Nottinghamshire Healthcare NHS Foundation Trust

Inspection report

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Date of inspection visit: 22 March 2022 to 28 April
Date of publication: 25/11/2022

Ratings

Overall trust quality rating	**Requires Improvement**
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Outstanding**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

We carried out this unannounced inspection of Nottinghamshire Healthcare NHS Foundation Trust of the mental health and community health services provided by this trust the services hadn't been inspected since for over three years and they had an overall rating of requires improvement.

At this inspection, we visited the three mental health services which had been rated as good in 2014 and four community health services, one of which had been rated as requires improvement in 2018. This inspection was carried out as part of our programme of ongoing checks on the safety and quality of healthcare services.

We also inspected the well-led key question for the trust overall.

At this inspection, the overall rating for the three mental health services we inspected went down to requires improvement. The ratings of the four community health services we inspected remained the same as good for three services and rated one as requires improvement.

At this inspection the overall ratings for mental health services stayed the same in safe and responsive, which we rated as requires improvement. Caring stayed the same, rated as good. The ratings for effective and responsive went down. We rated these as requires improvement.

The rating for well-led in mental health services, remained the same as requires improvement.

At this inspection the overall well-led provider rating improved stayed the same as requires improvement.

We inspected two mental health inpatient services, and one community based mental health service. The two mental health inpatient service inspections were unannounced. The community based mental health service was announced 24 hours before the inspection began.

- Long stay rehabilitation mental health wards for working age adults.

Our findings

- Wards for Older People with Mental Health problems.
- Community-based mental health services for older people.

We inspected all key lines of enquiry in all domains (safe, effective, caring, responsive and well-led) in these services.

We inspected four community health services. The community health inpatient service was inspected because of the ratings from the previous inspection. The other three community health services were inspected as they hadn't been inspected since 2014. The community health inpatient services inspection was unannounced and the remaining three community health based services were announced 24 hours before the inspection began.

- Community Health – Inpatients.
- Community Health – End of Life Care.
- Community health services – children, young people and families.
- Community Health – Adults.

We inspected all key lines of enquiry in all domains (safe, effective, caring, responsive and well-led) in these services.

We also assessed if the organisation is well-led and looked at areas of governance, culture, leadership capability and improvement. Our inspection approach allows us to make a judgement on how the trust's senior leadership leads the organisation and the provider level well-led rating is separate from the ratings of the services we inspected.

Prior to this well led review of Nottinghamshire Healthcare NHS Foundation Trust we also carried out two focussed inspections of forensic inpatient or secure wards and acute wards for adults of working age that had been rated as inadequate in 2019. To check if these services now met legal requirements**.** These inspections were unannounced.

We did not inspect the following core services previously rated as requires improvement:

- high secure hospital.

We did not inspect the following core services previously rated as good:

- child and adolescent mental health wards
- wards for people with a learning disability or autism
- community based metal health services for adults of working age
- mental health crisis services and health-based places of safety
- specialist community mental health services for children and young people.
- community based mental health services for people with a learning disability or autism.

We are monitoring the progress of improvements to these services and will re-inspect them as appropriate.

In rating the trust overall, we took into account the current ratings of the seven services we did not inspect this time and the two focussed inspections.

Our overall rating of this trust stayed the same. We rated them as requires improvement because:

Our findings

- The trust had not responded in a timely way to eliminate shared sleeping arrangements (dormitories). At the last inspection in 2019 we told the trust that they should have an action plan to eradicate dormitories at Bassetlaw and Millbrook Mental Health Unit. We were pleased to see that this plan was in place with set deadlines for this work to be completed. However, we were concerned that the timelines within the plan had slipped due to the significant additional remedial works and refurbishment of a newly purchased hospital site. The impact of these delays meant that a total of 80 patients, on nine wards across the trust were required to share sleeping accommodation. Whilst the bed areas were separated by curtains the bedroom areas did not promote privacy or dignity of the service users admitted into these areas.
- Whilst the trust had a robust appointment process for all board directors, they did not ensure that that the senior leaders personal files met General Data Protection Regulations (GDPR) and the fit and proper persons checks had not been reviewed as they should have been.
- We found that the trust equality impact assessments required improvement and had not fully delivered on reducing inequalities that they were designed to deliver. The trust agreed with this. Although, we were assured that the equality impact assessments were always completed and approved by the board.
- In two of the community health core services and one mental health core service inspected we found that were issues with medicines management. This included, the ineffective audit system processes, omissions in recording when a patient had self-administered critical medication, incorrect storage, and ineffective monitoring, use, and correct disposal of prescription pads.
- Patients at Thorneywood Mount did not have up to date crisis or contingency plans. The absence of these plans meant that if a patient's mental health deteriorated either on the units or when in the community, their carers, or staff would not know what action should be taken to ensure their safety. Whilst the provider addressed this issue within two weeks of our inspection, we did not feel the processes for updating these plans had sufficient time to become embedded into practice.
- In two mental health core services and one community health core services staff were not up to date with mandatory training. The compliance rates fell below the expected 75% compliance rate for specific training. It was acknowledged that the pandemic and COVID-19 outbreaks on wards and community teams had impacted on staff training.
- Governance systems and processes, and the strategy of the organisation had been extensively reviewed since our last inspection but was not fully embedded into services. It was not clear how the divisional teams used governance processes and measures to make positive, sustainable changes. Many of the leaders within mental health and community health core services did not use the trust governance process and reports effectively within their roles.
- Not all governance processes operated effectively at team level. Some of the mental health and community heath core services were still waiting for the roll out of the governance dashboards. It was planned within the next 10 months they would all be in place. Governance processes including clinical and pharmacist audits and recording of meeting decisions were not embedded into practice and therefore the service might not be aware of findings that would improve practice. In addition, governance structures were not robust, and this meant that there were gaps in training and supervision.
- The trust had a digital strategy in place. The use of digital technology was evident in some areas throughout the trust. However, divisions across the trust did not have designated digital leads. In addition, we were not clear how the board were using information and communication technology (ICT) as a key enabler to service change and transformation. We found there were delays with some digital produces such as Electronic Prescribing and Medicines Administration (EPMA).

Our findings

- Whilst managers ensured staff had access to regular, constructive clinical supervision of their work, clinical supervision compliance rates in four of the inspected core services did not meet the trusts target rate of 80%. We could not ascertain if this was because staff had not accessed supervision or recorded that supervision had taken place.
- There were not always additional alarms for staff working in the wards for older people if staffing numbers increased. This meant staff could not get help quickly if there was an emergency.
- Within two mental health core services and one community health core services inspected we found that staffing numbers did not always provide enough suitably qualified staff on duty to meet patient needs.
- In long stay rehabilitation mental health wards for working age adults, the environment had not been well maintained and maintenance teams had not undertaken repairs in a timely way. At Thorneywood Mount showers had not worked properly for nearly two years; managers had reported the showers for repair on at least six occasions. On all occasions a temporary fix was made but the issue remained.

However:

- The executive board members were proactive, accomplished, open and responsive to feedback and passionate about improving the organisation. The trust demonstrated succession planning at board level. Since the last well led review there had been changes to the executive team; this had been strategically planned to ensure that the changes were implemented effectively with minimal impact on the running of the trust.
- Non-executive and executive directors were clear about their areas of responsibility. The trust used the organisational risk register and its board assurance framework to support good governance. Individual directorates were held to account by the board on financial, performance and quality.
- The board recognised that they needed more work to ensure the diversity of the board reflected the diversity of the communities it served.
- The trust had a Quality Mental Health legislation committee which chaired by a non-executive and lead by an executive. They provided leadership and held mental health operational groups, across the three divisions within the trust. The trust had reviewed their responsibilities and requirements under the Mental Health Act. This led to an organisational change in the structure of the mental health act teams.
- The trust had a clear vision and a set of values with quality and sustainability as the top priority. The trust worked inclusively when developing its strategy for 2022-2026. The strategy was launched in April 2022 and was the culmination of 18 months of engagement with a wide range of stakeholders. The strategy clearly demonstrated the trusts ambition over the next five years. It detailed the way in which they planned to improve the delivery and quality of care, support the workforce and embed a culture of continuous improvement across the organisation.
- The strategy was aligned with the local health economy and took into account the needs of the developing Integrated Care System (ICS). It outlined the need for collaboration and building strong clinical and non-clinical alliances between the health and care services to reduce barriers and improve patient care. The trust had responded proactively to the Integrated Care Board (ICB) development, and specifically the development of provider collaboratives.
- The trust had identified that they needed to further develop the culture to allow people to perform at their best and where everyone was able to be themselves, with a zero tolerance for inequality, harassment, discrimination and bullying. The trust promoted inclusivity and celebrating diversity in daily work and provided opportunities for staff development and career progression.

Our findings

- The Black and minority ethnic network was one of the longest and best established staff groups in the trust with 285 members. We heard from some of the staff in this network. The network reported that their ideas and suggestions for change had been listened and heard by the trust, but they had not been followed through to bring about change.
- The trust continued to provide an extensive range of health and wellbeing offers to staff. Leaders of the trust viewed staff wellbeing as a high priority. The trust worked closely with their staff health and wellbeing leads to ensure that they supported colleagues in line with the staff feedback from the staff survey. The trust had a strong emphasis on safety and wellbeing of all staff and promoted a culture of having the right support in place for all staff.
- The trust was committed to patient involvement and experience and working with volunteers. The trust had an active volunteer network within excess of 185 volunteers.
- The trust had a people and culture committee which coordinated and supported implementation and development of the trust equality and diversity action plan with associated equality and diversity initiatives. At an executive level the trust had a good understanding of the equality, diversity and inclusion challenges and how the trust was meeting these challenges.
- Since the last inspection the trust corporate governance structure had been reviewed, redeveloped and improved. The structure was effective at board level with clear process and systems of accountability to support the delivery of the trusts strategy.
- The board recognised that that risk management was an essential and integral part of good management practice. The trust had a risk process in place to manage current and future performance. The trusts risk register report was comprehensive and identified risk to the organisation. The Board had developed a well-documented Board Assurance Framework and Risk Register. Most actions for assurance were clearly set out and were specific, measurable, achievable, and timely.
- During our inspection it was evident that clinical staff took part in clinical audits, benchmarking and quality improvement initiatives. Senior leaders supported improvement and innovation work and there was a strong programme of staff training.
- Quality improvement was high on the agenda of the trust. We were pleased to hear and see how quality improvement was in action. The trust had a quality improvement lead and has participated in Quality, Service Improvement and Redesign programme since 2020.

How we carried out the inspection

During the inspection, our inspection teams carried out the following activities across 10 wards and 11 community mental health teams, 4 community health services inpatient services and two community health teams:

- reviewed 97 care records
- reviewed 60 medication records
- interviewed 153 staff and 20 managers
- held 13 focus groups
- interviewed 43 patients
- spoke with 35 family members or carers of patients
- observed 20 episodes of care, multidisciplinary meetings.

Our findings

During our well-led inspection, we spoke with 33 senior leaders of the organisation and looked at a range of policies, procedures and other governance documents relating to the running of the trust.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

We spoke with nine patients receiving care from the Community-based mental health services for older people. Their feedback was continually positive about the way staff treated them. Patients told us there was a strong focus on person centred care. One patient said the service had sign posted them to a Parkinson nurse to support them. Another patient said the doctor had visited her at home about mobility problems and provided options and advice. A third patient told us they had knowledge about their medicines as staff always provided full explanations which gave them a better understanding of their condition. A fourth patient told us staff had spent time explaining their diagnosis and answering their questions.

Other patient feedback received, “The service had transformed our lives. “Staff were very patient and took time to explain, you never felt rushed” “All matters were discussed openly.” Patients told us the service was wonderful, staff were kind, will go out of their way to help and support you, the service had been a lifesaver, enjoyed visits from the team. Patients consistently told us staff were motivated went over and above their duties.

We spoke with six patients and five carers on Wards for Older People with Mental Health problems. Feedback was generally positive. They said staff were compassionate and caring and that staff always made time for them. Patients also said they saw their consultant regularly.

Some patients in multiple occupancy dormitories said they would prefer to have their own bedroom.

Patients spoke positively about the food including the range of options, although one patient said they wanted more healthy choices including fruit and vegetables.

Patients said they were encouraged to take part in activities and to exercise.

Carers described the challenges of COVID-19 and not being able to go on to the ward but said that they had been able to visit patients outside of the ward.

Carers mostly said staff kept them informed of care and treatment decisions, including explaining the purpose and side effects of medication to them. One carer said they had not received a call back from the consultant in a timely manner.

We spoke with five people using the service and four carers within Long stay rehabilitation mental health wards for working age adults. Patients we spoke with were all positive about how the service was helping them to move on and treated them as responsible adults. They all agreed that the staff were great and even when busy they could make time to listen to patients.

Patients felt that lock down had been a difficult time particularly as many of them had only recently started to get more freedom to access community activities and home visits but the lock down rules had prevented them from doing these things. Patients told us that during lock down staff had gone out of their way to ensure they still did meaningful activities and explained how those activities would support their mental health recovery.

Our findings

However, all patients we spoke with commented that the showers at both 106 and 145 Thorneywood Mount were awful and had not worked for a long time. Two patients said they did not like the bedrooms as they did not have their own shower and toilet and the building (145) was very old fashioned. Though another patient described the same building as homely. Patients from 106 told us there was very little space on that ward and no therapy space and they had to come to 145 for group therapy and craft type activities.

Carers we spoke with said communication with the wards was good and all four carers knew who their relatives named nurse was and knew they could ring them if they had queries. Three carers said they had copies of their relative's care plans but only after permission had been gained another carer said their relative did not want them to have a copy of the care plan.

Two carers commented on how good the doctors were and how they had time to explain things to them clearly and without rushing.

All carers said they could see improvement in their relative's mental health and wellbeing. One carer said staff try to create a community on the ward, give patients responsibility for themselves as much as possible and help people to become friends. Another carer said, "her son was much happier since moving to this service, he got into a lot less trouble with other patients and for the first time in many years said he felt safe on the ward".

We spoke with 13 patients across the Community Health – Adults service, and three carers. Every patient and carer we spoke with told us how caring and respectful the staff were. Every patient and carer we spoke with talked highly of the service and of the staff.

All patients and carers said that staff used gloves, aprons and masks which made them feel safe with COVID-19. Patients and carers were aware that visiting staff had been regularly tested for the virus.

All patients and carers had a contact number so that they could contact the service if needed. Most patients had used this.

One patient explained that they were awaiting some new dressings from her GP. A visiting nurse had managed to locate a few while they were awaiting the delivery.

One patient described the nursing service as "very efficient" and said that they "help me emotionally".

One patient confirmed that the nurses had got to them very quickly when they experienced a blocked catheter.

Two patients said that they had experienced a cancelled visit but had been visited the following day. Staff had called them individually and had explained to them why and offered an apology.

We spoke to 12 family members and three patients within the Community Health – Inpatients service. All three patients spoke positively about their experiences on the ward. One family member was not positive about the care of her family member or the way staff had communicated with them and three other families told us that they thought communication from staff on the ward could be improved. Not all families knew how to make a complaint, but they did say that they would ask staff if they wanted to raise a concern and some families said they would like to know more about activities on the ward.

Our findings

However overall families reported that patients were well cared for on the ward and that patients were well-nourished and hydrated. They told us staff were kind and caring and that the ward environments were very clean. They did not report any issues in respect of patient safety and said that medication was well managed, including pain relief. Three families referred to the wards being short of staff some of the time.

We reviewed 23 complements across the Community health services – children, young people and families service that recognised the team's individual clinicians, including health visitors, school nurses, orthotics, speech and language therapists, and nurse family practitioners. The following are examples of the comments we reviewed; "we could not express more gratitude to the Home Talk scheme," "so dedicated and passionate and truly enabled my daughter to feel proud of the progress and "the nurse helped with sorting out problems with GP."

We spoke with nine parents; they were overwhelmingly positive about both the care and the staff. Three parents said that the staff were outstanding and had gone the extra mile to ensure children and young people's voices were heard and their needs considered.

They said staff were caring, respectful and supportive and they felt very valued and involved in their child's care and treatment.

Outstanding practice

We found the following outstanding practice in Community Health – End of Life Care:

- We found that John Eastwood Hospice had engaged with charities businesses in the local community in order to get donations to create welcome and exit packs for patients. These packs provided patients with items to make them more comfortable, hygiene and personal care products and messages of support. The exit pack also included food and provisions to make hot drinks to ensure that patients did not return home to empty cupboards.
- John Eastwood Hospice had created a safe, supportive space for loved ones to pay their respects to patients who had passed away. Within this space there were items placed in a memory box so that loved ones could collect handprints or a lock of hair. Consideration had been given to supporting loved ones in the grieving process.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with one legal requirement. This action related to Wards for Older People with Mental Health problems. This legal requirement was also applicable for Acute wards for adults of working age which had been inspected in March 2022.

