to training and supervision. Supervision of staff within the wards was done regularly and in a robust manner. Nursing staff received both clinical and managerial supervision. The supervision sessions followed a set structure and included feedback on learning and audits. The percentage of staff undertaking supervision was monitored and the number undertaking supervision sessions were high. For example, in March 2014, 92% of staff on Silver Birch ward had received supervision.

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.

Most staff had received annual appraisals and had performance development plans in place. For example, in the last year 100% of staff employed for more than six months had received a performance review within the last 12 months

When staff began working on wards they were supported to ensure they had the skills to undertake their role. In addition to the trust induction, the wards had clear inductions that staff followed when they first arrived. This included orientation on the wards and shadowing of shifts. Students were allocated mentors to support them.

The skills of staff were developed to meet the needs of people. For example, the trust has a healthcare support worker development programme, which staff in the older people's service were undertaking. Staff we spoke with were positive about the support this programme offered. Each ward had an environmental care coordinator to support the management of the ward. This meant managers were supported to put the Releasing Time to Care Agenda, a programme that focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care, into practice.

Some of the wards were designed and decorated in an appropriate way to promote a therapeutic environment. For example, Cherry ward had a number of pictures and decorations to give it a more homely feel. Large photographs had been placed in the garden to add colour and cover the fence. Other wards were more clinical in feel. For example, in Bestwood and Daybrook wards the environments were less homely. The wards were all well-equipped, clean and tidy and well organised with good administration to support the releasing time to care agenda. Information was clearly displayed.

Not all of the wards (for example Bestwood and ward B1, Bassetlaw) had treatment rooms with examination couches suitable for reviewing and examining inpatients. This meant that people would have to be assessed on their beds, sometimes in a dormitory room.

When people required specialist support to manage their physical health needs they were receiving this support. For example, on Silver Birch ward if someone was identified as at risk of developing pressure ulcers support was received from the physical health team. On Amber ward the geriatric

service was providing support, although there was no service level agreement for this. If this was in place it may enable the service to increase the support it receives for physical healthcare.

Equipment was checked regularly and monitored. Equipment is subject to cleaning schedules and labels were used to demonstrate when it had been completed. Service checks were completed annually. For example, blood pressure machine calibrations.

Multidisciplinary working

Assessments on wards were generally multidisciplinary in approach, with involvement from medical, nursing and specialist teams. For example, on Silver Birch ward the multidisciplinary team involved, where appropriate, input from a range of specialisms and therapies including occupational therapists, speech and language therapists, pharmacists, dieticians, physiotherapists and clinical psychologists. On Amber ward, there was a high value on the use of physiotherapy in the service. Staff told us they felt the process worked well and they were able to provide their specialist input.

However, there were some areas where the input was not consistent. For example, on Cherry ward clinical psychology was not always available consistently throughout the year due to staff rotations.

Information sharing between wards and community services was taking place. For example, community staff were attending discharge planning meetings. However, staff told us they felt this could be improved. In some cases information was not shared regarding an admission or discharge. One reason for this was the lack of an electronic information system. Staff also told us they felt that communication should be improved to ensure that they were always kept informed when a person was going to be discharge.

On Amber ward a centralised admission/discharge pathway had been developed to support the team and meet targets more effectively.

Mental Health Act (MHA)

The use of the Mental Health Act was generally good in the older people's inpatient wards. MHA documentation reviewed was generally found to be compliant with the Act and the Code of Practice in the detained patients' files we examined. Care plans, risk assessments and patient involvement were generally documented.

Are services effective?

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Good 🟢

Detention renewals were timely and appropriate. Each ward was monitoring when renewals where due and ensuring they were completed as appropriate.

Evidence of capacity assessments was recorded in most records we reviewed. However, On Daybrook ward one file did not record that a conversation had taken place regarding the person's consent to treatment, in accordance with s 23.37 of the code of practice.

Medication was given in accordance with appropriate authorisations in most of the notes we assessed. On Silver Birch ward the documentation of use of medication was good, although in one case we found that a detained patient had been prescribed a medication which had not been authorised by T3 SOAD authorisation.

Standardised leave authorisations were in evidence on the files we assessed.

Information on the rights of people who were detained was displayed in wards and advocacy services were available to support people.

Staff at all grades had undertaken training and were aware of patients' rights.