Trust wide

Our findings

- The trust must ensure that the newly developed governance structure is embedded within the divisional teams used governance processes and measures to make positive, sustainable changes. (Regulation 17)
- The trust must ensure that the are compliant with General Data Protection Regulations and with the completion of fit and proper persons checks. (Regulation 17)
- The trust must ensure that they embed the digital strategy across the trust. (Regulation 17)
- The trust must ensure they have a robust plan in place with timescales to implement the Electronic Prescribing and Medicines Administration (EPMA) and divisional governance dashboards. (Regulation 17)
- The trust must ensure that they review and improve the equality impact assessments to reduce reducing inequalities. (Regulation 17)

Long stay rehabilitation mental health wards for working age adults

- The trust must ensure that processes for managing medicines and the clinic rooms, including accurate, regular completion of audits are embedded in practice. Regulation 12
- The trust must ensure that all patients crisis plans are regularly updated and embedded into practice. Regulation 12
- The trust must ensure that all staff have completed mandatory training at Thorneywood Mount. Regulation 12
- The trust must ensure that the long-term plans for refurbishment of the showers and improvement of the water pressure at Thorneywood be completed at the earliest opportunity. Regulation 15
- The trust must ensure that the plans to refurbish 106 and 145 Thorneywood Mount are completed within a reasonable time frame. Regulation 15
- The trust must ensure that all governance processes including clinical audit and recording of meeting decisions are embedded into practice and the findings are used to improve practice. Regulation 17
- The trust must ensure that all managers are aware of, understand and use all available governance systems and processes to monitor and improve the service. Regulation 17
- The trust must ensure that all blanket restrictions are properly managed and reviewed. Regulation 17
- The trust must ensure that all staff receive and record annual appraisal, and clinical and managerial supervision as per the trusts policy. Regulation 18
- The trust must ensure that there are sufficient numbers of nursing and support staff to meet patients' safe care and treatment needs and maintain safety for nursing staff in the evenings. Regulation 18

Wards for Older People with Mental Health problems

- The trust must ensure that it adheres to guidance on mixed sex accommodation and national guidance. All mixed gender wards must have female only lounges. Regulation 10
- The trust must ensure that it adheres to national guidance regarding shared sleeping arrangements. All patients must have access to single occupancy bedrooms. Regulation 10
- The trust must ensure that it has an adequate supply of alarms, including access to additional alarms for visitors or where staffing numbers increase. Regulation 12
- The trust must ensure that it has enough qualified and unqualified nursing staff and staff from across clinical disciplines to meet clinical need. Regulation 18

Our findings

- The trust must ensure that staff submit safeguarding referrals where appropriate and in a timely manner to safeguard patients from abuse/ improper treatment. Regulation 13
- The trust must ensure that managers complete clinical supervision in a timely manner and provide staff with an appropriate appraisal of their work. Regulation 18
- The trust must ensure that the service holds regular team meetings to enable information sharing, provide clinical updates, and for staff to be able to raise concerns. Regulation 17
- The trust must ensure that there is staff have access to complaints data to enable them to monitor complaints and identify themes. Regulation 17

Community-based mental health services for older people

- The trust must ensure sufficient numbers of suitably qualified staff are deployed. Regulation 18
- The trust must ensure staff are up to date with mandatory training including Infection prevention control level two and Care programme approach training. Regulation 18
- The trust must ensure staff receive appropriate supervision and appraisal. Regulation 18
- The trust must ensure that the senior managers are present and visible to staff; and information systems and processes are established and operated effectively to ensure compliance. Regulation 17

Community Health – Inpatients

- The trust must ensure that patients are offered the opportunity to eat in the dining area, even if this is adapted to maintain social distancing measures. Regulation 9
- The service must ensure that staff are compliant with mandatory training and offered other relevant training for their role, are supervised regularly and able to attend meetings relevant to their work. Regulation 18
- The trust must ensure staff complete falls risk assessment and care plans so that staff are best placed to support patients and minimise risk. Regulation 12
- The trust must ensure there are enough staff to keep patients safe and ensure the quality of the service and wellbeing of staff. Regulation 18
- The trust must ensure critical medicines are recorded properly when administered by staff or when patients self-administers, that physical health observations are recorded and that medicines are audited and stored securely. Regulation 12
- The trust must ensure that they have effective governance structures in place to ensure:

Staff understand that capacity is decision specific.

That medical staff follow trust policy and use the reSPECT form for advanced decisions.

There are governance structures in place to ensure staff completed care records fully, attend training, supervision and team meetings. Regulation 17

Community Health – End of Life

Our findings

- The trust must ensure that documentation relating to medicines is stored correctly, monitored and disposed of in line with guidance. Regulation 12

Community Health – Adults

- The trust must ensure that staff are competent and knowledgeable before providing treatment at patient clinics. Regulation 18
- The trust must ensure that staff receive regular, constructive clinical supervision in line with their policy. Regulation 18

Action the trust SHOULD take to improve:

Long stay rehabilitation mental health wards for working age adults

- The trust should ensure that there is an easily identifiable system at Thorneywood Mount for staff to log out when leaving the wards. Regulation 12

Wards for Older People with Mental Health problems

- The trust should ensure that staff receive appropriate mandatory training to enable them to carry out their duties effectively. Regulation 12
- The trust should ensure that it continues to review and monitor discharges to prevent patients' staying in hospital longer than they need to. Regulation 12
- The trust should consider how it ensure that the environment and layout of patient areas meets the needs of patients and enables them to orientate themselves to the ward. Regulation 15
- The trust should ensure that agency and bank staff can access patients' electronic care records to review and update clinical information. Regulation 12

Community-based mental health services for older people

- The trust should ensure access to the Gedling and Hucknall community mental health team based are reviewed to ensure patients are able to access the automatic front door safely; and ensure adequate signage to the location on the hospital site. Regulation 15
- The trust should ensure staff are up to date with Safeguarding Adults Think Family Level 3 training. Regulation 18

Community Health – Inpatients

- The trust should ensure that they communicate with the families of patients about their care and ensure families know how to complain should they need to. Regulation 9
- The trust should ensure that patients who are not deprived of their liberty know how to leave the ward. Regulation 10
- The trust should ensure that it can provide suitable medical cover for the service and in a psychiatric emergency. Regulation 12

Community health services – children, young people and families

- The trust should ensure that all staff receive an annual appraisal. Regulation 18

Our findings

Community Health – Adults

- The trust should ensure that all staff complete and keep up to date with mandatory fire training. Regulation 18

Is this organisation well-led?

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

The trust had a senior leadership team in place with the appropriate range of skill, knowledge and experience to perform its role. They had a good understanding of the services they had responsibility for. When senior leadership vacancies arose the recruitment team reviewed capacity and capability needs. The executive board members were proactive, accomplished, open and responsive to feedback and passionate about improving the organisation.

Non-executive and executive directors were clear about their areas of responsibility. The trust used the organisational risk register as its board assurance framework to support good governance. Individual directorates were held to account by the board on financial, performance and quality.

However, the trust board was facing significant changes in its composition. The director of finance and estates had left the trust in late 2021 after a short tenure; and the deputy director of finance was, for the second time, acting as interim director. The vice chair and chair of the audit committee was coming to the end of their tenure in mid-2022; and three non-executive directors had recently been appointed. The chief executive had announced their intention to retire; and two executive director posts shared with another trust were out to advertisement.

The trust demonstrated succession planning at board level. Since the last well led review there had been changes to the executive team; this had been strategically planned to ensure that the changes were implemented effectively with minimal impact on the running of the trust. Succession planning had been invested in and was in place providing assurance to identify potential leaders to fill the soon to be vacant positions. It was clear that the chair of the trust was experienced in managing changes with a board team. It was refreshing to hear that that the trust was questioning ‘what is the CEO and board members that the trust needs now’ rather than replacing like for like.

The board leadership behaviours had been developed, embedded and demonstrated by the board members and amongst the senior leaders. The executive team provided clear leadership by setting clear goals, and priorities for ensuring sustainable, compassionate, inclusive and effective leadership.

The chief executive had been in post since 2019 and had built a strong executive team and developed a supportive collaborative culture within the trust board. We heard that early on in their appointment there was a lack of trust from staff regarding the leadership team. A review of the leadership team was carried out with a sharp focus on culture, values and behaviours. The non-executive directors reported that the trusts leadership had changed and it was now more inclusive. The non-executive directors told us that there was confidence in the capability of the executive leadership of the trust and that they had the capacity to fulfil their roles. They felt there was transparency across the board and honesty in communications. Staff throughout the trust spoke positively about the leadership from the chief executive and were very supportive of the changes that they had brought to the trust.

Our findings

The board recognised that they needed more work to ensure the diversity of the board reflected the diversity of the communities it served. Of the 10 non- executive directors only two were from a black or Asian background and both were women. The split of male and female was equal at five each. All members had extensive experience working in the NHS, local authority and voluntary organisations.

Whilst the trust had a robust appointment process for all board directors, they did not ensure that that the senior leaders personal files met general data protection regulations (GDPR) and the fit and proper persons checks were not reviewed as they should have been. We reviewed seven files and found that copies of non-appointed interview candidates paperwork had been filed in appointed senior leaders personal folders. This was not in line with GDPR guidance. In addition, the trust completed annual fit and proper persons reviews. However, this had not been completed in 2021. We raised these issues with the trust, who completed a review of the files and confirmed the errors and omissions. Within 24 hours we received an action plan to address the issues we found and to ensure this did not reoccur.

There was continued focus on developing the clinical pharmacy support to community mental health services. Additionally, the pharmacy team structure was being revised to strengthen governance and management support to the expanding team. A revised internet page and social media was being used to support recruitment to the pharmacy team along with a focus on development opportunities for existing staff.

The visibility of leaders in the trust had improved since the last inspection. Although the pandemic hindered leaders to sustain this improvement in conventional ways, however, use of technology meant that staff still had access to the leaders. The majority of the staff we spoke with during the inspection were positive about the executive directors accessibly and visibility throughout their services. Staff spoke highly of the chief executive daily briefings and how it made them feel valued.

Vision and Strategy

The trust had a clear vision and a set of values with quality and sustainability as the top priority. It highlighted the trust commitment to make a difference, acted as a framework for future planning and resource decision was considered and prioritised.

The trust worked inclusively when developing its strategy for 2022-2026. The strategy was launched in April 2022 and was the culmination of 18 months of engagement with a wide range of stakeholders. It had been informed by service users and developed by staff across the trust and the board. In excess of 700 staff and patients attended workshops, team meetings, surveys, staff networks; they directly advised on their ambitions for the trust. In addition, there was significant board scrutiny and engagement in the development of the strategy. The new strategy for 2022-2026 embedded the vision and values and supported the key priorities for the trust.

The strategy clearly demonstrated the trusts ambition over the next five years, detailing the way in which they plan to improve the delivery and quality of care, support the workforce and embed a culture of continuous improvement across the organisation.

In order to meet the strategic vision, the trust set four strategic objectives which were designed to create the capability and capacity to deliver the trust strategic vision:

- Our people
- Our Care

Our findings

- Our Performance
- Working Together.

The strategy clearly outlined the reason why each strategic objective had been set, the goals for the next five years and what success will look like. We found that these objectives were underpinned by strategic goals and associated success measures which were specific, measurable, achievable, relevant and timely (SMART) wherever possible and mirrored the newly redeveloped governance structure.

The strategy outlined annual priorities that would be set each year through the trusts annual planning cycle. This would drive actions that will support the delivery of the strategic objectives and priorities. Aligned to this were six enabling strategies (workforce plan, financial plan, estates strategy, green plan, digital strategy and food and nutrition strategy) to support the delivery of the objectives and form the trust strategic framework. Three of these strategies were in place, one will be delivered later on in 2022 and two were being developed and ratified. In addition, the new strategy was underpinned by the newly developed governance structure and identified what success looks like with defined attainment targets.

Senior leaders had scrutiny and oversight processes in place to ensure that the enabling strategies were developed. For example, the workforce strategy showed a clear understanding of the drivers of workforce risk and had quantified gaps that needed to be filled. Within the annual priorities the trust will need firm plans and trajectories to give assurance that the strategy will be delivered.

Following a successful bid, the trust was preparing to roll out electronic prescribing and medicines administration across both inpatient and community services from September 2022.

Every member of the leadership team interviewed knew their role in delivering the strategy and the contribution their teams made to achieving the objectives, including divisional and corporate annual plans.

Whilst leaders across the trust were able to talk about the trust vision and strategy and the part they had played in developing them, this was not the case for some middle managers and ward staff.

The strategy was aligned with the local health economy and took into account the needs of the developing integrated care system (ICS) It outlined the need for collaboration and building strong clinical and non-clinical alliances between the health and care services to reduce barriers and improve patient care.

The trust had responded proactively to integrated care board development, and specifically the development of provider collaboratives. The trust had recently formed two new committees of the board, covering strategy and commissioning: the latter to ensure that the board remained sighted on quality, finance and outcomes in commissioned services. The trust had assumed responsibility for the commissioning, as well as provision, of forensic services. In interviews, some executives expressed concern about the overlap of roles and responsibilities between committees and potential risk of duplication. Given the changes at board level, these emergent concerns should be kept under review.

The trust had reviewed their responsibilities and requirements under the Mental Health Act. This led to an organisational change in the structure of the mental health act teams. The trust previously had five Mental health legalisation teams. These teams were dissolved and a trust wide team was formed with 20 staff including three

clinicians. The new structure covers both the Mental Health Act and the Mental Capacity Act and provides a clearly defined escalation process. The clinician's role within the team was to embed the Mental Capacity Act across the trust. We heard examples of how they were redeveloping and improving e-learning and providing advice and support to teams across the trust.

We heard during the inspection that the new Mental Health Act structures had improved, a network of expertise support across the trust, cross working across the directorates had improved and the management structure was more clearly defined. The new structure had been clearly articulated across the trust using not only by the Mental Health Act leads within the clinical teams but information regarding trust responsibilities was easily assessible via Connect, the trusts intranet.

Culture

The trust had identified that they needed to further develop the culture to allow people to perform at their best and where everyone was able to be themselves, with a zero tolerance for inequality, harassment, discrimination and bullying. The trust promoted inclusivity and celebrated diversity in daily work and provided opportunities for staff development and career progression. The values and behaviours displayed within the trust were based on a just and restorative culture and a philosophy of curiosity and continuous improvement. The trust leadership were committed to investing in people to ensure that people had the skills and confidence to champion the best possible quality patient care.

We held focus groups with staff ahead of our inspection. The majority of staff we spoke with told us they felt proud to work for the trust. All staff valued their teams and were proud to make a difference to those who used services. Staff told us they were particularly proud of the dedication staff gave to their work during the COVID-19 pandemic.

The trust continued to provide an extensive range of health and wellbeing offers to staff. Leaders of the trust viewed staff wellbeing as a high priority. Staff praised the trust highly on its wellbeing offer through the COVID-19 pandemic. The trust offered wobble rooms, daily briefings, debriefs, flexible working, IT provision for remote working, risk assessments on personal circumstances and advice on keeping well.

The trust responded to the feedback they received in the staff survey about staff burnout. The trust worked closely with their staff health and wellbeing leads to ensure that were supporting colleagues in line with the staff feedback. At the time of the inspection there were three 3 leads in post for staff health and wellbeing – an occupational health lead, a health and wellbeing lead and staff counselling lead.

The trust had placed a strong emphasis on the safety and wellbeing of all staff and promoted a culture of having the right support in place for all staff. In January 2020, the trust became an employer for carers member. This supported the trust to promote the importance of supporting working (staff) carers and develop a carer-friendly workplace. In March 2020 the work that the trust had completed was recognised and they were named a 'carer confident active employer'.

We held a focus group with the council of governors who told us that the trust board was transparent and open with them in regards to the trust performance. The council had noticed positive improvement's and the hard work that had taken place to improve the culture within the trust since the appointment of the chief executive. In addition, they felt that the board members welcomed challenge and were honest with the council if they could not answer the questions, but the answers were always sought and forwarded the council outside of the meetings.

Our findings

The 2021 staff survey response rate had improved to 57% in the last 5 years. For the first time the survey was aligned to the seven themes of the NHS People Promise, alongside the previous elements of staff engagement and morale. The trust was scored out of 10 for each of the nine areas. The highest score was for 'we are compassionate and inclusive' at 7.4. The lowest was for 'we are always learning' at 5.4. The other areas scored an average of 6.5.

The trust was committed to patient involvement and experience and working with volunteers. The trust had an active volunteer network within excess of 185 volunteers. Last year the trust celebrated national volunteers' week.

The trust held an annual event the 'OSCARS', the trust award scheme. The trust used this as an opportunity to acknowledge and celebrate the work that all staff clinical, non-clinical and volunteers did through the year. The trust intranet had an achievements page, where they celebrate individual achievements across the trust.

The trust held celebrating excellence annual awards events. In 2020, the virtual event was held to reward 41 members of staff who had been shortlisted for 13 award categories. Over 200 nominations were received for the 2020 awards.

The trust had a people and culture committee which coordinated and supported implementation and developing of the trust equality and diversity action plan with associated equality and diversity initiatives. At an executive level the trust had a good understanding of the equality, diversity and inclusion challenges and how the trust met these challenges. We found that the trust equality impact assessments required improving and did not fully deliver on reducing inequalities that they were designed to deliver. The trust agreed with this. We were assured that the equality impact assessments were always completed and approved by the board.

The equality diversity and inclusion lead was experienced in their role and fully understood their role and accountability. They had excellent understanding of the limitation of workforce race and equality standard (WRES) and how the trust in partnership with the Black, Asian and minority ethic network has been developing a wider action plan with clear actions.

Workforce disability equality standard trust wide metrics data table (2018-2021) highlighted that out of the 10 metrics the trust had measured against they were compliant. In the main, improvement had been made and there was evidence of good practice, but inequalities were still present.

We were told about the diversability equality steering group/network which was co-chaired by a disability staff champion and an age equality staff champion, supported by a board champion. Both board champions regularly attended meetings and championed issues at board level. The disability board champion in particular engaged with disabled staff on the workforce disability equality standard and sourcing solutions to any barriers/blockages, real or perceived. We were pleased to hear that staff from estates and facilities attended the meetings so that they could personally hear the voice of disabled staff and be held accountable for the agreed actions.

WRES employer aspirational goals/expectations for 2021 for senior grades of staff (Band 8a to 9) exceeded the goal. The trust had planned for 36 staff to be recruited to these bands and by 21 March 2022 the actual total was 45. The plan set for 2022 was 38 which they had already achieved.

We were assured that staff networks were well established within the trust. They were working well and delivering on supporting staff to impact on both workforce inequities and health inequalities. The Black and minority ethnic network had been instrumental in developing and delivering a ready now development program with a neighbouring trust. The early evaluation of the ready now programme was positive and many delegates on the course had now been promoted.

Our findings

The Black and minority ethnic network was one of the longest and best established in the trust with 285 members. We heard from some of the staff in this network. The network reported that their ideas and suggestions for change have been listened and heard by the trust, but they have not been followed through to bring about change.

Senior leaders were proud of the parallel learning partnership programme. This programme supported dual learning between staff from Black and minority ethnic groups' colleagues and senior managers. It pairs staff from Black and minority ethnic groups' staff members with member of the executive and senior leadership team to work together as equal learning partners to engage in open dialogues and to share and learn from each other. The purpose of the learning partnership was to generate a better understanding, to challenge each other and remove unnecessary barriers. The programme was launched at the Black and minority ethnic staff network on 08 October 2020 and was implemented in April 2021. The first cohort completed the programme in March 2022.