Older people mental health community services
Assessment and delivery of care and treatment

Assessment processes were in place, and were implemented and monitored in line with key national targets. Advance directives were being built into the assessment process, with recovery principles being developed for older adults. The assessment packages were consistent across services and were monitored and reviewed monthly. Standard risk assessment tools were used. When staff required guidance this was available on the trust intranet. Care plans were generally recovery focused and in the plans we reviewed we saw user and carer involvement and agreement. Advance care planning was evident in people's care plans.

The assessment proforma was lengthy and very thorough. While this was appreciated by some members of staff, such as community psychiatric nurses, other members of staff, including those with more experience and medical staff, found that this document was extremely time consuming to complete detracting from their ability to provide effective care.

The clinical effectiveness group would assess guidance information and share this with team managers and teams. This was then shared with staff in team meetings and supervisions. E-mails were also sent.

The trust had developed a number of specialist services to support people. Day hospitals, such as St Francis, were delivering a range of time-limited, therapeutic interventions. For example, cognitive stimulation therapy was delivered to a defined group over a course of seven weeks. Some people can then access a longer term maintenance programme if they have benefitted from this. The service was also undertaking six-week assessments. The IRIS (Intensive Recovery Intervention Service) offered intermediate care support to people, with the intention of supporting them to live successfully in a community setting. It supported people from 7am to 10pm, seven days a week.

The dementia outreach team was providing specialist advice and assessment for people with challenging behaviour in care homes. The team used multidisciplinary working to provide support to people, and had developed an innovative approach to care. For example, the team had developed training networks for care home managers and activity coordinators.

Outcomes for people using services

The community mental health teams were using a number of measures to measure the effectiveness of its service. Note keeping audits were done monthly electronically. Information from this was fed back directly to the staff member responsible during supervision, monitored through older peoples governance systems as well as being shared with the central governance team.

Staff, equipment and facilities

Most staff we spoke with told us they felt supported in their roles and had good access to training and supervision. Supervision of staff within the wards was done regularly and in a robust manner. Nursing staff received both clinical and managerial supervision. The supervision sessions followed a set structure and included feedback on learning and audits. The percentage of staff undertaking supervision was monitored and the number undertaking supervision was high. Most staff had received annual appraisals and had performance development plans in place.

Staffing in the community teams was generally sufficient to meet the needs of people using the service. However, some

Are services effective?

Good ●

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teams had vacancies and some staff told us they felt under pressure. For example, the Newark and Sherwood CMHT only had two WTE (work time equivalent) permanent community psychiatric nurses (CPNs). However, gaps were being filled by long term agency and bank staff and recruitment was being undertaken.

The service was using paper records in conjunction with electronic systems. Staff told us this was complex and causes problems in communication. However, the trust was developing the use of electronic records and had plans in place to move to electronic records in July 2014.

Multidisciplinary working

Assessments were generally multidisciplinary in approach, with involvement from medical, nursing and specialist teams. Specific services, such as the memory clinics and day hospitals, have been developed to provide specialist assessment and care. Clear evidenced care pathways and protocols were in place to ensure continuity of service. Staff told us they felt communication between these teams was good and they worked well alongside each other.

Information sharing between inpatient wards and community services was taking place. For example, community staff were attending discharge planning meetings. However, staff told us they felt this could be improved. In some cases information was not shared regarding an admission or discharge. One reason for this was the lack of an electronic information system. Staff also told us they felt that communication should be improved to ensure that they were always kept informed when a person was going to be discharge.

The community teams did not have direct social service input. If social service involvement was required referrals have to be made again to social services. This meant there was a delay in people receiving social worker involvement.

Community teams had developed relationships with community agencies. For example, the Alzheimer's society undertook some joint sessions with the teams at the day hospitals. The dementia outreach team was visiting care homes to offer advice, support and guidance.

Are services caring?

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

Outstanding ☆

Summary of findings

All of the staff we had contact with demonstrated outstanding levels of care and responsiveness to people using the service and their carers, and were skilled and sensitive in the delivery of care.

Our findings

Older people mental health inpatient services
Kindness, dignity and respect

People using the service and their relatives were generally very positive about the kindness and respect staff had shown them. The following were examples of some of the feedback we received from people:

"The staff are brilliant. Very respectful and observe my dignity." [Cherry ward]

"The staff know me and treat me very well." [Bestwood ward]

"I trust the staff and they keep him [their relative] safe." [Daybrook ward]

"The staff have steered me through one of the worst times of my life." [Kingsley ward]

We saw that the interaction between people who used the service and staff members was positive and that staff responded to people with patience, kindness and ensured that they were treated with dignity. We observed many examples of staff engaging with people in a kind and respectful manner on all of the wards. For example, on Silver Birch ward we observed staff taking time to talk with a person and reassure them when they became distressed. On Daybrook ward a member of staff was observed at a reminiscence session. Ten people using the service were involved in the session and seemed to be enjoying the session. On Cherry ward a staff member was talking to a person using the service as they were laying the table together for lunch. On B1 we saw that staff had worked with a person with challenging behaviours to support them in an environment that was safe for them and others, away from communal areas and was respectful to his needs.

When we observed lunch being served on Daybrook and Cherry wards we saw that it was done promptly and that people were offered a choice. When people needed support, this was offered.

Some of the wards had dormitory rooms, such as Bestwood ward, which were cramped. However, we saw that staff tried to ensure that privacy was maintained. We saw that when they needed to support someone with personal care they would do so in a manner which maintained their privacy.

Single sex accommodation was maintained in all the wards.

Staff had undertaken equality and diversity training and when assessments were undertaken the cultural requirements of a person was assessed. They demonstrated a good knowledge of the need to support people in their cultural needs. For example, staff described how they would offer culturally appropriate food and would have input from the chaplaincy service on the wards.

People using services involvement

When we spoke with people using the service and their carers, most told us they had a high level of involvement in their care and have had issues clearly explained to them clearly. For example, when we spoke with people on Kingsley ward they told us their care and treatment was clearly explained to them both individually with their nurse and within the multidisciplinary team meetings

On Bestwood and Cherry ward the Royal College of Nursing and the Alzheimer's society 'This is me' document was being used to allow people using the service or their relatives to collate information on the person, which could then be used in planning the person's individual care.

The service was developing models of care to increase people's involvement, especially in self-administering medications. For example, on Kingsley ward people were being supported with the self-administration of insulin.

On each of the wards we visited information on Independent Mental Capacity Advocates (IMCA) and Independent Mental Health Advocates (IMHA) was available should people wish to talk with them. We saw that advocates had been involved in some decisions where appropriate.

Are services caring?

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

Outstanding ☆

Where a person lacked capacity to make a decision we saw that capacity assessments were undertaken for most people. There was a best interest checklist proforma to ensure that clinical decisions were made in the person's best interests, and that this was documented clearly.

Meetings were being undertaken on wards to gather the views of people. For example, on Daybrook ward people told us they felt the weekly meeting gave them a good opportunity to raise any concerns they have.

The views of people using the service was collected on an ongoing basis through the 'Your feedback' form. The themes from these were collected in the service user and carer experience report and plans put in place to address concerns. Responses to this survey were generally very positive. For example, for the first three months of 2014, over 90% of respondents had rated the service quality on Bestwood ward had rated it 'good' or 'very good'. None had rated it worse than 'fair'.

Emotional support for care and treatment

We saw that staff demonstrated a high level of emotional support to people on the ward at an individual level and took time to explain and support people in a sensitive manner.

When we spoke with relatives of people, most told us they felt that communication with staff was good and that they were kept informed by staff. They told us they were invited to assessments and felt involved. For example, one relative on Daybrook ward told us "they always listen and I feel like they are looking after me also." On Cherry ward the consultant held a weekly session where families and carers were invited to discuss their concerns and the support for their relative.

Information booklets had been developed on Bestwood ward. This included information on the service provided and the ward, including contact details of key staff members. The method for providing feedback was also included.

During the assessment process a number of tools were used to ensure staff supported the wider needs of people using the service and their carers/relatives. For example, there was a trust signposting guide for carers. This advised staff on the contact details of support organisations they could refer people to.

Older people mental health community services
Kindness, dignity and respect

People using the service and their relatives were generally very positive about the kindness and respect staff had shown them. Examples of feedback we received from people receiving community services at day hospitals included the following:

"I like coming here. It is really relaxing."

"She [staff member] is lovely."

"I never knew the NHS could be so good."

When we observed staff interaction with people using the service, we saw they were kind and respectful to people. For, example, we observed an exercise session at St Francis day hospital. We saw staff taking time to support people in a kind manner.

Staff we spoke with were generally extremely proud of their relationships with each other and with people using the service. They demonstrated a strong commitment to each other and the service they provide. When they discussed the needs of the people they were supporting, their working knowledge of their needs was good.

Staff had undertaken equality and diversity training and when assessments were undertaken the cultural requirements of a person was assessed. They demonstrated a good knowledge of the need to support people in their cultural needs.

People using services involvement

When we spoke with people using the service at the day hospitals, most they told us they had a high level of involvement in their care and have had issues clearly explained to them clearly.