The trust employed around 900 LGBTQ+ staff. We heard from some of those staff who reported that they could bring their whole self to work. We were pleased to hear about the LGBT+ allies and how well this had been received across the trust and how many staff wanted to be involved. Unfortunately, the pandemic impacted on the LGBT+ network to run as it used to but following lockdown, was back up and running again regularly with a good attendance, promoting social relationships, education and awareness. Although the network had not been running as it should we were pleased to hear that seminars, Pride events took place and the network met with the trusts Chair to provide input into the development of the trust strategy. We heard that the intranet relaunch for the LGBT+ network took place during the inspection, with refreshed information. Running alongside the LGBT+ network was the gender identity and sexual orientation network. This was a steering group that at the time of inspection had a focus on reviewing trust policies.

The trust applied their statutory duty of candour effectively. There was a clear process in place when things went wrong. A 'culture of candour' was promoted and had been embedded in the trust investigation process. The trust offered an apology for incidents and followed guidance for statutory duty of candour when required. When there was a serious incident that required investigation duty of candour was considered at the start of the enquiry so that the trust could formally apologise and ensure families were involved in setting the terms of reference for the investigation.

The trust had systems in place to gain assurance that the Mental Health Act and Code of Practice was followed within the trust. In addition, there was a culture of scrutiny of detention papers. The culture was one of positive challenge which was readily accepted by all. We heard examples of where responsible clinicians would challenge poor mental health act paperwork and accept legal challenge when given. The Mental Health legislation and quality group and the trust wide restrictive intervention group supported the assurance process. The Mental Health Act leads, and the Mental Health Act teams carried out audits across the trust to identify areas of good practice or areas of improvements. Within each division across the trust, 'mini logs' were used to record the outcomes of audits and identified actions and themes for other divisions to learn from.

At the last inspection we asked the trust to continue to work on developing a culture that enabled staff to raise concerns without fear. We were pleased to see and hear that the trust had developed a culture of speaking up which was supported by a freedom to speak guardian. The work that the guardian had undertaken was recognised nationally with the trust being placed as the sixth most improved in the country. The trust had a pool of freedom to speak up champions across the services. The champions supported the freedom to speak up function by championing a culture where raising concerns is the norm. The trust was continuing to expand the champions network, at the time of inspection there were 31 trained champions with another 18 awaiting training. In addition, a champions steering group/ development team had been recently formed. The group had multidisciplinary membership to help drive the improvement action and make sure that freedom to speak up was embedded as a clinical quality indicator as well as an organisation culture indicator.

Our findings

Governance

Since the last inspection the trust corporate governance structure had been reviewed, redeveloped and improved. The structure was effective at board level with clear process and systems of accountability to support the delivery of the trusts strategy and make quality improvements and sustainable services. There were clear responsibilities, roles and systems of accountability between executive and non-executive directors to support clear governance and management at board level.

The trust had structures, systems and processes in place to support the delivery of its strategy including board committee, divisional committees, team meetings and senior managers.

Although the new governance arrangements had been reviewed and improved, we were concerned that they had not been effective as they could have been in addressing issues that had been raised at previous inspections.

Whilst we found the governance structure had been embedded at board level, there was still more work to do within the divisional management teams governance structure. It was not clear how the divisional teams used governance processes and measures to make positive, sustainable changes. Many of the leaders within core services did not use the trust governance process and reports effectively within their roles. We found that this was due to the complexity of the data/reporting measures. The reports were produced in way that was meaningful for the senior leadership team but not for the core services/divisions. It was less meaningful for the, middle manager/directorates and not all had access to the dashboards. So were concerned that they could not drive improvements, be monitored or measured against set outcomes.

The trust, in order to meet good governance arrangements, had clear reporting lines to ensure that information was shared from board to ward and vice versa. There were seven committees that fed through to Board and these included risk committee, people, culture equality and inclusion committee, strategy, risk and audit committees. Information was escalated to these committed from 19 organisational groups, these included digital groups, health and security, safeguarding, risk, restrictive interventions, inclusion, medicines patient involvement and safer staffing.

The trust had a quality mental health legislation committee which was chaired by a non-executive and led by an executive. They provided leadership and held mental health operational groups, across the three divisions within the trust. All groups were well established and produced logs of any issues that were found with actions to be addressed. These committees were held to account by the board of governors, who in turn ensured that the non-executive directors took action to address areas of identified need.

The governance arrangements under which the divisional management teams operated were clearer since our last inspection, although they were not always used in the way that they were designed. Divisional management teams were supported by appropriate finance, human resources, communications and clinical expertise and had an improved governance structure since our last inspection that gave increased confidence that key risks were reviewed on a monthly timetable.

Whilst staff at all levels were clear about their roles and they understood what they were accountable for and to whom. It was not clear how, at a service/directorate the governance structures had been implemented to support the directorate to make improvements.

Our findings

The revised the governance arrangements included medicines optimisation. Divisional medicines optimisation groups had been reinstated to strengthen and align governance structures, promoting ownership and oversight of medicines optimisation at local level. However, these changes were not yet embedded into practice, with the terms of refence for the overarching trust medicines optimisation group under review. Formats for assurance and exception reporting remained to be agreed.

The annual controlled drugs and medicines optimisation report suspended for 2021 was to be reinstated for 2022-23. The trust was also in the early stages of planning a revised medicines storage and prescribing audit (on a digital platform) aimed at increasing accessibility and ownership of audit findings at ward or team level.

The trusts antimicrobial stewardship programme promoted the appropriate use of antimicrobials. A recent audit demonstrated good overall compliance with areas for improvement being shared with the divisions for communication back to prescribers.

Management of risk, issues and performance

The board recognised that risk management was an essential and integral part of good management practice. The trust had a five year risk management strategy which outlined the risk management framework and how it integrated in significant activities and functions. The framework was understood by staff and embedded into everyday working practice. Board members were assured that risks were identified and managed in an effective way.

The trust had a risk process in place to manage current and future performance. They had clearly outlined four steps within the process, identify and evaluate the risk, assess and score the risk, control and manage the risk and lastly monitor and review. Executive validation of the process and emerging risks took place within the monthly risk committee meeting. Public and stakeholder oversight and scrutiny of the process and performance took place within the board meetings. This validation and scrutiny challenged the trust to ensure that they were complaint with statutory and regulatory requirements regarding the effectiveness and adequacy of the risk management processes.

The trusts risk register report was comprehensive and identified risk to the organisation, gave each risk a severity and likelihood score, which when added together gave a total risk score. A target score was then set which the board were tasked to achieve. The risk scores were reported in the context of the boards risk controls, gaps in controls, internal and external assurances, including gaps in assurance, evidence used to demonstrate action or risk, gaps and actions with time frames, which set out how the trust intended to achieve a target risk.

The Board had developed a well-documented board assurance framework and a risk register. Actions for assurance were clearly set out and were generally specific, measurable, achievable, and timely. However, there was evidence of optimism in the time that actions would take to be achieved. The board had sought and gained assurance that actions were being taken to manage and mitigate risk.

Following the Grant Thornton well led review, which was completed in June 2020, a risk committee had been formed, reporting to the audit committee. This risk committee was chaired by the chief executive, and the audit committee chair was in attendance. The work of the committee was to review divisional and corporate risks; the minutes did not appear to demonstrate picking up of cross-cutting themes and wider lessons learned. The board assurance framework and risk register were well-developed but demonstrated that SMART targets were consistently missed. Notwithstanding clear

identification of slipped deadlines and gaps in assurance, ratings assurance on the board assurance framework were shown uniformly as green positive assurance. There was not a clear narrative as to the governance process and how risks were escalated through committees to board in a timely way; although the chair is recommencing non-executive director site visits to assist with the triangulation and escalation of risk.

Senior leaders within the trust could articulate how they used the risk management process to prevent or reduce events or actions to reduce risk. In addition, they told us that risk was a language that was now developed in the organisation and staff understood their roles and responsibilities and accountabilities. Staff at ward level knew how to escalate risks to their divisional team, and in turn this could be escalated to board level through appropriate committees and the improved governance structure.

The trust had a strong track record in achieving financial targets, albeit frequently by non-recurrent means, and we noted the accuracy of its financial forecasting

The trust had a track record of delivering its financial targets. For 2021-22 it had a turnover of £595.3 million; and the trust told us that it was expecting to achieve its agreed revenue financial targets for the year, albeit through one-off savings. It was expected that expenditure on capital would slip by approximately £2.6 million, owing to late notifications of capital allocations and delays on its Sherwood Oaks project. For the 2020-21 financial year the trust's external auditors had issued an unqualified audit opinion, and the same was expected for 2021-22. Assurance from the internal auditors 360 review about the operation of internal controls in 2021-22 was said to be significant.

Budgets had not, at the time of the inspection, been finalised for 2022-3. We were told that the Nottinghamshire integrated care system had not yet agreed a balanced financial plan and further work was required before firm financial plans, including cost improvements, could be agreed. In addition, we were told that further work was required on the disaggregation of expenditure on forensic services as part of the devolution of specialised commissioning funds. In its financial plan submitted to the NHS, the trust estimated its underlying deficit was approximately £15million, and it was projecting a deficit of £5.4million for the 2022-23 financial year. The assessment of the underlying deficit was approximately £15million, and there was a cost improvement plan of approximately £17million.

The board had not agreed its budget and cost improvement plan for the year 2022-23. Given the date of the inspection in late April 2022, the late start to approval of the plan is a delivery risk. The interim director of finance concurred with this assessment.

The financial position of the trust and its track record of delivery indicates that it had a sufficiently strong balance sheet to manage non-recurrent financial pressures.

The audit committee functioned effectively with a non-executive director as chair with membership from directors, and external audit partners. The committee reported to the board in order to assure that they were complying with their duties to challenge and scrutinise the systems and processes in place for the management of internal control.

In the last twelve calendar months (2021/2022) the trust had received two prevention of future death reports. We were cited on these reports and the trust response to the reports prior to the inspections. The trust acknowledged that whilst they had put plans in place to address areas that needed improvement these plans had not been effective as the similar concerns had been noted in both prevention of future death reports.

We reviewed a further three of the trust investigations into individual deaths of patients who were receiving care at the time they died. We found that the investigations followed the trusts policy, and all had an initial review completed

within 72 hours. It was clear that the investigations were people focussed and the trust offered an apology and involved family members in the investigation process, if they wished. The reviews were carried out by senior managers within the trust and any learning from the death was clearly recorded within the investigation. However, whilst we found that investigation focused on lessons learnt and learning and these had been clearly documented we were not assured that due to the issues raised within the prevention of future death reports that this had resulted in a positive change to practice.

Since our previous inspection, action had been taken to improve the monitoring of service level agreements with neighbouring trusts, including improved oversight of medicine errors and incident reporting.

We saw that management of medicines risks identified through audit were considered at both trust and divisional level. For example, a recent audit of rapid tranquilisation identified concerns with recording patients' physical health observations. The report was escalated to the trust quality operational group and shared with the divisions. Recommended actions included a trust wide quality improvement project, with divisional engagement, to better understand the current position. Concerns regarding physical health monitoring during clozapine imitation were similarly escalated.

The trust told us about its estate's risks. At the last inspection in 2019 we told the trust that they should have an action plan to eradicate dormitories at Bassetlaw and Millbrook Mental Health Unit. We were pleased to see that this plan was in place with set deadlines for this work to be completed. The board had made progress in ensuring capital investment to eliminate dormitory style accommodation at the two sites although there had been significant delays. Both the chair of audit and the interim director of finance talked to us about the problems arising from the purchase of the Sherwood Oaks site from a private sector provider, and the consequent impact on the delivery of the capital programme. The trust agreed the purchase of these premises and undertook significant and appropriate due diligence reviews in respect of the tenure, site, building and infrastructure. However, when the trust's contractors commenced refurbishment and began its intrusive surveys, it was found that significant additional fire compliance and general remedial works were required, resulting in an extended timeframe and increased capital investment to achieve the trust compliance level of standards, therefore the Sherwood Oaks original plans were extended, and eradication of dormitory accommodation plans subsequently delayed.

As a result of due diligence, extended compliance works timeframe and comprehensive work that was required to be undertaken, the estates strategy had been amended to reflect the change in timescale for the Eradication of Dormitories Programme for the Trust. This meant that the work to eliminate dormitories would not be fully completed until 2024/25.

Information Management

Information on performance and quality formed an integral part of the board and committee agendas. The reporting of information to the board was supported by the various committees. We reviewed thee trusts integrated performance report. and found that it provided metrics for workforce, quality and safety, finance and operational performance. Within the report, the trusts' dashboard and executive summary support the review of the information and key performance issues. In addition, the input from the directorates across the trust was collected and analysed to further inform the board and to be challenged to make positive improvements in patient care.

The roll out of the divisional dashboards had been completed for some divisional teams. Where they had been rolled out managers and leaders used the data and information to drive conversations about performance and report information through the various committees up to the board.

Our findings

Non-executive directors and the council of governors told us, and we observed that they been given the opportunity to challenge reported information and that challenge was met positively by the board.

Staff at all levels of the organisation had access to information technology equipment and systems needed to do their work. For example, roll out of a virtual private network, to allow homeworking staff to access the trust intranet. Staff focus groups told us how responsive the trust had been in ensuring staff had the right technology to meet patient need and continue services during the COVID-19 pandemic. The trust was highly praised by staff for being responsive to need at this time.

The trust had various information systems in which data was collected and from which performance against local and national indicators was calculated. Mental health services electronic patient record was used effectively to pull data for readmissions, delayed transfers of care, early intervention in psychosis, and data completeness and outcome indicators. Community health services used a different electronic patient record system and collated, reviewed data and completeness indicators to improve patient care and experience. Electronic staff records were used to record and monitor sickness and appraisal rates, we noted a finance system that produced information about staff turnover and vacancy rates and an electronic incident and complaint system.

Data from these systems is extracted into national datasets such as the national reporting and learning system (NRLS) and the mental health services data set (MHSDS) and community services data set (CSDS). These reports included external benchmarking data quality reports to give an overall picture of the trust's data quality for commissioning data sets (CDS).

Since December 2021 to March 2022 the trust had continued to improve their score within data quality maturity Index (DQMI). This index measured aspects of data quality across a range of national data sets that Trusts submit on a monthly basis to NHS Digital. The trusts score improved from 96.4% to 97.2%, respectively. These scores were above the national average.

The trust completed the data security and protection toolkit. The toolkit reviewed and examined the effectiveness of controls that the trust had in place. The trust had met the standards set within the toolkit since 2018.

The trust acted in response to the information commissioner's office (ICO) audit completed in 2021. The report highlighted that the information governance structure in the trust required strengthening. Therefore, the trust formalised their risk management system by appointing and training an information asset for the trust. However, we found that the use of digital technology was evident in some areas in the trust but we found that the digital strategy had not been embedded across the trust. Divisions across the trust did not have designated digital leads.

In addition, we were not clear how the board were using information and communication technology (ICT) as a key enabler to service change and transformation. We found there were delays with some digital projects such as electronic prescribing and medicines administration (EPMA) and governance dashboards for some divisions across the trust.

The trust made available information about how the trust worked to the public in a way that could be easily understood. The trust provided a range of accessible information on their website and access to various links that would enable staff, patients, carers and the public to find out how the trust operates and where to get more information.

Engagement

Our findings

The trust continued to work on its equality and diversity agenda. Strategic areas of focus and key objectives for equality were clearly articulated within the trust strategy. However, there was still more work to be done to embed and reap the positive reward and outcomes of the agenda.

The trust had continued to develop and use their collaborative service change model that was developed in partnership with service users/carers and local organisations, and with the support of the Kings Fund. The collaborative partnership highlights, 'think, talk and plan together from the start'. In line with this model the trust set up a 'collaborative service change network'. The network held three monthly meetings and was open to service users, carers, staff and volunteers

The trust valued the views of patients, carers, families and local communities to help them understand what people want and help them to shape the services they provide to meet the needs of the diverse communities within Nottinghamshire. In March 2022 the trust launched a campaign to understand people's views about whether mental health services for older people wards should be mixed sex or single sex, as an example. Another example was the Sherwood Oaks steering group, attended by staff and patients, to write the operational policy, engage with a local college for the design of outside spaces. In addition, a competition was held to name the wards within the hospital.

In March 2022 to improve families and patient engagement within incident or investigations the trusts' family liaison team became operational. The team was set up to ensure that the patient/family voice was not only heard but also represented within investigations.

The trust formed part of the Nottinghamshire integrated care system and had submitted its financial plans for 2022-23 into the system. It was part of two provider collaboratives, working with two Nottinghamshire acute trusts in a collaborative "at scale" and in an alliance of east midlands mental health trusts, where it led of the commissioning of specialised forensic services.

The trust had worked with a local clinical commissioning group (CCG) to audit valproate prescribing in women of childbearing age, identifying some areas for improvement where the valproate pregnancy prevention programme was not fully adhered to. Initial discussions were underway to extend this work across primary care in Nottinghamshire.

In addition to this collaborative working the medication optimisation team worked with other trusts to share learning regarding the planned expansion of their medicine's administration technician role from offender health to support medicines administration in adult mental health wards.

The council of governors consisted of elected representatives from three areas, service users/patients, public, staff and appointed representatives of key local stakeholder organisations. They told us that they had been involved in the decision making about the appointment of the chief executive officer and non-executive directors. In addition, they had strong links to the volunteers within the trust and local stakeholders such as Healthwatch and the acute trust. At the time of the inspection they were working together to look at the more deprived areas of Nottinghamshire and access into services within the county.

Learning, continuous improvement and innovation

During our inspection it was evident that clinical staff took part in clinical audits, benchmarking and quality improvement initiatives. Senior leaders supported improvement and innovation work and there was a strong programme of staff training. The trust demonstrated a commitment to research in partnership with the local universities and there was involvement in national projects such as reducing restrictive interventions, including a black and minority ethnic restraint project.

Our findings

The trust work in partnership with a university and an institute of research. The aim of the collaboration is bringing together healthcare staff and academics to lead mental health research designed to improve diagnosis, treatment, and care. This has been in place since 2006. In March 2022, two of Nottinghamshire Healthcare's clinical psychologists won national institute for health research (NIHR) development and skills enhancement (DSE) awards.

The trust used social media, national weeks or days for particular issues to support learning and continuous improvement and innovation. For example, children's mental health week (07-12 February 2022), time to talk day, which promoting and signposting to our self-referral mental health services including, let's talk-wellbeing service, CAMHS, mental health crisis line, crisis sanctuaries, parentline, chathealth and 'NottAlone'.