Care plans we reviewed showed involvement from people and, where appropriate, their carers, especially in relation to advance directives and ongoing care.

Where a person lacked capacity to make a decision, we saw that capacity assessments were being undertaken for most people. There was a best interest checklist proforma to ensure that clinical decisions were made in the person's best interests, and that this was documented clearly.

Are services caring?

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

Outstanding ☆

The views of people using the service was collected on an ongoing basis through the 'Your feedback' form. The themes from these were collected in the service user and carer experience report and plans put in place to address concerns.

Emotional support for care and treatment

The teams had a number of processes for supporting carers. When an initial assessment was done by the community team, a process was in place to refer carers to social services for an assessment.

As part of the programme of cognitive stimulation therapy, the day hospital at St Francis runs a carers' session, which is co-facilitated with the Alzheimer's society bi-monthly. This has the aim of providing information for people on accessing wider emotional support networks within the community.

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

Services were generally responsive to people's needs. They were close to where people lived and had clear protocols for when people should be seen. However, communication between inpatient and community services could be improved, the duty roster system made more consistent, and consultant time on wards increased in order to improve support for people using the service.

Our findings

Older people mental health inpatient services

Planning and delivering services

The inpatient service was planned with a number of specialist wards, with people with functional and organic conditions being cared for separately. Silver Birch was designated the dementia intensive care unit, which means it specialises in supporting people with challenging or difficult to manage organic conditions. Wards were spread throughout the county, although due to the size of the county there were still some areas that did not have a local service. The service was reducing the number of inpatient beds it had and intends to close Daybrook and Bestwood ward, in order to focus on managing a larger number of people in community settings.

The assessment process and care pathways were clear and well evidenced in practice. Issues and targets were clear and there was a strong emphasis on meeting critical targets relating to the planning and delivery of care. Clear policies and protocols were in place in terms of the care pathway, and local practices were being implemented. For example, most recently an admission and discharge protocol for the wards had been implemented.

Most of the wards visited were gender specific. Where they were not, for example on Silver Birch ward, there were separate male and female areas.

Equipment was available when required. For example, pressure relieving mattresses and cushions were kept in stock for when they were required.

Care planning followed set assessments that included a person's individual equality characteristic, such as their cultural background. Interpreters could be sought when required.

Right care at the right time

Care was delivered in the inpatient service by a multidisciplinary team. In addition, there was input from specialist teams, such as physical healthcare, when required. However, on the wards the amount of consultant sessions was limited. For example, on Cherry ward the consultant only had four sessions weekly on the ward. This meant that the amount of time they had to manage people's care, meet with relatives and supervise junior doctors was limited, and that consequently this could lead to delay in people receiving appropriate assessment and treatment. This ward had introduced nurse led discharge for non-complex admissions to try and ensure that discharge was not delayed.

The service was aiming to care for more people within the community settings, where this was more appropriate. As a result targets had been set to reduce length of stays and clear policies and protocols were in place in terms of the care pathway. For example, the health of the nation outcome scales, were used to guide when a person should be admitted.

Care pathway

The service was developing its pathway for admission and discharging to community teams. For example, on Amber ward care pathways regarding admissions were being introduced and the staff were developing relationships with community services. On Silver Birch ward links had been developed with local care homes to support people with high needs, and to try and improve the pathway should people need to move into such accommodation. Discharge planning was taking place early in a person's admission to try and limit the amount of time they were an inpatient. However, communication between teams could be improved to ensure that information was shared effectively and in a timely manner.

When we visited the day hospital at Millbrook, capacity for people with functional mental health problems was not being utilised despite a busy acute functional unit. People who may benefit from this service were potentially not being referred.

Are services responsive to people's needs?

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

The wards were completing Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms, where it was judged that this was appropriate. During our visit we reviewed eight forms across the wards. Although the sample size was small, these did not all contain evidence of capacity having been assessed or involvement of relatives or carers where appropriate. The reason for the decision was not always recorded in detail. For example, on Bestwood and Silver Birch wards 'progressive dementia' was noted as the reason for the decision. Further detail was needed to show the reason why DNACPR should not be attempted. This means people had not had their resuscitation status assessed appropriately.

Learning from concerns and complaints

Information was available on the wards regarding PALS (Patient Advice and Liaison service) and how to complain should people wish to. Information on advocacy services was also displayed. When we spoke with people, most told us they felt they would be able to raise a concern should they have one. Feedback was also collected from people using the service and their relatives/carers in feedback forms. When comments were made suggesting improvements these were reviewed by the ward manager. Responses, either explaining changes or the reason why changes could not be made, were then displayed in the wards on 'you told us and we did' posters.

When complaints were made we saw that these were responded to in an appropriate manner and any learning points identified. For example, on Daybrook ward we saw that action plans had been developed in response to a complaint and this was fed back to staff through one-to-one supervision sessions and team meetings.

Older people mental health community services

Planning and delivering services

The service provides support for people with functional conditions aged over 65 and people with organic conditions of all ages. A number of specialist services had been developed to meet the needs of these groups. These included the memory assessment service to provide assessments in community settings, the dementia outreach team to provide guidance to other providers of care services, and a working age dementia service for younger people with organic conditions.

When a person with a functional condition reached the age of 65 they were supported by the service. The trust did not have an older person's crisis team. In addition, the

community support service was not providing out-of-hours support. This meant that people seeking specialist mental health support out of hours would have to contact their local GP or A&E.

A model of care focusing on community-based services had been developed and clear pathways and protocols were in place to facilitate this. Services had been planned to ensure they were available close to where people lived. Community services were provided by teams spread across the county and city. Memory clinic services have extended to work at more locations and some GP practices. For example, a memory clinic had now been developed at Ollerton.

Day hospitals were also operating in a number of locations. These had developed a range of focused interventions, such as cognitive stimulation therapy, which were delivered in set, time-limited programme. New approaches, such as the 'mindfulness' approach, were also being used.

Care planning followed set assessments that included a person's individual equality characteristic, such as their cultural background. If required, support could be put in place for people to meet their needs. For example, interpreters could be sought when required.

Right care at the right time

The service was aiming to care for more people within the community settings, where this was more appropriate for the person. To enable this, clear policies and protocols were in place in terms of the care pathways to try and ensure people were not admitted to inpatient facilities inappropriately. For example, the health of the nation outcome scales, were being used to guide when a person should be admitted.

Waiting times for services were monitored. Services were generally quite responsive. For example, the Nottingham City South CMHT had no waiting list from referrals. People awaiting assessment from the dementia outreach team were usually seen within two weeks. However, depending on the make-up of the local CMHT there were sometimes delays in accessing therapies, such as occupational therapy or psychology, as there may be limited availability locally.

Are services responsive to people's needs?

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

Good ●

Care pathway

The service was developing its pathways for admission and discharging between inpatient and community teams. For example, an inpatient admission criteria policy had been put in place to ensure people were seen at the correct point.

Work had been undertaken to assess how well some services were meeting the needs of people from minority groups. For example, St Francis day hospital has undertaken work to assess whether their service was meeting the needs of BME (Black and minority ethnic) groups. It looked at the cognitive stimulation therapy and assessed how it could be adapted to different cultural groups. This work had then been used to develop recommendations for how they can better support people.

Learning from concerns and complaints

Information was available in information leaflets regarding Patient Advice and Liaison service (PALS) and how to complain should people wish to. Feedback was also collected from people using the service and their relatives/carers in feedback forms. When a complaint was received, the teams were aware of the process for investigating it and identifying learning.

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

The service had a vision for how it would develop and had good systems in place for monitoring the quality of the service it provides. It had clear structures to support the management of the teams. Feedback from nurses was generally positive. Medical teams felt less supported and felt pressed for time.

Our findings

Older people mental health inpatient services

Vision and strategy

Clear trust vision and strategies for the service were evident and staff had a good understanding and knowledge of these. Generally the staff were supportive of the changes, felt engaged with the process and had seen positive outcomes for service users. On the wards, such as Silver Birch, there was a 'vision tree' displayed on the wall. This took corporate objectives and applied them to the ward environment.

Responsible governance

Clear structures were in place to ensure that learning was embedded following incidents. For example, on Daybrook ward we saw that clear action plans had been developed and that evidence of actions being met, which had been embedded in the action plan document and shared with the central governance team, demonstrating actions that had been taken. We also saw that learning was shared appropriately across the service. At a previous inspection conducted by CQC in October 2013 at Highbury Hospital, the service had failed to meet some of the standards. This was because the trust did not always act in accordance with legal requirements with regard to a person's capacity to consent, care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare, and the trust did not have appropriate arrangements in place to manage medicines. In response to this, the trust had developed an action plan to improve the safety of the service and ensure they were meeting the standards. We found that the learning from this had been shared across the service. For example, one

area of concern had been the quality of risk assessment and physical health note keeping. In response a regular monthly notes audit was now undertaken by ward managers in each of the wards.