The trust were proud of the work they had completed in order for some services to be accredited in recognised schemes. In December 2021, the Nottingham Centre for mindfulness team accredited by the British association of mindfulness-based approaches. The centre has become one of the first health education England and NHS England and Improvement, recognised and accredited training sites, to deliver mindfulness based cognitive therapy in psychological therapy services in the UK. The rapid response liaison psychiatry teams and department of psychological medicine received re-accreditation and the healthy family team achieved the UNICEF baby friendly initiative gold sustainability award.

We heard about the 'DadPad' App which had been launched in January 2022. The app is a resource developed by dads for dads, with information about a wide range of issues which can affect new parents. For example, perinatal mental illness, support mums with breastfeeding and details on local support groups. The trust were promoting the app across the integrated care system by using a media pack of resource that the trust partners can share with GP's, midwives and health visitors.

South Yorkshire housing association employment service awarded 'centre of excellence for mental health' status for work with Bassetlaw local mental health team.

The trust participated in the national apprenticeship week during 7-13 February 2022. They used this opportunity to promote their apprentices and promote the role across the trust. 'Build the future'; reflected on how apprenticeships can help people to develop the skills and knowledge required for their career.

The trust launched its green plan on 31 January 2022. The plan outlined a five-year strategy to deliver sustainable healthcare with objectives within it which support the Trusts aim of net zero carbon by 2040.

The trust had a quality improvement lead and has participated in quality, service improvement and redesign programme since 2020. This is a tailored quality improvement course developed by NHSI/E that aims to provide staff with the skills to design and implement more efficient patient-centred services. As of March 2022, over 1700 staff had been trained in quality improvement at bronze level. 48 staff have been trained in sliver level quality improvement. In addition, on 25 March 2022 the trust launched quality improvements coaches. The coaches were in place to offer support and guidance to people across the trust who were carrying out quality improvement projects.

Quality improvement was high on the agenda of the trust. We were pleased to hear and see how quality improvement was in action. The quality improvement team produced and published a regular newsletter highlighting the improvement that had taken place the project aims and outcomes.

Our findings

The trust had used external reviews to has invited peers from similar trusts or the royal college to support them in investigating where things have gone wrong or not delivered the required outcomes. For example, the trust commission an external support via the clinical senate to undertake a review of the learning disability service.

The trust reviewed deaths using the national structured judgement review (SJR) process. A Mortality Surveillance Group is in place and reviews deaths and identifies trends and issues for trust-wide learning

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Nov 2022	Requires Improvement ↓ Nov 2022	Outstanding ↑ Nov 2022	Requires Improvement ➔➔ Nov 2022	Requires Improvement ➔➔ Nov 2022	Requires Improvement ➔➔ Nov 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Ambulance	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Adult social	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Mental health	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Community	Requires Improvement	Requires Improvement	Outstanding	Good	Good	Good
Primary medical	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall trust	Requires Improvement →← Nov 2022	Requires Improvement ↓ Nov 2022	Outstanding ↑ Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist eating disorders service	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Perinatal services	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Forensic inpatient or secure wards	Requires improvement May 2022	Good May 2022	Good May 2022	Good May 2022	Good May 2022	Good May 2022
Child and adolescent mental health wards	Good May 2019	Requires improvement May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019
Wards for people with a learning disability or autism	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018
Acute wards for adults of working age and psychiatric intensive care units	Inadequate Sep 2020	Requires improvement Mar 2020	Requires improvement Sep 2020	Requires improvement Mar 2020	Inadequate Sep 2020	Requires improvement Sep 2020
High secure hospitals	Inadequate Jan 2020	Requires improvement Jan 2020	Requires improvement Jan 2020	Requires improvement Jan 2020	Inadequate Jan 2020	Inadequate Jan 2020
Community-based mental health services of adults of working age	Good May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019
Community mental health services for people with a learning disability or autism	Good May 2019	Good May 2019	Good May 2019	Requires improvement May 2019	Good May 2019	Good May 2019
Mental health crisis services and health-based places of safety	Requires improvement May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019
Wards for older people with mental health problems	Requires Improvement Nov 2022	Requires Improvement Nov 2022	Good Nov 2022	Requires Improvement Nov 2022	Requires Improvement Nov 2022	Requires Improvement Nov 2022
Community-based mental health services for older people	Requires Improvement Nov 2022	Good Nov 2022	Good Nov 2022	Requires Improvement Nov 2022	Requires Improvement Nov 2022	Requires Improvement Nov 2022
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement Nov 2022	Requires Improvement Nov 2022	Good Nov 2022	Good Nov 2022	Requires Improvement Nov 2022	Requires Improvement Nov 2022
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good → ← Nov 2022	Requires Improvement ↓ Nov 2022	Outstanding ↑ Nov 2022	Good Nov 2022	Good → ← Nov 2022	Good → ← Nov 2022
Community health services for children and young people	Good Nov 2022	Good Nov 2022	Outstanding Nov 2022	Good Nov 2022	Good Nov 2022	Good Nov 2022
Community health inpatient services	Requires Improvement Nov 2022	Requires Improvement Nov 2022	Good Nov 2022	Requires Improvement Nov 2022	Requires Improvement Nov 2022	Requires Improvement Nov 2022
Community end of life care	Requires Improvement Nov 2022	Good Nov 2022	Good Nov 2022	Good Nov 2022	Good Nov 2022	Good Nov 2022
Overall	Requires Improvement	Requires Improvement	Outstanding	Good	Good	Good

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Is the service safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

While all wards were safe and clean, they needed redecoration and the showers at Thorneywood Mount were not fit for purpose due to extremely low water pressure.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Ligature audits were present, in date and identified all known risks that remained. This was an improvement on our previous inspection. Staff we spoke with knew where the existing ligature points and blind spots were and the provider mitigated risks to keep patients safe through careful admission risk assessments and ongoing reviews of patients' risk.

The wards complied with same sex accommodation guidance. There was no mixed sex accommodation as males were located in 145 Thorneywood Mount and females were located in 106 Thorneywood Mount. However, due to lack of space at 106 Thorneywood females did use the therapy areas at 145 Thorneywood Mount.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

The showers at 145 Thorneywood Mount were not fit for purpose. On the first floor there were 12 bedrooms each with a small hand basin. The 12 male patients shared four toilets on the same floor one toilet had a shower in it and the other toilet had a bath and a shower in it. There was a fifth toilet on the ground floor. Staff and patients told us, and the maintenance records we viewed showed the showers had not worked properly due to poor water pressure since September 2020. On the day of inspection, we found that neither shower gave an adequate flow of water for effective bathing. We saw evidence that the showers had been reported for repair on at least six occasions between 30 September 2020 and 13 October 2021.

On each occasion while a temporary fix had been completed reports from staff and patients as evidenced in community meetings, governance meetings and team meetings showed the showers were still not effective. The trust was aware of the problem and replacement of the showers and infrastructure works to improve water pressure at 106 and 145 Thorney Mount were part of their long term refurbishment plans for this site. The inspection team felt it was unreasonable to expect 12 male patients to share one bath and the alternative option available, washing in the small sink in the patient's bedroom was not adequate bathing provision. This could pose a hygiene and health issue for patients. Patients and staff felt frustrated because they were reporting the issue, but the trust were not doing anything to resolve the issues long term.

However, within two weeks of our inspection the manager told us that the estates department had revisited the site and carried out emergency works to fit a domestic cylinder in the roof cavity. He stated that both showers were now in good working order. We subsequently saw copies of very recent patient community meeting minutes confirming the patient's happiness with this outcome. The provider also sent us details outlining their long-term plans for the showers to ensure they remain fit for purpose.

Whilst ward areas were clean, they needed refurbishment and decoration. The décor was dated, and paintwork was discoloured in places such as the kitchen, dining room and some bedrooms, there was chipped paintwork around doors and on skirting boards in both 106 and 145 Thorneywood. There was wallpaper peeling off the walls outside bedrooms 5 and 6 at 145 Thorneywood. The environment did not support positive mental wellbeing, the environment felt neglected and did not instill a sense of being cared for or value for patients. Within two weeks of our inspection the trust submitted evidence showing that they had commissioned a private painting contractor to paint the unit. The plan for completion was July 2022 and this was achieved.

Staff made sure cleaning records were up-to-date and the premises were clean. Cleaning records were made available by housekeeping staff and kitchen cleaning records were present in the kitchen areas.

Staff followed infection control policy, including handwashing. We saw numerous signs around the wards and observed staff sanitising their hands between patient areas and upon exit and entry to the wards.

Seclusion room

The service did not have any seclusion rooms. Due to the patients' stage of rehabilitation, seclusion was rarely used or required. There was a trust policy around seclusion practice and staff we spoke with understood what seclusion was and told us that if patients began to show emotional distress they supported them discreetly in quieter areas of the ward. Staff also told us that because the unit was small, and they were lucky to have a stable staff group they got to know the patients very well. This meant that they could recognise early signs of any distress and use distraction strategies to good effect. They also encourage the patients to talk about their feelings and any worries as part of daily interaction and we saw this recorded in the daily care notes and reported on it at nursing handover meetings.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff visually checked regularly.

While audits showed that staff maintained, and cleaned equipment regularly, one out of five clinic audits available was not correct. The incorrect audit suggested there was a nebuliser on the unit. However, when we tried to check the maintenance date of the nebuliser, we could not find the actual nebuliser, this was raised with a nurse who confirmed that to her knowledge they did not have one on the unit. Following our inspection, the manager confirmed that they had reviewed their clinic auditing systems and implemented plans "to check the weekly clinic room jobs on a weekly basis and provide evidence these have all been completed to the Quality and Risk meeting on a monthly basis".

Safe staffing

Staffing establishment on the wards was not adequate at night-time.

Thorneywood Mount and Bracken House were two separate locations and each location had two wards, a male ward and a female ward, with shared staff, managers, policies, procedures and practices. At Bracken house the two wards were sited alongside each other, and Thorneywood Mount was two houses, on opposite sides of the road. However, the

trust considered each location to be just one ward and based the nursing establishment for the service on this information. Due to the current staffing establishment, there was frequently a lone worker for periods of time on the female wards at night, and we felt each ward at each location required its own nurse staffing establishment on all night shifts to meet all the needs of the patients and keep themselves safe.

Established staffing levels for each unit was. Early shift two registered nurses and five Healthcare support workers (HCSW's) (with one registered nurse and two HCSW's on the female wards, and one registered nurse and three HCSW's on the male wards). Late shifts were the same numbers as early shifts. Evening shifts had two registered nurses and three HCSW's at each location (one registered nurse and one HCSW on the female wards and one registered nurse and two HCSW's on the male wards).

While we understood there was a twilight staff member on each location at Bracken House between 3.00pm and 10pm and members of the multidisciplinary team supported nursing staff in the daytime this was not adequate staffing number for the night shift. The impact of this was that if one staff member from the female ward needed to respond to an emergency or other duty on the male ward this left alone worker on the female wards. Staff told us the reasons for the self-catering kitchens were closed from 7.30pm until the morning, was due to there not being enough staff to monitor patients use of these areas at night-time. Staff also told us they often felt guilty because they knew they had not been able to help patients with their rehabilitation needs as much as they would like. Patients told us that sometimes they had to wait longer than expected to go out or start their rehabilitation programmes, because staff were not always available when required.

However, managers confirmed that they could request additional staffing where patients enhanced observation levels dictated this. Within two weeks of our inspection the manager advised us that there had been an urgent establishment review in the week following our inspection to consider the staffing levels at Thorneywood and Bracken House, but we did not know the outcome of that meeting.

Nursing staff

While the service had enough nursing and medical staff to meet their establishment numbers, the number of staff allocated to evening shifts was insufficient. However, these staff knew the patients well and received basic training to keep people safe from avoidable harm.

While the service had enough nursing and medical staff to meet their establishment numbers, staff allocated to evening shifts was insufficient as reported above. However, staff worked well together and knew the patients well enough to keep people safe from avoidable harm.

The service had low vacancy rates compared with other services in the trust. At Thorneywood they had 2 whole time equivalent (wte) out of 16.2 wte registered nurse vacancies and at Bracken House 2 wte out of 14 wte registered nurses' vacancies. At Thorneywood they had 0.6wte out of 18.4wte healthcare assistant vacancies and at Bracken House they were overstaffed by 1.0wte.

The service had average rates of bank and agency nurses and healthcare assistants compared to other services in the trust. During period 01 April 2021 to 31 March 2022 Thorneywood had 371 shifts filled by bank or agency staff and 289 shifts not covered. While Bracken house had 845 shifts filled by bank and agency staff and 544 shifts not covered. The manager at Bracken house told us they had experienced more COVID-19 outbreaks than Thorneywood Mount and this had resulted in more staff needing to isolate and hence the requirement to cover more shifts with bank and agency staff.

Managers limited their use of agency staff and relied on filling vacant shifts with bank staff who were familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had low turnover rates compared with other services in the trust. For the period March 2021 to January 2022 the turnover rate for the service was 3%.

Levels of sickness for this service for the period 31 March 2021 to 31 February 2022 had fluctuated between 21% in March 2021, 14% in July 2021, 35% in September 2021 to 41% in January 2022 and settling at 27% in February 2022. Managers told us the reasons for such fluctuating numbers was due to COVID-19 outbreaks in the service and staff testing positive for COVID-19 requiring them to isolate.

Managers supported staff who needed time off for ill health.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift based on their establishment and they could adjust staffing levels according to the enhanced needs of the patients.

Patients told us they had regular one-to-one sessions with their named nurse, and in the absence of their named nurse they could choose who else they received one-to-one session with if they needed them.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. This was a rehabilitation service and as such most patients had unescorted leave to community activities, unless multidisciplinary risk assessment indicated that escorted leave was advisable for short period of time.

With the exception of late night shifts as reported above the service had enough staff on each shift to carry out any physical interventions safely.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.

At Thorneywood Mount the responsible clinician role was filled by an advanced clinical practitioner nurse. This staff member had received additional training to fulfil the role of a responsible clinician and worked under the supervision of the consultant for the service. This post had been agreed and ratified by the trusts Clinical Governance meeting, following changes to the 1983 Mental Health Act made by the 2007 Act, these changes broadened the group of practitioners who could take on the functions previously performed by the responsible medical officer and the approved social worker. The role of responsible clinician replaced that of the responsible medical officer. The responsible clinician does not need to be a consultant psychiatrist but must be an approved clinician.

At Thorneywood Mount the responsible clinician was supported by a general practitioner with special interest in mental health who attended the unit two sessions weekly. While at Bracken House they had a 0.5 wte responsible clinician doctor and 1.0wte specialist registrar.

Out of hours and night-time emergency cover was provided through the trusts out of hours on call doctors rota.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum medical staff had a full induction and understood the service before starting their shift.

Mandatory training

While mandatory training compliance was good at Bracken House, mandatory training compliance was not so good at Thorneywwod Mount.

Overall compliance for the service was 85%, with overall compliance for Bracken House at 90% and Thorneywood Mount 80%.

Overall compliance by course was as follows: Basic life support 86%; Breakaway 73%; Care program approach 83%; Clinical risk assessment and management 91%; Equality and diversity 93%; Fire safety 82%; Immediate life support 77%; Information governance 94%; Infection control 91%; Manual handling 72%; Mental Capacity Act 84%; Mental Health Act 86%; Managing violence and aggression 82%; Promoting safer therapeutic services 93%; Safeguarding adults level 3 75%; Safeguarding children level 3 92% Suicide awareness and self-harm 81%;

Compliance rates at Bracken House ranged from 81% to 100%, while at Thorneywood Mount they ranged from 50% to 94%. Courses at Thorneywood Mount falling below the trusts desired 80% and CQC expected rate of 75% included Basic life support 67%; Breakaway 60%; Fire safety 74%; Immediate life support 59%; Manual handling 59% and Safeguarding adults' level three 72%. The manager acknowledged that these figures were lower than Bracken House due to COVID outbreaks that prevented staff accessing the courses.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff.

Although staff assessed and managed risks to patients and themselves well. At Thorneywood patients did not have crisis plans, though staff gave us reasons for this. Despite this we found that the service achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they rarely used restraint and only then after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

We reviewed 11 patients risk assessments. Staff completed comprehensive risk assessments for each patient on admission and reviewed this regularly in multidisciplinary care and treatment meetings including after any incident.

Staff completed risk assessments for each patient on admission, using the short term assessment risk tool (START) a recognised tool, this was followed up with a more comprehensive historical clinical risk management tool (HCR 20). Risk assessments were reviewed regularly, including after any incident.

However, we found that at Thorneywood patients did not have up to date crisis plans. We reviewed 11 risk assessments and none of them included up to date crisis or contingency plans. The absence of these plans meant that if a patient's mental health deteriorated either on the units or when in the community they, their carers, nor staff would know what action should be taken in case of acute mental health deterioration. Staff we spoke with explained that a basic crisis plan was part of the admission process and it was their belief that they were not updated until the patient was nearing discharge. Within two weeks of the inspection managers confirmed that following an audit of all care notes including

risk plans, all patients now had an up-to-date crisis plan in place. Managers confirmed that crisis plan update had been added to the patient care and treatment review template which the named nurse updated after every care and treatment meeting. While we were pleased to see the manager had addressed this issue we felt the process needed time to become embedded in practice.

Management of patient risk

Staff we spoke with knew about any risks to each patient, acted to prevent or reduce risks, and could identify and respond to any changes in risks posed by, patients. However, we were not assured that staff always shared key information to keep patients safe when handing over their care to others. We saw evidence that staff were holding regular shift handovers, risk meetings and safety huddles however we could not be assured that decisions from all these meetings were recorded. This meant that staff not present at the meeting might not always be aware of any changes that were needed to practice or patients' care.

Staff followed procedures to minimise risks where they could not easily observe patients. The service had recently introduced electronic observation records to monitor patient's whereabouts. Staff confirmed this had improved the observation recording process.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

However, we found blanket restrictions in respect of the self-catering kitchens at Thorneywood needing to be locked at 7.30pm, and the bathroom and shower rooms on the first floor at 145 Thorneywood Mount needing to be kept locked. Staff we spoke with were unsure why the restrictions were in place, though two staff told us they thought the kitchen was locked at 7.30pm because they did not have enough staff on duty in the evenings to monitor people using the kitchen and the bathrooms were because of COVID 19 cleaning. Though no other patient only use areas including toilets were locked for this reason. While blanket restrictions, i.e. restrictions that apply to all patients regardless of individual risk, are acceptable in some circumstances the manager should be able to demonstrate why these restriction are required and how they are regularly reviewed to ensure they remain in place only when necessary and for the shortest possible time. We saw no evidence to suggest that any of these criteria had been addressed and felt this was a governance issue.

Use of restrictive interventions

Levels of restrictive interventions were low and reducing. For the period 01 November 2021 to 31 February 2022 there was only one restraint at Thorneywood Mount and eleven restraints at Bracken House, nine of which ended in rapid tranquilisation. Staff at Bracken House explained that during this time they had been looking after an acute patient admitted from the community while awaiting transfer to an acute treatment unit. Medicines charts confirmed that it was the patients request to be tranquilised at times of heightened distress and when de-escalation was not working.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. We saw evidence of discussions around reducing restrictive interventions in local governance meeting minutes.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff we spoke with could describe the fundamental principles of the Mental We saw how Capacity Act and how it applied to their work with patients.

Long stay or rehabilitation mental health wards for working age adults

Staff followed national institute for health and care excellence (NICE) guidance when using rapid tranquilisation. Medical records and daily care notes showed how when rapid tranquilisation had needed to be used the correct measures and observations were used. Due to the nature of the patient's presentations the service did not use seclusion or segregation.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. At Thorneywood Mount 72% of staff received safeguarding adults training and at Bracken House 77% of staff received this training. Those staff who had not completed this training were booked on upcoming courses. Staff we spoke with could describe what safeguarding was and what might be considered abuse including physical, emotional, financial and sexual abuse. Staff knew how to make a safeguarding referral and who to inform if they had concerns and knew where to go for additional support or advice if required.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. While Bracken House had a family friendly visitors' room away from the main ward at Thorneywood family visitors and particularly children were encouraged to meet off site at local coffee shops, parkland areas or in the garden area at 106 Thorneywood Mount.

Managers took part in serious case reviews and made changes based on the outcomes. We saw appropriately completed safeguarding reports that had been investigated with outcomes logged.

Staff access to essential information

While staff had easy access to clinical information and it was easy for them to maintain high quality electronic clinical records, the system for recording when staff left the unit were not robust.

Patient notes were comprehensive, and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

However, the system at Thorneywood Mount for staff and patients to complete when going off the unit was not reliable. The system in place used an ad hoc system of advising office staff when anyone was going out. This meant that if busy, office staff might not always record a staff members absence from unit which could have implications for any fire drills or other emergencies where knowledge of staff whereabouts would need to be known. Though we acknowledged there were no known incidents of issues arising from this long standing practice. This was discussed with the ward manager who agreed to have formal marker board or a sign in register placed in the entrance areas at 106 and 145 Thorneywood for staff and patients to sign themselves in and out. Post inspection we was advised that this had been done.

Long stay or rehabilitation mental health wards for working age adults

Medicines management

The service did not always use efficient audit systems and processes to record, monitor prescribing and store medicines. The manager was not sure what audits were carried out by pharmacy or where the actions from these audits were recorded and actioned. However, the service did use systems to safely administer medicines and staff regularly reviewed the effects of medications on each patient's mental and physical health.

We looked at 16 patient's prescription charts. Staff did not always complete medicines audits accurately and the manager could not be assured that all audits were up to date or actioned.

Staff could not be certain that all systems and processes to prescribe medicines safely were being followed.

We found clinic audits were not completed properly, some audits were incorrect and there was confusion around what audits were carried out by pharmacy colleagues and at what frequency. Pharmacy audits should be completed weekly, but we could not find any completed pharmacy audits since December 2021. Staff could not confirm if these audits had been completed.

We could not find an up to date audit schedule for the clinic or medicines management at Thorneywood. No one knew what, if any, actions might have been recommended by the pharmacists to improve medicines management or medicines compliance. This meant that medicines could be mislaid or removed without permission, medicines could go out of date, and become hazardous to health or ineffective at treatment, medicines might not be stored under optimal conditions.

We found two medicines, Haloperidol and Salbutamol that went out of date in February 2022. We also found some eye drops that had been opened with an expiry date of 30 days after opening but no opening date written on the box. We advised the manager of these issues who arranged for immediate disposal of these medicines that were no longer required by the patients they were prescribed for.

However, within two weeks of the inspection visit the manager submitted evidence of having revised their medicines auditing processes to ensure that an effective clinic room audit schedule and overarching responsibility was in place. This included trust pharmacy audits. These plans ensured that the deputy manager was given responsibility for carrying out monthly overarching clinic room and medicines audit checks and report to the manager on any feedback from the audits to ensure that no action points were missed. The manager had also introduced a weekly clinic room checklist to ensure that no clinic room jobs were missed. The manager reported on the unit's medicines compliance to the trust's monthly Quality and Risk meeting. We noted that the trusts mitigation has gone some way towards assuring robust audit of clinic and medicines management activity, at this inspection it was too soon to state that the changes proposed have been successfully embedded in practice.

Patients at Thorneywood, and who were on the self-medicating pathway, did not have a secure place to store their medicines in their bedrooms. Managers felt that having a locked bedroom was sufficient security. National Institute of Clinical Healthcare Excellence (NICE) guidance states that all medicines should be stored in a locked secure place at all times. While it is accepted that patients can lock their bedrooms this was not considered sufficient security as other patients could access the bedrooms either by invite or if the doors were left unlocked for any reason. We would expect patients to have a secure lockable cabinet or cupboard in their bedrooms for storage of medicines or other valuables. Within two weeks of the inspection, the manager advised us that until they could put lockable cabinets in patients' bedrooms at Thorneywood Mount managers had decided to suspend self-medication above level one on this unit. This meant that while patients remained on the self-medication pathway they would not progress beyond level one (dispensed in front of nurse in the clinic room) until adequate medication storage was available in their bedrooms.

Medicines charts we looked at showed staff did review each patient's medicines regularly and leaflets were available in the clinic offering patients and carers advice about their medicines.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff learned from safety alerts to improve practice. We saw safety alert posters in the clinic rooms. An example of this was seeing notices advising about the ban on having plastic bags on the wards.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Medicines charts showed no overuse of sedative or tranquilising medication.

Staff reviewed the effects of each patient's medicines on their physical health according to National institute of clinical healthcare excellence (NICE) guidance.

Track record on safety

The service had a good track record on safety. Reporting incidents and learning from when things go wrong. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

For the period 01 December 2021 to 31 February 2022 there had been a total of 135 incidents reported, 120 of which had been low level and no harm incident. While seventy five of these incidents related to one patient the remaining 15 incidents were spread across the service and four had resulted in the submission of a safeguarding concern. Staff we spoke with knew what incidents to report and how to report them. Incident data showed staff reported serious incidents clearly and in line with trust policy.

The service had zero never events on any wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We reviewed complaints records and saw when duty of candour discussions had taken place with patients. We also saw a complaints response letter where the provider had been open and honest about a minor medication error that had occurred. Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations as appropriate.

Staff received feedback from investigation of incidents, both internal and external to the service usually in the form of service e mail, team meetings or in supervision if an incident had involved a specific staff member.

Staff met at team meetings and senior management meetings to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. Such as using the gazebo in the garden at 106 Thorneywood for family visitors and introducing the role of Advanced clinical practitioner nurse to support the services Mental Health Act and Mental Capacity Act function.

Long stay or rehabilitation mental health wards for working age adults

Managers shared learning with their staff about never events that happened elsewhere.

Is the service effective?

Requires Improvement

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

We reviewed 11 patients care plans and tracked four patients care records. Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. A general practitioner with specialist interest in mental health held twice weekly clinics at Thorneywood offering patients opportunity to discuss any general physical health problems they might be experiencing. Nurses could refer consenting patients for physical health examination, advice and treatment if required.

Staff in co-production with patients developed a comprehensive care plan for each patient that met their mental and physical health needs.

Staff regularly reviewed and updated care plans when patients' needs changed.

Care plans were personalised, holistic and recovery-orientated. There was evidence of patients having contributed to the care plans, including some patients who had chosen to complete advance directives or wellness recovery plans.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes.

Staff provided a range of care and treatment suitable for the patients in the service. The service based its treatment on a combination of trauma informed care and the recovery model using self-determination and patient facilitation. This model for delivering care was in line with best practice and national institute of healthcare excellence guidance.

Staff made sure patients had access to physical health care, including specialists as required both within the trust and within primary care. The service had weekly key performance targets set by the trust which they were able to achieve.

Staff identified patients' physical health needs and recorded them in their care plans. Both units had a staff member identified as a physical healthcare lead. This staff member had received additional training in phlebotomy and

electrocardiogram (ECG) monitoring. Their role was to check patient records for regular physical health assessment, follow up any patients with known physical health problems and ensure that they had access to specialist advice, tests, and treatments as required. The physical health lead also acted as liaison between the service and community general practitioners.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Patients were encouraged to be self-catering where possible and staff gave support and advice around healthy living plans and balanced nutrition, especially where patients might be on special dietary plans or were wanting to monitor their weight.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Such as encouraging patients to take part in the daily healthy walk, meaningful day, and smoking cessation.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Occupational therapists used the full range of model of human occupation outcome measures as appropriate for each patient. Combined with the model of human occupation self-assessment tool to ensure that patients were fully involved in their treatment planning and goal setting. All staff we spoke with were familiar with the recovery star.

The service used Health of the Nation's Outcome Scales and were working towards AIMS rehabilitation accreditation, though COVID- 19 had stalled this progress over the previous year.

Staff used digital technology to support patients, such as electronic observation, mobile exercise and fitness applications, language line and encouraged patients to use safe digital search engines for information they may require.

However, staff did not always participate in as much clinical audit as they could have done. Though there was some evidence of benchmarking and they did embrace the trusts quality improvement plans for the service. Managers told us they were keen for staff to use more clinical auditing so the results could be used to make service specific improvements. Plans to make this achievable included identifying staff to take on specific lead roles such as those for physical healthcare, carers lead, equality, diversity and BAME, infection control, trauma informed care leads, safeguarding lead and learning and development lead.

Skilled staff to deliver care

While managers recognised the importance of supervision, rates in the service were poor and appraisal rates at Thorneywood Mount had dropped in the last year. However, the ward teams included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers provided a comprehensive induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward. This included access to doctors, specialist nurses, advanced practitioners, occupational therapists peer support workers and activity co-ordinators. While they did not have their own social worker or psychologist they could access these staff from the community mental health teams or continuing care services operated by the trust. The manager explained the problems they had recruiting to on site psychologist and described a new initiative to have a shared therapy service across Bracken House and Thorneywood Mount to address the issue.

Long stay or rehabilitation mental health wards for working age adults

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Occupational therapists had completed specialist assessment of motor processing skills training and most staff had received additional training in patient stabilisation and understanding impact of trauma, as well as recovery model. Staff we spoke with were keen to share their specialist knowledge and skills with each other through learning events and case reviews.

Managers gave each new member of staff, including any agency staff, a full induction to the service before they started work.

Whilst managers recognised the importance of staff receiving regular, constructive staff appraisals compliance rates at Thorneywood Mount had dropped during the period March 2021 and February 2022 from 89% to 68%. While Bracken House had remained constant at 84%. Mangers explained that this was due in part to a change of manager at Thorneywood Mount in early 2021 and periods of staff absence due to COVID-19 and sick leave during June 2021 to early 2022. All medical staff had completed revalidation.

Managers did not support all non-medical staff through regular, constructive managerial supervision of their work. Managerial supervision compliance for this service overall was poor at 54%. Thorneywood Mount compliance rates had dropped from 100% in April 2021 to 56% in February 2022, while at Bracken House they had dropped from 93% in April 2021 to 62% in February 2022.

Managers did not support all non-medical staff through regular, constructive clinical supervision of their work. Overall clinical supervision compliance rates for this service were poor and the rates had dropped significantly between April 2021 and February 2022. Clinical supervision compliance for this service was 53% overall. Thorneywood Mount compliance rates had dropped from 97% in April 2021 to 40% in February 2022, while at Bracken House they had dropped from 96% in April 2021 to 53% in February 2022. However, we saw how managers supported medical and allied health professions' staff to access profession specific clinical supervision outside of the service.

While staff training needs were not always picked up through the formal supervision and appraisal processes, staff and managers were able to identify and discuss training needs as they arose during the day to day working with patients. Once identified managers gave staff he time and opportunity to develop their skills and knowledge, and managers made sure staff received any specialist training for their role such as training in recovery model and skills acquisition.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We saw the minutes from regular staff handovers, staff team meetings and local governance meetings. We also attended a staff morning huddle to review immediate safeguarding and patients issues however this meeting was not recorded.

Managers recognised poor staff performance and could identify the reasons and dealt with these.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge and engaged with them early on in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Ward teams had effective working relationships with other teams in the organisation.

Long stay or rehabilitation mental health wards for working age adults

Ward teams had effective working relationships with external teams and organisations. We saw examples of staff accompanying patients to joint meetings with community staff and other professionals as part of discharge planning. We saw how staff at Thorneywood Mount engaged with community mental health teams to access psychology and social workers. We saw how staff in the rehabilitation service had initiated care program approach meetings for patients and engaged with general practitioners and community psychiatric nurses.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Data for the period 30 March 2022 showed that 86% of all eligible staff had completed Mental Health Act Training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice and confirmed that this support came from the trusts' Mental Health legislation team. .

Staff knew who their Mental Health Act administrators were and when to ask them for support. There was Mental Health Act lead on each unit and the telephone number of the Trusts Mental Health Act advisor on the wall in the office.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. There was information on display in wards areas about independent mental health advocates (IMHA) and how to access the advocacy service. Patients told us they knew of advocacy and how to access this if they needed it.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. There was a system in place to flag patients' rights' and ensure these were revisited at regular intervals.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. We saw one record of this having occurred, however due where patients were in their pathway through rehabilitation services second opinion doctors were rarely used.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Long stay or rehabilitation mental health wards for working age adults

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Data for the period 30 March 2022 showed that 84% of all eligible staff had completed Mental Capacity Act Training.

There were no Deprivation of Liberty Safeguards applications made in the last 12 months.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. There was a Mental Capacity Act lead on each unit and the telephone number for the trusts Mental Capacity Act advisors on the wall in the office.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. The records we inspected contained evidence that capacity for specific care and treatment decisions was routinely assessed, recorded and revisited. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. There was also evidence that staff held best interests' meetings where necessary. Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve. Managers told us they completed regular audits of the mental Capacity Act Compliance and that the results of these audits were required for the trust's monthly service governance reports.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Long stay or rehabilitation mental health wards for working age adults

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

We spoke with five patients. All patients said staff were discreet, respectful, and responsive when caring for them. Patients told us that staff gave them help, emotional support and advice when they needed it.

Care plans, daily care notes and observations of patient and staff interactions showed that staff supported patients to understand and manage their own care treatment or condition.

Care plans indicated that staff directed patients to other services and supported them to access those services if they needed help. One care plan showed how two patients were supported to attend a local weight watchers' group, and another patient was supported to access a local specialist clinic.

Patients said staff treated them well and were kind. Patients felt that staff understood and respected their individual needs.

Staff we spoke with felt they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients if they saw this happening.

Staff followed policy to keep patient information confidential. Staff told us they only completed care records in the office and they always reminded patients to keep any hard copies of activity plans or letters in their bedrooms and to not leave them in the communal areas.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. **They ensured that patients had easy access to independent advocates.**

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. We saw very clear information explaining the purpose of the ward, who the staff were and what the wards could offer in the patents and carers information leaflet. Staff gave these leaflets to prospective patients and carers upon initial assessment and usually before they arrived on the ward**.**

Staff involved patients and gave them access to their care plans and risk assessments.

Staff made sure patients understood their care and treatment and when necessary found ways to communicate with patients who had communication difficulties, such as large font or in digital format.

Staff involved patients in decisions about the service when appropriate, and patients could give feedback on the service and their treatment and staff supported them to do this. We saw this was usually through patient community meetings.

Staff supported patients to make decisions on their care. We observed this on a home visit.

Staff made sure patients could access advocacy services. There were notices around the ward telling patients about this service and how to access it. Patients also told us about their experiences of using the advocacy service.

Long stay or rehabilitation mental health wards for working age adults

Involvement of families and carers

Staff informed and involved families and carers appropriately.

We spoke with four carers. All carers told us that staff supported their loved ones and kept them informed about their loved one's care and treatment. One carer told us this was usually through written correspondence as she could not get to the hospital very often.

All carers knew of the carer's forums and the peer support worker whose role it was to ensure families and carers were involved with treatment planning, discharge plans and service developments.

Staff helped families to give feedback on the service. Carers were encouraged to share their thoughts about the service online and direct to the manager as well as through carers forum and the peer support worker.

Patients could give feedback on the service and their treatment and staff supported them to do this here of the four carers told us that staff had explained what a carers assessment was and how to get one.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' move out of hospital. As a result, patients did not have to stay in hospital when they were well enough to leave.

Data for the period 01 February 2021 to 31 January 2022 showed that across the service managers made sure that bed occupancy did not go above 85%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Over the previous two years March 2021 to February 2022 average length of stay in this service was 16 months.

The service had no out-of-area placements.

Managers and staff worked to make sure they did not discharge patients before they were ready. In the twelve months prior to inspection Thorneywood had discharged 24 patients and Bracken House had discharged 17 patients.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

Staff told us that while an acute bed could usually be found for patient requiring this, psychiatric intensive care beds in the trust were at a premium and not always available immediately.

Discharge and transfers of care

No patients had experienced delayed discharge. However, managers knew how to monitor the number of patients whose discharge might be delayed and took action to prevent this.

Patients did not have to stay in hospital when they were well enough to leave.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. This was demonstrated in patients discharge plans and care records.

Staff supported patients when they were referred or transferred between services. We accompanied a staff member and patient on a community visit, this was in preparation for the patient to leave the ward. Staff told us about another patient who had regular leave to a potential community placement to help with the transition and get used to where they would be living.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. While each patient had their own bedroom patients shared toilets, bathrooms and shower rooms. All patients had keys for their bedrooms and could lock their bedrooms when not in use. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time. Most patients were self-catering when they were able to, and staff were willing to give patients support to do this whenever required.