Staff were aware of the management structure and where to seek support. For example, when we asked staff about safeguarding processes they told us that they would seek advice from the trust's safeguarding team if they required it.

Data on performance was collected regularly. Each ward completed a balanced scorecard that recorded their performance against a range of indicators. Where performance did not meet the expected the standard it was risk flagged and the reason was investigated. Information was also being collected on other indicators, such as length of stay. When we spoke with managers on wards they told us their performance against these targets was monitored centrally through their supervision framework.

Leadership and culture

Leadership on the wards was outstanding. On all the wards we visited ward managers were visible and staff told us they felt supported. The staff had received appraisals and regular supervisions. Staff we spoke with were open about the challenges they faced in the role, but almost all told us they felt they were in good teams and that they felt they were delivering good care.

On Bestwood and Daybrook wards, which were planned to close at the time of the inspection, staff told us they would like to receive more information on the future development of their roles.

Staff had access to development programmes. For example, ward managers and deputy ward managers had access to development programmes. In addition, healthcare support worker development programme, which staff in the older people's service were undertaking.

Medical staff felt they could be better supported in their roles in terms of senior medical leadership. They felt their involvement in designing and delivering services could be strengthened.

Engagement

The views of people using the service was collected on an ongoing basis through the 'Your feedback' form. The

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.

themes from these were collected in the service user and carer experience report, with plans put in place to address concerns. Responses to concerns were posted on the walls on the wards.

On each of the wards we visited information on Independent Mental Capacity Advocates and Independent Mental Health Advocates was available should people wish to talk with them. We saw that advocates had been involved in some decisions where appropriate.

Meetings were undertaken on wards to gather the views of people using the service. For example, on Daybrook ward people told us they felt the weekly meeting gave them a good opportunity to raise any concerns they have.

The views of staff were collected through supervision sessions. Wards also had team meetings were concerns could be raised. Staff we spoke with told us they felt they would be able to raise concerns. Medical staff we spoke with told us they felt that when they were engaged they were not always listened to and their concerns were not always acted upon.

Performance improvement

The wards had clear objectives, which all staff were working towards as part of their performance development. Regular and structured supervision sessions were undertaken, which included individual feedback. For example, following an audit of notes the named nurse would receive feedback on areas for improvement as part of their next supervision.

Staff told us they were held to account where issues were raised. For example, many told us they had increased their skills and awareness in relation to physical healthcare following a need for improvement being identified.

Older people mental health community services

Vision and strategy

The trust had a clear vision for the service, involving increasing the community provision. The service had also developed a model of care based around the principle of enabling people. These strategies for the service were clearly evident and staff had a good understanding and knowledge of these. Generally the staff were supportive of the changes and felt engaged with the process.

Responsible governance

Clear structures were in place to ensure that learning was embedded following incidents. Staff were aware of the

management structures and where to seek support. For example, when we asked staff about safeguarding processes they told us they would seek advice from the trust's safeguarding team if they required it.

When an incident occurred, staff were aware of how to report this. If an action plan was put in place, evidence to monitor the progress was provided to the central governance team.

Leadership and culture

Members of staff in all the community teams we visited told us they felt that the management of the team was good and that they felt supported by their team manager. They felt that they had good access to training and development opportunities. Managers and staff we spoke with told us they had a good interface with the trust. Most told us they felt part of the wider service and were not isolated in their teams. Engagement was undertaken through intranet, surveys, and questionnaires on staff satisfaction.

Some community mental health team managers were responsible for a number of aspects of the service, for example, including memory assessment services. This meant some were limited in the time they could spend with their teams and placed them under pressure.

Many staff we spoke with told us they felt there was an open culture. For example, one member of staff told us they would "have no hesitation contacting the chief executive if I had concerns." However, some medical staff felt that they were not able to contact the Medical Director easily or effectively.

Engagement

The views of people using the service was collected on an ongoing basis through the 'Your feedback' form. The themes from these were collected in the service user and carer experience report and plans put in place to address concerns. These were shared with people on an ongoing basis or, if they were receiving a time limited intervention at the end of their programme.

The views of staff were collected through supervision sessions and through team meetings. Most staff told us they felt confident in being able to raise concerns.

Performance improvement

The teams had clear objectives, which all staff were working towards as part of their performance development. Regular and structured supervision sessions

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were undertaken, which included individual feedback. For example, following an audit of notes the named nurse would receive feedback on areas for improvement as part of their next supervision.