Each patient had their own bedroom, which they could personalise, and all patients had keys to their own bedrooms. However, two patients said they would prefer ensuite facilities rather than shared toilets and bathrooms.

While patients at Bracken House had a secure place to store personal possessions. Patients at Thorneywood did not have a secure cupboard or locker in their bedrooms and were encouraged to keep their belongings in their locked bedroom for safe keeping.

While staff used all available rooms and space to support treatment and care, at 106 Thorneywood Mount space for therapy was very limited. Managers acknowledged this and told us of the trusts planned space utilisation review for the location and which was part of the trusts overall site improvement plans.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private.

The service had an outside space that patients could access easily.

Patients could make their own hot drinks and snacks and were not dependent on staff.

Although most patients were self-catering the service offered a variety of good quality food for those who were not at that stage yet. All patients received self-catering risk assessments, and these were used to let staff know what level of support individual patients required.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients to access these. Staff and patients told us that during COVID-19 lockdown a lot of these activities did not take place due to closure but since late last year the places were beginning to slowly open up again.

Staff helped patients to stay in contact with families and carers. This was done either through telephone calls, face to face visits or face time and other digital methods.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy, cultural and spiritual support.

While Bracken House could support and make adjustments for people with mobility difficulties, due to the layout and design of the buildings Thorneywood Mount was not able to accommodate people with mobility issues. The trust were aware of this and accepted that if someone with mobility difficulties needed a bed on a rehabilitation ward they would use Bracken House.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service had information leaflets available in languages spoken by the patients and local community. We saw information leaflets around the wards and staff told us they could be provided in large print and other languages as required.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

The service had received one formal complaint in the previous year and no local complaints. We saw how this complaint had been investigated and partially upheld. We saw how the provider had responded to the complainant and changed communication practice as a result of the investigation.

Patients, relatives and carers were able to explain how they would make a complaint or raise concerns if they needed to.

Long stay or rehabilitation mental health wards for working age adults

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

The majority of leaders had the skills, knowledge and experience to perform their roles. All leaders had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

The majority of leaders had the skills, knowledge and experience to perform their roles. One manager was a relatively new manager having taken on the role and the service at the height of a COVID-19 outbreak. As such the manager was still learning about the complexities of managing a unit such as this and all the functions of this role.

All leaders had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

There was a vision for this service that was understood by staff and most patients and carers. There were also posters around the wards promoting the providers vision and values. However, managers acknowledged it needed updating, as it had been established for many years.

The strategy for the service was undergoing review as part of the providers Ward 2 Board (W2B) roll out plan.

Culture

Long stay or rehabilitation mental health wards for working age adults

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff we spoke with said they felt respected, supported and valued. They also told us about the trust's wellbeing programs that amongst other issues promoted the need for open conversations about equality, diversity and inclusion. Staff told us about the opportunities they had to progress in their careers and develop better job satisfaction through taking on lead and champion roles. Staff were encouraged to upskill to allow them to do more complex tasks within their grade such as the advanced clinical practitioner nurse, and the trust offered staff funding to train for nurse associate roles and registered nursing courses.

Staff said they understood how to use the trust's whistleblowing process. Staff told us they had received additional training to understand more about the role of the Freedom to speak up guardians (FTSUG) and knew they were based at the trust's main hub.

Senior managers were keen to be visible and accessible in the service and to support this made frequent visits to both Thorneywood Mount and Bracken House to understand some of the challenges staff faced on the units. Managers told us they felt very supported by the senior management team.

Governance

Our findings from the other key questions demonstrated that not all governance processes operated effectively at team level on all wards.

Despite the ward manager reporting the broken showers at Thorneywood Mount the trust had not taken effective measures to ensure that the service had fully working showers all the time on all wards. Both 106 and 145 Thorneywood Mount needed redecoration and refurbishment.

We were not assured that all blanket restrictions were reviewed as they should be.

Not all wards used the trusts governance systems to monitor performance on the wards. For example, clinic audits were not carried out as per the clinic audit schedule. Managers were not clear when pharmacy audits had been competed or if any actions for improvement had been identified. Managers did not ensure clinical decisions from handovers and huddles were being recorded and therefore might not always be aware of any changes that were needed to practice or patients' care. The overall impact of this lack of governance could lead to poor practice, non-compliance with guidance and regulation and potentially be putting staff and patients at risk of harm

We raised this issue at the time of the inspection. Within two weeks of the inspection the trust submitted an action plan on how they were going to address them. We reviewed this action plan and the evidence gathered on inspection and noted that the trusts mitigation has gone some way towards assuring good governance of the service. However, they need to have robust process in place to identify these issues in the first instance. In addition, the service needs time to successfully embedded in to practice the proposed changes.

Managers had ensured the he service had enough nursing and medical staff to meet their establishment numbers during the day. They did not identify that the number of staff allocated to evening shifts was insufficient and carried out of this after this was raised during the inspection.

Long stay or rehabilitation mental health wards for working age adults

The showers at Thorneywood Mount had not worked effectively for over two years and the ward managers had reported them on eight occasions. While the trust had responded with temporary fixes they had not resolved the problem. However, within two weeks of our visit and after discussions with the estates department a new header tank was installed which increased the existing water pressure and the manager and patients confirmed they did now have working showers.

Thorneywood Mount 106 and 145 needed redecoration and refurbishment. While the trust had acknowledged this there was no definite start date for these works.

Managers were not regularly reviewing the blanket restrictions that were in place at the service. . We reviewed local governance meetings and there was no evidence that the locking of the kitchen at 7.30pm and locking of the bathrooms in the daytime were regularly discussed and reviewed.

Management of risk, issues and performance

Although teams had access to the information they needed to provide safe and effective care, we could not be assured that staff performance was always manged well. Staff supervision, a key part of monitoring staff performance, was low for this service.

While the majority of risk was managed well on the wards, and identified local risks matched those on the trusts risk register, the lack of some overarching governance processes at Thorneywood Mount such as clinic audits and not recording decisions from huddles and handovers, could lead to potential risk to patients without management being aware of this.

Compliance with managerial and clinical supervision, and annual appraisal in the service was low. Managerial supervision is a key part of monitoring staff performance. Clinical supervision helps managers ensure that staff are working to safe protocols and practice guidance. Annual appraisal helps managers ensure that staffs ongoing development and training is maintained. The service had very low compliance rates for staff clinical and managerial supervision and annual appraisal. Compliance rates for clinical supervision had dropped from 96% in April 2021 to 53% in February 2022, and managerial supervision rates had dropped from 95% in April 2021 to 54% in February 2022. While compliance rates for appraisal in this service was 76%. The trusts target was 80% for compliance. Managers cited Covid 19 and staff absence as reasons for this drop.

While the service had enough nursing and medical staff to meet their establishment numbers, we did not feel the number of staff allocated to evening shifts was sufficient. This frequently left staff lone working on the wards at night.

Information management

While staff collected and analysed some data around clinical outcomes and performance, specifically around the efficacy of therapy programs, diagnosis, carer forum feedback and complaints outcomes, we felt the service could use other information such as clinical audits and supervision records to further inform their service.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Long stay or rehabilitation mental health wards for working age adults

We saw minutes of meetings and development plans showing how the service had actively engaged in local quality improvement activities particularly around the interface of in patient and community mental health rehabilitation services.

Learning, continuous improvement and innovation

Managers expressed an eagerness to learn from feedback including that from inspection reports, as evidenced in their post inspection responses. Managers identified the following initiatives that were at various stages of approval and completeness. Overall site improvement plans for Thorneywood Mount 106 and 145, this included refurbishment and space optimisation on both units to provide better therapy space. Enhanced performance dashboards to allow teams to routinely monitor their own performance and which will be visible to operations, workforce, quality and safety teams and finance. Introduction of a generic e mail for staff, patients, carers and members of the public feedback. Wider use of user friendly electronic surveys across the directorate every quarter.

Community end of life care

Good

Is the service safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. We found that all locations we inspected had training compliance rates above 90% which was above trust set targets.

The mandatory training was comprehensive and met the needs of patients and staff. New starters induction included all subjects that new starter would require to prepare them to work in the service. This included safeguarding training and manual handling. The ongoing mandatory training included all subjects that would need to be refreshed to ensure that staff maintained their skills and knowledge

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Compliance with mandatory training was one of the key performance indicators that was included on the managers dashboard

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

All staff received training specific for their role on how to recognise and report abuse. This included safeguarding training level three.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff we interviewed were able to tell us who their safeguarding lead was.

Staff followed safe procedures for children visiting the ward. We saw examples in patients notes of plans for child visiting.

Community end of life care

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on wards and transporting patients after death.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

The services we visited were visibly clean and well maintained. We saw cleaning records that showed that all areas were cleaned regularly and there was a system of ensuring that deep cleaning happened regularly in all areas.

Staff followed infection control principles including the use of personal protective equipment (PPE). In inpatient services we saw that hand washing stations were in place around the ward areas that were being used by staff. We were also directed by staff to use handwashing stations upon entering these areas, Staff working in the community informed us that they had good access to PPE and always used it.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

There were clear protocols in place to transport people to the mortuary after death. The services worked with an approved undertaker who arranged transportation. Both services had a room set aside for laying out and preparation for transport. These rooms were also used so that the family of the deceased could have time with them prior to them being moved.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called.

The design of the environment followed national guidance. This included day areas and outpatient areas such as community hubs.

Staff carried out daily safety checks of specialist equipment. We found that all equipment that required daily testing had been checked and there was a record that checks had been undertaken regularly

The service had suitable facilities to meet the needs of patients' families. Visiting rooms were comfortable and well presented.

The service had enough suitable equipment to help them to safely care for patients. We found that all nurses in the community teams had their own equipment to monitor patient health. This meant that they always had everything they needed to deliver care.

Staff disposed of clinical waste safely. We saw that there were systems in place across all of the locations we visited to ensure

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

Community end of life care

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. All records we looked at contained risk assessments that had been undertaken upon admission to the service and had been updated regularly when the patient's condition had changed

The service had 24-hour access to mental health liaison and specialist mental health support. There were systems in place at all locations we visited for staff to access appropriate mental health support if required.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe. We observed 2 hand over meetings during our visit and found that they were complete and covered all information that staff would need.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. We found that vacancy rates were less than five percent across the service.

South Community teams have access to Haywood House Hospice medical staff, which provides weekday and out of hours support to nurses on duty if they require specialist advice. Community Macmillan staff also have weekly supervision with a consultant to review complex cases and seek support, advice and guidance.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. The trust used a trust wide tool to estimate the number of nurses and healthcare assistants which the service complied with.

The managers could adjust staffing levels daily according to the needs of patients. Managers could draw from the trusts nursing bank and use agency nurses if required

The number of nurses and healthcare assistants matched the planned numbers. We looked at staff rotas and found that staffing levels daily matched estimated numbers

The service had low vacancy rates, low turnover rates and low use of bank and agency staff

The service had low sickness rates. Though there had been a spike during the recent pandemic it had settled down to pre-covid levels.

Managers limited their use of bank and agency staff and requested staff familiar with the service. In addition, they made sure that all bank and agency staff had a full induction and understood the service.

Community end of life care

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. Access to doctors for community teams either relied on the patients GP or specialist referrals to doctors in teams throughout the trust depending on the condition. For inpatient services there was appropriate medical cover for all the teams we visited. Bassetlaw Hospice commissioned their medical team differently to other teams; however, cover was still appropriate.

The number of medical staff matched the planned number. There was a vacancy in the medical team at Bassetlaw Hospice but this had been filled by seconding a member of staff from a different team while recruitment was undertaken.

The service had low vacancy rates, low turnover rates and sickness rates for medical staff. At the time of the inspection there was one vacancy across the service.

Managers could access locums when they needed additional medical staff. We were told by clinical leads that there was access to locums if required though their use had been rare. This included the use of locums throughout the Covid Pandemic

Managers made sure locums had a full induction to the service before they started work.

The service always did not have its own consultants on call during evenings and weekends. We were told that if medical cover was required at these times it could be sourced from other teams in the trust. This did not impact on patient care.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. We found that the electronic system used in the service captured all data required and was easy to navigate.

When patients transferred to a new team, there were no delays in staff accessing their records. Because the trust used an electronic recording system, other teams could access patient notes immediately.

Records were stored securely.

GPs were informed that a person has been identified as requiring EOLC by community teams. Medication changes, in particular those of older people with complex needs were communicated promptly to the GP, and care home staff or domiciliary care staff if appropriate. GPs had direct access to a medical consultant within the team for advice on the phone

Staff supported patients to make advanced and informed decisions about their care. In line with trust policy staff completed ReSPECT forms. We saw that staff worked with patients and their families to understand what mattered to them at the end of life. Ceilings of care were discussed to ensure that everyone involved understood what would happen. The ReSPECT forms had been signed by an appropriate senior clinician.

Community end of life care

The provider shared comprehensive discharge summaries with patients' GPs, care home or domiciliary care staff, including details of any surgery, implants or medication changes to ensure effective continuity of care in the community.

When a patient has been seen by a member of the mental health liaison team, their mental health assessment, care plan and risk assessment were accessible to staff on the ward or community team via the shared electronic record

The staff team could access advice from mental health liaison about what to do if the patient attempts to discharge themselves or refuse treatment.

If required staff had access to patient-specific information, such as care programme approach (CPA) care plans, positive behaviour support plans, health passports, communication aids.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, staff did not have robust process in place to safely store and dispose of prescription pads.

Staff followed systems and processes to prescribe and administer medicines safely. This included when people were discharged from inpatient settings.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. There was appropriate anticipatory prescribing in place and suitable dosages clearly were written

Staff completed medicines records accurately and kept them up-to-date. There was correct authorisation in place to enable administration of anticipatory medicines.

At Bassetlaw hospice we found more than 10 prescription pads that were locked away in the incorrect cupboard. Due to this staff had not monitored the use of these prescription pads or recorded of the serial numbers on the pads in line with guidance. Some of these pads were assigned to doctors who no longer worked at the service and had not been disposed of properly.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. We looked at incident recording and found that incidents had been reported and documented correctly

Staff raised concerns and reported incidents and near misses in line with trust policy.

Community end of life care

The service had no never events on any wards.

Managers shared learning with their staff about never events that happened elsewhere in the trust. Managers held regular staff meetings with staff where improvements and changes to working practice was discussed.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff received emails form the trust which outlined findings from investigations into incidents if these findings drove improvement or changed working practice.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident. Managers had access to psychologists to deliver support and debrief sessions to staff after serious incidents if required.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We viewed a range of documentation and policies linked to the service which showed that the service followed national guidance in the delivery of care.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. All services we visited linked with mental health professionals in the creation of risk assessments and care plans linked to patients mental wellbeing.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We attended two handover meetings and saw that staff routinely discussed patients mental health and emotional support.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Community end of life care

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. We saw that community teams routinely monitored patients fluid and nutritional intake and asked about diet and appetite as part of the visit. We observed staff on inpatient wards we visited encouraging patients to eat and drink.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. In all notes we looked at where fluid and dietary intake required monitoring, we found that it was in place and being done correctly

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. We were told by staff that dieticians and speech and language therapists could be arranged quickly if required.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients received pain relief soon after requesting it. We found that pain assessment and relief was quickly arranged if a patient requested it. We also saw evidence in patients notes of ongoing monitoring and regular review of pain medication.

Staff prescribed, administered and recorded pain relief accurately. In all patients notes we checked we saw that administration and recording of all medications was undertaken and the medication charts were up to date and correct,

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements in care and improve patient experience.

Outcomes for patients were positive, consistent and met expectations, such as national standards.

Staff completed the integrated palliative care outcomes scaled (IPOS) for patients in both hospices to ensure that the patient experience informs care decisions and multidisciplinary working.

Managers and staff used the results to improve patients' experience. All teams we inspected had regular staff meetings to discuss the experience of people using the service and to review care they had provided in order to improve the service

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We found that staff and managers were involved in undertaking audits.

Managers shared and made sure staff understood information from the audits. Information was shared in a number of ways that included emails, staff meetings and information posted on notice boards in nursing offices and home bases for community staff.

Community end of life care

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Many of the staff we spoke with had worked in the service for long periods. All of the staff we interviewed told us that they had been given the skills and knowledge to undertake their roles through training and development and that the service kept them updated with new learning to enhance their skills.

Managers gave all new staff a full induction tailored to their role before they started work. All staff undertook an induction before starting with the service. They also had a buddy system for new starters. New members of staff were regularly reviewed to ensure that they were developing the skills and knowledge needed to work in the service independently.

Managers supported staff to develop through yearly, constructive appraisals of their work. 97% of staff that required an appraisal had received one over the twelve months prior to our inspection. Staff that had not received an appraisal were on long term sick leave.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. We saw that all areas we visited were compliant with trust set targets for staff of 90% for staff supervision.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medics we spoke with told us that they all received supervision in line with the national guidance. We were also told that extra support and supervision could be arranged if an individual felt that they needed it.

The clinical educators supported the learning and development needs of staff.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Team meetings occurred monthly for all teams we visited and staff confirmed that they would be updated quickly if they were unable to attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Community end of life care

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We attended a multi-disciplinary team meeting for both the community team for South Nottinghamshire and the inpatient team at John Eastwood House. We found that they were complete and focussed on the delivery of care.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Seven-day services

Key services were available seven days a week to support timely patient care.

In inpatient services we visited, Consultants led daily ward rounds on all wards Monday to Friday. Consultants were available nine to five seven days a week and there were established on call rotas in place to cover services out of hours Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. There was provision for support from other departments on weekends.

Health promotion

Staff gave patients practical support to help them live well until they died.

The service had relevant information promoting healthy lifestyles and support on wards/units. In all services we visited that patients were seen onsite we saw that information was posted on noticeboards and could be given to patients upon request. For patients seen in the community, the service has developed a welcome pack of information that was given to patients at their first visit.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. All staff we spoke to told us that they had received training in capacity and consent as part of their mandatory training.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. All notes we viewed showed us that consent had been considered and gained.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Community end of life care

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mental Capacity and DoLS training formed part of staffs annual mandatory training.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw that community staff had developed strong links with patients and carers. They were able to communicate well with them in a caring and professional manner whilst also giving consideration to support and human interaction. The inpatient teams were extremely supportive of patients in a kind and considerate manner. We also saw that family members were treated well and included in conversations and interactions in a professional and caring manner.

Patients said staff treated them well and with kindness. Every patient we spoke with informed us that the staff had treated them with kindness and dignity and gave positive feedback about the service.

Staff followed policy to keep patient care and treatment confidential. All staff we spoke with understood confidentiality and were careful to ensure that they followed policy and guidance.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Community end of life care

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We noted discussions were had, at handover meetings and multi-disciplinary team meetings, specific to patient and carers emotional needs and how staff could support them.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Access to interpreter services including access to signers for the deaf could be arranged quickly if required. This included interpreter telephone services out of hours.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service.

Staff supported patients to make advanced decisions about their care.

Staff supported family members when loved ones had passed away. They offered emotional support and had set up memory boxes and a comfortable private area that people could pay their respects and spend some time with loved ones before they were collected by the coroner or undertaker.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Community end of life care

Managers planned and organised services so they met the needs of the local population. We found that managers had engaged with the local community to improve its service delivery. At John Eastwood house mangers had engaged with local business to arrange donations for patients welcome and exit packs.

Staff knew about and understood the standards for same sex accommodation and knew when to report a potential breach.

Facilities and premises were appropriate for the services being delivered. All inpatient services we visited were well presented with all the equipment required to deliver care.

Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. We saw in care notes that extra support had been arranged for patients that required it.

Managers monitored and took action to minimise missed appointments.

Managers ensured that patients who did not attend appointments were contacted. At the handover and multidisciplinary team meetings we attended, there were reviews of patients that had not attended appointments. In all cases strategies to follow up with these patients were set out.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. We saw that information in patients notes, relating to disability or sensory conditions, was individualised and included guidance for staff

The service had information leaflets available in languages spoken by the patients and local community. We saw that information was available in patients native languages on request.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. This included both the inpatient staff and people working in the community teams.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

Community end of life care

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Between February 2021 and January 2022, the average time from referral to first clinical contact was five days. We found that all of the teams complied with trust set targets in reference to treatment times and access to services.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

Managers reviewed the reason for cancelled appointments. They sought to adapt appointments to meet the needs of the patients and their families.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Managers monitored that patient moves between wards/services were kept to a minimum. Staff did not move patients between wards at night. Any movement between services were arranged for normal working hours and only occurred when necessary

Managers and staff started planning each patient's discharge as early as possible. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Patients choice of place of death was recorded and discharges planned in line with the patients wishes. Staff considered a range of support options and chose measures that best suited the patients circumstances.

When patients were discharged from inpatient services, staff ensured that they had support at home and exit packs had been developed with essential groceries to ensure that patients could feed themselves and have hot drinks like tea and coffee immediately following their discharge.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

Staff supported patients when they were referred or transferred between services. Managers monitored patient transfers and followed national standards.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. All of the patients and carers we spoke with told us that they would know how to make a complaint if they needed to.

The service clearly displayed information about how to raise a concern in patient areas. There was information about how to make a compliant and contacting the patient liaison service on notice boards and in welcome packs.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Community end of life care

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced.

Leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. We were told that the senior management team had undertaken work to be more visible and approachable since our last inspection and staff felt that this work had improved the service and the trust overall.

All staff we spoke to stated that they knew who their most senior managers were and that they would be comfortable to approach them if they needed to. They spoke highly of their direct line managers and the senior management team for the trust.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Leaders and staff understood and knew how to apply them and monitor progress. All staff we spoke to knew what the visions and values for the trust were. We noted that there were documents posted in all the areas we visited that informed staff of the trusts visions and values and local managers had developed information specific to the service that mirrored these.

Culture

Managers promoted a positive culture within the service and ensured that staff felt respected, supported and valued. Staff were complimentary of the managers within the service and stated that they were visible and approachable. Staff were focused on the needs of patients receiving care. Managers promoted equality and diversity in daily work and provided opportunities for career development.

Managers promoted an open culture where patients, their families and staff could raise concerns without fear. We were informed by all staff that we spoke to that they were extremely proud to be working in this service. They felt like the service brought value to the community it served and that they were well respected by the trust and other healthcare providers

Community end of life care

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. They met regularly with managers from other services within the trust. Managers from partner organisations were included in meetings where required.

Managers had access to governance dashboards to monitor compliance against the trusts key performance indicators. They used the key performance indicators to drive improvements in performance and patient care. In addition, managers used this information to keep relevant stakeholders informed of progress.

Managers met regularly with staff at all levels to ensure that they were clear about their roles and accountabilities in relation to monitoring and reporting key performance indicators outcomes. In addition, staff were provided with regular opportunities to meet, discuss and learn from the performance of the service.

All managers we spoke with used their dashboard to monitor compliance with trust set key performance indicators and had implemented systems to ensure that the performance of staff was monitored through supervision and appraisal.

Management of risk, issues and performance

Managers had access to information that they needed to provide safe and effect care. They used this information to identify, monitor and evaluate risks. Managers ensured that any risks were added to the services risk register and where required were escalated and placed on the trusts risk register.

Managers had contingency plans in place to cope with unexpected events, such as winter pressures and outbreaks of Covid- 19.

Managers contributed to decision-making to help avoid financial pressures compromising the quality of care. They ensured that all staff within this service had access to regular staff meetings to review risk issues and performance issues. Managers put plans in place to reduce the risk and provide training or support where required.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

We saw high levels of patient and carer engagement throughout our inspection from staff and managers. We were told by patients and carers that we interviewed that staff were considerate and helpful. They also stated that they would be confident to contact the mangers to give feedback about the service.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Managers encouraged innovation and participation in research. Specific sessions and days were set up to ensure that staff were updated about improvements. In these sessions

learning was considered. We spoke to staff that had requested personal development training. This has been considered via a trust wide assessment and where appropriate this training had been sourced and delivered**.** We also saw several projects, such as the memory boxes that relatives could use to help with mourning the loss of a loved one, that managers had supported staff to develop and introduce.

Community health services for children and young people

Good

Is the service safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff had completed and kept up to date with their mandatory training. Overall, 96% of staff had completed mandatory training.

The mandatory training programme was comprehensive and met the needs of children, young people, and staff, and included, promoting safer and therapeutic services, safeguarding level three for both children and adults, sepsis and level two infection prevention and control.

Managers monitored mandatory training compliance rates and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role and described how to apply it. Training records showed staff were up to date with their safeguarding training for adults and children. Compliance rates for adult level three was 95% and children level three was 97%.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Managers had worked with staff to ensure they were aware of when and how to raise safeguarding concerns and make referrals to external agencies when required. Staff we spoke with were able to describe in detail what action they would take if they needed to make a safeguarding referral. In addition, staff confidently told us how they could recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Safeguarding formed part of regular clinical supervision as well as reflective practice sessions which focussed on learning from safeguarding incidents.

Staff followed clear procedures to keep children visiting the service safe, there were dedicated waiting rooms, which were age appropriate.

Staff participated in the “working in partnership to safeguard children & young people”, a multi-agency initiative.

Community health services for children and young people

Staff worked closely with the local authority, school nurses and health visitors to ensure joined up care for children who were subject to a child protection plan.

The trust had a policy in place to safeguard young people with, or at risk of, female genital mutilation.

Staff told us they had attended a training session of the awareness and reporting of child sexual exploitation.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinic areas were clean, well-maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean, Staff completed a toy cleaning record which was up to date. Housekeeping staff were present throughout our inspection. Compliance rates for level two infection prevention and control was 96%.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw staff were bare below the elbow when seeing patients in a clinic and used protective equipment appropriately.

Staff followed the provider's infection control policy, including handwashing, the hand hygiene audit in November 2021 showed 98% compliance. We were assured staff were following safe infection prevention and control procedures to keep people safe. We saw anti-bacterial hand soap dispensers in all clinical areas. Staff wore masks in all areas we visited. There were clear signs up in reception and around the hospital to communicate the visiting arrangements and COVID-19 precautions. The hospital had a good supply of personal protective equipment (PPE), and staff had received extra training on handwashing and PPE use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. When providing care in children and young people's homes staff took precautions and actions to protect themselves and children, young people and their families.

The design of the environment followed national guidance. We saw the clinical areas were appropriately equipped, baby and child-friendly; and that waiting areas had suitable play and recreational equipment.

We observed four home visits, specialist equipment was provided in two instances, equipment was appropriate and fit for purpose.

The environments were suitable and spacious enough to accommodate the equipment required to meet the needs of disabled children who were able to access play and recreation facilities with toys and equipment suitable to their age and individual needs.

We saw staff dispose of clinical waste safely and according to trust policy. This included classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.

Community health services for children and young people

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

Staff used the paediatric early warning systems for detecting and responding to clinical deterioration in children (PEWS) a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately.

Staff identified and acted to prevent or reduce risks. Multidisciplinary staff discussions determined the level of risk for each patient, developed a risk management plan and agreed the level of intervention needed.

Staff completed risk assessments for each child, using the trusts risk assessment tool, and reviewed this regularly, including after any incident.

Staff knew about and dealt with any specific risk issues. We saw risk assessments in relation to continence, audiology, physiotherapy and dietetic needs.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. We saw records of appropriate information sharing with local authorities, mental health services and schools.

Staffing

The service had enough nursing, Allied Health Professionals and Health Care Assistants staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and staff a full induction.

The service had enough nursing, allied health professionals (AHP) and support staff to keep children and young people safe.

Managers accurately calculated and reviewed the number and grade of staff, in accordance with national guidance.

The service had low vacancy rates. The establishment for registered staff was 109, at the time of the inspection there was 98 in post, this equated to a 13% vacancy rate. The establishment for unregistered staff was 26 at the time of the inspection 23 were in post, this equated to a 0.8 % vacancy rate.

Managers had an active and ongoing recruitment programme.

The service had reducing rates of bank and agency staff. Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff understood the service before starting their shift and had a full induction where necessary.

The service had low turnover rates. During the 12 months prior to the inspection the average rate was 3%.

Managers supported staff who needed time off for ill health. Levels of sickness were very low at 0.4% against a provider target of 4%.

The service had enough staff on each shift to carry out any physical interventions safely.

Community health services for children and young people

Staff shared key information to keep patients safe at handovers and during the morning management meeting.

Records

Staff kept detailed records of children and young people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

We looked at 19 care and treatment records, they were in an electronic format, comprehensive and all staff could access them easily.

Managers told us when children and young people transferred to a new team, there were no delays in staff accessing their records.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff described what incidents to report and how to report them, this included how to report serious incidents

Managers shared learning with their staff and across the service, this was via email and posters of the service virtual governance board displayed on notice boards. Staff received feedback from investigation of incidents via regular team meetings, bulletins and by email.

Staff described their responsibilities under duty of candour, and we saw letters that had been sent to families apologising when care had not met expectations.

Managers debriefed and supported staff and patients after any serious incidents.

Managers investigated incidents thoroughly. We saw the trust had an investigating serious incidents policy which described how patients and their families could be involved in the investigations where appropriate.

Staff and patient representatives met to discuss the feedback and look at improvements to patient care in the clinical governance meetings.

There was evidence that changes had been made because of feedback. For example, there was a “you said, together we did” update which described how staff had sent out an information leaflet to schools of how to access speech and language services following feedback.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

Community health services for children and young people

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people in their care.

Staff developed a comprehensive care plan for each patient that met their health needs.

We inspected 19 care and treatment records, staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We saw children and young people's physical, mental health and social needs were holistically assessed, and this was reflected in the care plan.

The service followed National Institute for Health and Care Excellence (NICE) guidelines for transition from children to adults' services for young people using health or social care services.

Staff described to us how they protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice.

The service had a dedicated training team who provided support and training to a range of agencies caring for children and young people with additional healthcare needs in the community.

The training provided is evidence based, in line with local and national standards and was regularly evaluated and reviewed. The training provided included, epilepsy, asthma, nasogastric tube and oxygen awareness.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.

The service participated in relevant national clinical audits, for example the National Neonatal Audit Programme (NNAP), epilepsy in children and young people and the National Paediatric Pneumonia Audit. Outcomes for children and young people were positive, consistent and met expectations.

Managers and staff used the results to improve children and young people's outcomes. We saw work had been undertaken to review the "was not brought" policy, which advised staff on actions to be taken if a child or young person did not attend their appointment, following an audit. Managers shared and made sure staff understood information from the audits via the quality and risk meeting where improvement was checked and monitored.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There was a well-established audit calendar which was updated when audits had been completed.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. We saw that staff had undertaken a variety of specialist training such as the Nottinghamshire Safeguarding Children Partnership, safe sleep, minor illness's, mental health, bereavement, tissue viability and cytotoxic medication training.

Community health services for children and young people

The trust had practice development leads who supported the learning and development needs of staff.

Managers gave all new staff a full induction tailored to their role before they started work, we looked at an induction folder which was comprehensive and up to date.

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of the inspection the appraisal rate was 87% across the teams, the trust target was 95%. The staff we spoke with gave examples of how the appraisal process had contributed to their development, for example by identifying training and shadowing opportunities.

Managers supported staff to develop through regular, constructive clinical supervision of their work. At the time of the inspection the clinical supervision rate was 81.5% across the teams, the trust target was 80%.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We reviewed minutes from the speciality team meetings, speech and language, occupational/physiotherapy, community nursing, phlebotomy, training and family nurse partnership. The standard agenda included safeguarding, training, risk and wellbeing.

Managers we spoke with said they identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit children, young people and their families. They supported each other to provide good care and communicated effectively with other agencies.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. We looked at the minutes between the service and the multi-agency safeguarding hub where individual complex family issues were discussed, and actions agreed.

Staff worked across health care disciplines and with other agencies when required to care for children, young people, and their families, for example midwifery and neonatal services, schools, and the youth criminal justice team.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health, depression, two parents we spoke with confirmed this.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles. The service delivered the healthy child programme for the 0-19 age group. This is an integrated public health nursing service providing advice care and interventions to families living in Nottinghamshire. They worked closely with GPs (General Practitioners), nurseries, childcare providers, schools, midwives, children's centres, and social care.

The service provides advice and support in relation to parenthood, maternal mental health minor illness, periodic child assessments, resilience and well-being and transitioning into adulthood. Staff assessed each child and young person's health and provided support for any individual needs to live a healthier lifestyle.

Community health services for children and young people

The children's community training team provided training and support to a range of agencies caring for children and young people who have additional needs within the community. The training team is accessible for any service caring for a young person in Nottinghamshire and is provided in a variety of settings including schools, nurseries, early years setting and short break and residential services.

This Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people, and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff we spoke with described how and when to assess whether a child or young person had the capacity to make decisions about their care.

We looked at 19 care records staff had ensured children, young people and their families consented to treatment based on all the information available and documented this in the notes.

We saw when children, young people or their families could not give consent, staff made decisions in their best interest, considering their wishes, culture, and traditions.

Staff clearly recorded consent in the children and young people's records.

Nursing and clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Compliance rates for training at the time of the inspection was 92%.

Staff gained consent from children, young people or their families for their care and treatment in line with legislation and guidance and recorded this in the care record.

Is the service caring?

Outstanding ☆

Our rating of caring improved. We rated it as outstanding.

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Children, young people, and their families are truly respected and valued as individuals and were empowered as partners in their care, and emotionally, by an exceptional and distinctive service. We attended four clinical home visits and one phlebotomy clinic, staff were consistently discreet and responsive when caring for children, young people, and their families. Staff took time to interact with children, young people, and their families in a respectful and considerate way. We saw staff using distraction techniques such as singing songs when children were anxious about having their blood taken.

Community health services for children and young people

Feedback from people who use the service, those who are close to them, and stakeholders were continually positive about the way staff treat people. We looked at six “books of brilliance” whereby teams had recorded things that had made them feel proud and wanted to share. The books contained numerous positive quotes and thanks from children, young people, and families. Parents we spoke with said staff went the extra mile and their care and support exceeded their expectations. There was strong, visible person-centred culture, we saw staff considering each child or young person's life experience, age, gender, culture, heritage, language, beliefs, and identity.

Staff were highly motivated and inspired to offer care that is kind and promotes people’s dignity. Relationships between people who use the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders. Staff recognised and respected the totality of people’s needs. They always took people’s personal, cultural, social, and religious needs into account, and found innovative ways to meet them. People’s emotional and social needs were seen as being as important as their physical needs.

People who use services and those close to them were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person. Staff always empowered people who use the service to have a voice and to realise their potential. They showed determination and creativity to overcome obstacles to delivering care. People’s individual preferences and needs were always reflected in how care is delivered. Staff recognised that people needed to have access to, and links with, their advocacy and support networks in the community and they supported people to do this. They ensured that people's communication needs were understood, sought best practice, and learn from it.

We saw children and young people were always treated with dignity by all those involved in their care, treatment, and support. Consideration of people’s privacy and dignity such as ensuring consulting rooms had do not disturb signs, was consistently embedded in everything that staff did, including awareness of any specific needs as these were recorded and communicated. Staff found innovative ways to enable children, young people, and families to manage their own health and care when they could and to maintain independence as much as possible. Videos, one to one training and other information were freely available to support this. We saw comments from children and young people which said they felt really cared for and that they matter. Parents and other stakeholders for example schools and nurseries said they valued their relationships with the staff team and felt that they often go ‘the extra mile’ for them when providing care and support.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people’s personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. Parents said the dedicated healthy family advice line was invaluable and that they were incredibly grateful for the support they had received.

Staff undertook training on breaking sad news and described how they gave empathy when having difficult conversations.

Staff told us about the emotional and social impact that a child or young person’s care, treatment or condition had on their, and their families, wellbeing, this was confirmed in the care records we looked at.

Community health services for children and young people

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment.

Staff talked with children, young people, and their families in a way they could understand, using communication aids where necessary.

The service had several ways that children, young people, and their families could give feedback on the service and their treatment and staff supported them to do this. There was a variety of questionnaires, text service and online feedback.

Staff supported children, young people, and their families to make informed or advanced decisions about their care, where appropriate and this was documented in the care record.

Patients gave positive feedback about the service. We saw numerous comments in the books of brilliance commending the staff.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. We were told there had been a 25% increase in referrals to the team. Staff told us they had reviewed how referrals were managed to ensure children and young people were seen in a timely manner. This looked at episodic care and a reduction in “checking in” appointments for children considered as low risk.

The service had systems to care for children and young people in need of additional support, specialist intervention.

Managers monitored and took action to minimise missed appointments. The service had a “was not brought” policy which set out actions to be taken should there be missed appointments with the clinical team. This ensured that children, young people, and their families who did not attend appointments were contacted.

Meeting people’s individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Community health services for children and young people

Staff used transition plans to support young people moving on to adult services, this was co coordinated in collaboration with the transitions lead and preparing for adulthood sessions.

Staff supported children and young people living with complex health care needs by using 'voice of the child' documents and passports and documented this in the clinical record.

Staff told us how they understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss.

The service had information leaflets and other aids such as videos available in languages spoken by the children, young people, their families, and local community.

Managers made sure staff, children, young people, and their families could get help from interpreters or signers when needed.

Staff had access to communication aids to help children, young people and their families become partners in their care and treatment. We were told how the speech and language therapy team used video calls which enabled staff to communicate with children and young people without the need of wearing a mask.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Managers monitored waiting times and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets. The service did not have any children or young people waiting for longer than agreed targets. The service had assessed the risks of children open to services at the beginning of the pandemic and had commenced face to face visits as soon as they were able, which was six weeks into the lockdown.

Managers monitored waiting times and made sure children, young people and their families could access emergency services when needed and received treatment within agreed timeframes and national targets.

Managers worked to keep the number of cancelled appointments to a minimum, they were sent a monthly report which supported them to manage the caseload.

When children and young people had their appointment cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance, they then reported this to enable managers to monitor and manage performance.

We spoke with nine parents three of which said the service them when their child was transferred between services, for example on reaching adulthood.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.

We spoke with nine parents all of which told us they knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in reception and waiting rooms.

Staff we spoke with described how they understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. In the 12 months prior to the inspection the service had received three complaints all of which had been resolved locally, two were in relation to service availability and one was about communication from the team.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service, this was displayed on the monthly virtual governance board poster.

Staff could give examples of how they used feedback to improve daily practice. They told us they gave families a choice of both appointment time and method and facilitated meetings with partners and stakeholders following feedback.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Staff knew who the leaders were of the service and reported they were visible and approachable, not only to them but for children, young people, and families too. Staff told us leaders were based alongside the clinical teams and had an open-door policy. Staff told us that leaders were a “breath of fresh air “who went above and beyond to support them and were always available whenever for whatever they needed. Managers ensured that all staff were part of the team and recognised and valued those staff who are not always seen but who have important roles such as administrative staff.

Managers had the right skills, knowledge, and experience to perform their roles, including a good understanding of the services they managed. Family nurse practitioner managers ensured the service met their targets in working with very vulnerable young people. They worked with their team to see people face to face during the Covid pandemic as this was the best way to safeguard young people and ensure they got the care, advice and support they needed. The managers ensured that they carried a small caseload to understand and keep up to date with their team. They provided detailed supervision with their team and supported them by being trained to safeguarding level 3. They shared their knowledge with colleagues across the trust and delivered additional training and support to external agencies including the local authority, teachers and a youth justice team. Specialised workers within the team were supported to access supervision from outside of the trust due to very few people nationally having expertise in their field.

Community health services for children and young people

We spoke with the four service leads as well as other members of the multi-disciplinary team and they confirmed development opportunities for career progression were available and were encouraged to take these up. Managers set up case studies learning to share best practice with the team that included life stories from the family, the work of the team and outcomes, impact of interventions, feedback from parents and carers and an analysis of the impact. We reviewed five studies about children with highly complex physical and emotional needs, including life limiting conditions. Each case detailed the complexity and specialised nature of the work and the support interventions to help children develop alongside the confidence gained from parents and carers.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Managers worked with staff to ensure they knew and understood the vision and the service values and how they applied to the work of their team. We heard about the clinical pathways for children and young people and how they contributed to this. Staff were able to articulate trust and service vision. In addition, managers we spoke with explained how they were working to deliver high quality care within the budgets available.

Staff were very motivated by and proud of the service. There were consistently high levels of constructive engagement with children, young people, families, and staff. Managers had developed their leadership skills and those of others, to ensure they were empowered to positive changes.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

There was a strong, visible person-centred culture. The service ensured staff in all roles were highly motivated and offered care and support that was exceptionally compassionate and kind.

We were told managers had developed a culture where issues were openly discussed and challenged, and staff were held accountable for their actions. Staff also said they felt comfortable in challenging each other and were actively supported to do this and felt listened too. Support workers told us they could raise any concerns without fear, and they were actively encouraged to speak up, if they felt they needed to raise an issue.

Staff we spoke with were also keen to tell us about the leadership and development opportunities open to them.

We spoke with 45 members of the team who were overwhelmingly positive about the service and the support they received from their manager. Staff told us they felt extremely respected, supported, and valued. They often said they were proud to work with their colleagues and managers because it allowed them to work in a way that was compassionate and truly patient focused. Staff wrote examples on a board in a corridor of the things they were good at to share with others that included; ‘flexible and responsive service facilitates patient care’, compassionate staff supervision’, ‘referrals triaged timely and visits booked within 48 hours’, ‘protected practice days’, ‘evidenced based training’. They said leaders promoted equality and diversity in daily work and provided opportunities for development, for example training and career progression, and they felt immensely proud to work for the trust.

Community health services for children and young people

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had effective governance structures in place to monitor the safety of the ward environment, performance, and risk. The service held monthly governance meetings which had an agenda including; safeguarding, health promotion, lessons learned and wellbeing. The service produced a monthly virtual governance poster which featured top risks, staff wellbeing, the "focus for the month," feedback, key learning from incidents and "you said, together we did" outcomes.

Managers had good oversight of clinical practice and performance. The service held monthly meetings at which key performance indicators were discussed and actions agreed.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Staff reported that referrals rose significantly during the Covid pandemic and there was huge demand placed on the service. Managers worked to adapt the way they worked to meet these demands to ensure that prioritised contact with children and families. This meant administrative tasks were less of a priority and supported staff with this but not to the detriment of patient care. Managers praised trust managers in being flexible and supportive.

Staff had access to the information they needed to provide safe and effective care and used that information to beneficial effect. Managers were supported to address performance issues in a timely way.

Effective multi-disciplinary meetings across the service helped to assess risks and keep children and young people and staff safe. The service looked at themes and trends of incidents monthly.

Staff notified and shared information with external organisations, for example, the local authority and CCGs. Staff were open and transparent and explained to families when something went wrong. We saw staff had excellent rapport with children, young people and families who said that staff were compassionate, and they felt safe. During the Covid pandemic, speech and language managers and colleagues innovated the way they worked with referrers by asking them to send a video of the child with written consent due to initial face to face contact. The service felt they were able to get a better understanding of the child rather than rely on paper-based assessments. In order to support this safeguarding and IT policies had been reviewed and updated to ensure that it was safe to do this.

We saw staff were offered the opportunity to give feedback and input into service development. Staff did this through listening events, online, team and governance meetings.

Staff said the service provided information governance systems to measure key performance indicators and to gauge the performance of teams which helped them provide consistent excellent quality care.

The service had business continuity plans for emergencies for example, adverse weather or a flu outbreak.

Community health services for children and young people

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities for example participating in the interagency safeguarding children programme.

Teams had access to the information they needed to provide safe and effective care and used that information to beneficial effect.

Access to equipment and information technology, including the telephone and patient record systems, worked well, and helped to improve the quality of care.

Information governance systems included confidentiality of records.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing, and patient care.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Managers engaged actively with other local and national health and social care providers to ensure an integrated health and care system was commissioned and provided to meet the needs of the local population.

Staff, children, young people, and families had access to up-to-date information about the work of the provider and the services they used, through the intranet, dedicated support line, bulletins, and newsletters.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service was very effectively monitored, through robust systems of governance. Leaders supported the teams to contribute to specialised work as part of a national programme managed by Department of Health and Inequalities team, this was based on work by University of Colorado. Leaders encouraged and supported staff to be involved in the monitoring of the performance of the team by attending relevant meetings. Staff told us they felt involved, consulted and that their views were genuinely valued and acted upon.

Community health services for children and young people

There was a particularly strong emphasis on continuous improvement. The views of children, young people, families, and staff were at the core of quality monitoring and assurance arrangements. Innovation was celebrated and shared. Operational managers used video therapy for older children to adapt to the challenges of Covid and reported it worked very well for this age group.

Community-based mental health services for older people

Requires Improvement

Is the service safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Safe and clean environment

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Not all locations had alarms, instead most staff used the lone working device alarm, this was not in line with the trusts policy.

Staff completed and updated yearly ligature risk assessments of all areas and removed or reduced any risks they identified.

Four of the five services we visited did not have integrated alarm systems in interview rooms to summon help if required. Staff told us they preferred to use their lone working device. This a pendant staff hold around their neck and pressed to summon help. Staff had repositioned the furniture in interview rooms to ensure staff had easy access to the door. At Rushcliffe community mental health team one consultant told us they didn't use a pinpoint alarm or lone working device and would shout out to summon help. However, the interview rooms were situated a distance away from reception staff. This was not in line with the trusts policy.

Bassetlaw community mental health team had built-in alarms. The staff team who respond to an alarm would be physical health care staff based at Bassetlaw Hospital. Staff accessed pinpoint alarms when meeting with patients in interview rooms and staff were available to respond. However, Bassetlaw community mental health team plan to move to a new base in July 2022 and will have built in alarm systems and two distinct waiting areas for patients. We saw most staff wore pendant alarms.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations. All areas were clean, well maintained, well-furnished and fit for purpose. Staff adhered to infection control principles, there were handwashing signs visible and surface wipes, hand sanitiser available in the clinic rooms and reception areas. Staff made sure equipment was well maintained, clean and in working order.

Safe staffing

There were not always suitably qualified staff on duty to meet patient needs. Not all staff were up to date with mandatory training. The number of patients on the caseload of the teams, and of individual members of staff, are not sufficient to prevent staff from giving each patient the time they needed.

Nursing staff

We visited the following community mental health services for older people:

- Bassetlaw Hospital- Bassetlaw memory assessment service, Bassetlaw intensive home treatment teams and Bassetlaw community mental health team.

- Lings Bar Hospital- Rushcliffe memory assessment service, Rushcliffe intensive home treatment teams and Rushcliffe community mental health team.
- Highbury Hospital – Gedling and Hucknall memory assessment service, Gedling and Hucknall intensive home treatment teams, Gedling and Hucknall community mental health team, City community mental health team, and City intensive home treatment teams.

There was not always enough suitably qualified staff on duty to meet patient needs. There were periods of understaffing which were not addressed quickly. The way that agency and bank staff were used does not ensure that patient's safety were always protected.

At the time of inspection there was a 3.1WTE vacancies for qualified nurses, 5.8 WTE vacancies for healthcare support workers.

The service also had vacancies within allied health professionals. There was a 5 WTE vacancies for occupational therapists.

The number of shifts not covered in the last 12 months from March 2021 to February 2022 were highest at Bassetlaw intensive home treatment team with 7998 and lowest at City intensive home treatment team with 980. Staff at the Bassetlaw intensive home treatment team told us they felt "stretched" and preferred to cover each other's caseloads rather than use bank or agency staff.

Managers told us when short staffed, shifts were offered to permeant staff to cover. Staff told us they preferred to cover each other rather than use temporary staff. Managers said they used limited bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Managers said they did not routinely use agency staff because the local staff agencies were often unable to supply staff with the range of skills needed to provide high quality care. One agency staff had worked at the city community mental health team long term. Agency and bank staff worked at the Gedling and Hucknall intensive home treatment team in 2021 during the COVID-19 pandemic. We saw community team leaders has raised the issues of staffing shortages to the risk register, with action to look across the other service teams for cover where no agency or bank staff are available.

Across service staff told us workloads increased during the COVID-19 pandemic and remained challenging. Staff caseloads varied across services. Nurses at City community mental teams held average caseloads of 35-45 patients. They told us this was high due to the social deprivation within the city locality. Nurses at community mental teams for Bassetlaw and Gedling and Hucknall held average caseloads of 30-40 patients. The intensive home treatment team case load averages were 11.

Managers reported an increase in staff absence due to the COVID -19 pandemic. Staff had been isolating and testing positive for Covid.

The trust provided staff sickness levels running from March 2021 to February 2022. This showed staff sickness levels were highest at Bassetlaw intensive home treatment team with 21%. The lowest sickness levels were both at Bassetlaw community mental health team and City intensive home treatment team with 5%. The trust target for sickness were 4%. Following the inspection, the trust told us the overall sickness rate for March 2022 were 8%.

Managers decided to cover staff sickness and absence and ensured that staff absence was on the trust risk register. Staff told us they preferred to cover staff absence from existing staff who knew the patients.

The trust provided data for staff turnover rates for each service in a 12-month period up to February 2022. Two services showed staff turnover rates Bassetlaw at 12.5% and Gedling and Hucknall intensive home treatment team 7%. All other services showed nil percentages for staff turnover.

Medical staff

The service had enough medical staff. There was prompt access to a psychiatrist either on site or on the phone during the opening hours of Monday to Friday, nine to five.

Mandatory training

Not all staff were up to date with infection prevention control level two and care programme approach training. Overall, the services' training compliance rate were 93%. The trust compliance rate target was 95%

The mandatory training programme was comprehensive and met the needs of patients and staff. Training provided were for example: promoting safer and therapeutic services, suicide awareness, manual handling and back care, clinical risk, equality and diversity, basic life support.

Training compliance was below 75% at three services: Infection prevention control level two the overall compliance rate were 87%. At Bassetlaw community mental health team 67%, Bassetlaw intensive home treatment team 63%. The care programme approach overall compliance rate was 94%. Rushcliffe intensive home treatment team compliance rate were 67%.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers told us this had been a challenge with staff absence and during the COVID-19 pandemic.

The following teams had the lowest training compliance rates: City intensive home treatment team and Gedling and Hucknall intensive home treatment team both at 75%, Gedling and Hucknall community mental health team 80%, City community mental health team 85%.

Fire safety awareness training compliance rates were 90%. At Bassetlaw intensive home treatment team 75%, Bassetlaw community mental health team 78%, and City community mental health team 85%.

Breakaway overall training compliance rates were 88%. City and Gedling intensive home treatment teams were both at 75%. Followed by Gedling and Hucknall community mental health team 80%, City community mental health team 85%.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.

Assessment of patient risk

We looked at 26 care records during this inspection. All of these included an up to date risk assessment. Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need. Crisis plans were created within the assessment process and for all patients under the care programme approach. Carers would be consulted in creating crisis plans if this was appropriate.

Management of patient risk

Where cases became urgent, staff saw the patient the same day or the next day and this was provided by the duty worker if required. Staff monitored the waiting list and wrote to the patients' GP advising them to telephone the service if the referral became urgent or if there had been deterioration in the person's health.

Staff followed clear personal safety protocols, including for lone working. Staff used a lone working device pendant and could summon help at any time. In addition, staff signed in and out from the office base, and used work mobiles. Staff also completed weekly electronic calendars detailing their visits. The duty worker checked where all staff were at the end of the day and anyone not accounted for would be contacted with escalation if contact was not achieved.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up to date with their safeguarding adults and children training. The overall safeguarding staff training compliance rate were at 95%. The only exception was for Safeguarding adults think family level 3 training for the Bassetlaw intensive home treatment teams, which had a compliance rate at 75% against the trust target of 98%

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff told us about referring patients to culturally appropriate services in the community for support.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them**.** Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us there were a safeguarding lead in each team, that staff could go for advice and guidance. A psychiatric nurse from the city team attended the statutory safeguarding forum and brought information back to the team with learning points.

Staff access to essential information

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Staff told us they used paper templates when working in the community and would scan and upload them when back at the office base. Staff made sure patients notes they were up-to-date and complete. Records were stored securely.

When patients transferred to a new team, there were no delays in staff accessing their records.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Community-based mental health services for older people

Staff followed systems and processes to prescribe and administer medicines safely. Team leaders told us that there was robust checking of medication and frequent dialogue with the team consultants and GPs to ensure that all mental health professionals were aware of current levels of medication and any changes made.

We saw detailed discussion during the multidisciplinary team meetings about medication, side effects and regular reviews. We saw evidence that regular monitoring was carried out for patients prescribed anti-psychotic and anti-dementia medication. We observed during one multidisciplinary discussion about an appropriate pain relief patch for a patient with early signs of dementia as the patient kept removing the patch. It was agreed an oral pain relief medicine would be a better option. Staff completed medicines records accurately and kept them up to date.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff stored and managed all medicines and prescribing documents safely. We saw a central controlled system for monitoring fridge temperatures. Staff had a secure case for transporting medicines to patients' homes.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff reviewed the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence guidance.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew how to report incidents and gave us examples of what kind of incidents they would report using the trust system. Incidents were discussed at the weekly multidisciplinary team meeting, at monthly team meetings and at supervision.

Staff told us that they were open and transparent when something went wrong. Staff received feedback from the investigation of incidents at reflective team meetings or individual supervision meetings. The trust sent out quarterly learning lessons electronic bulletin and featured on the trust intranet.

Debriefs were held immediately after incidents or as soon as possible thereafter. Staff were referred to a named clinician within the service if they required additional support following an incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

Community-based mental health services for older people

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.

We examined 26 care records and comprehensive assessments were completed in the review letter sent out to the GP for patients who were not on care program approach. All care plans were of a high standard, contained up to date information, personalised, holistic and recovery orientated. Care plans included the patient's history and social information (where available). The family and carers views were also included. We saw the patients voice was reflected throughout care plans with quotations from patients included. We saw patients were offered a copy of their care plan. Where patients declined this was recorded in their care plan. A frequent reason patient's declined care plans was recorded as where they did not want to know or see a diagnosis in writing. Staff regularly reviewed and updated care plans when patients' needs changed.

Staff completed a comprehensive mental health assessment of each patient. Staff made sure that patients had a full physical health assessment and knew about any physical health problems. Staff would undertake a brief physical examination for pulse and blood pressure. Patients at risk of falls may be referred to the fall's clinic, for scans or other outpatient services. One patient told us the occupational therapist were undertaking an assessment to help them obtain the right bed. Another patient was referred to a dermatologist for chronic eczema they had experienced all their life. The patient told us the eczema were successfully treated and were pleased the physical health assessment triggered a referral to the dermatologist. They said, "This changed my life.".

At the memory assessment service following an initial appointment, patients may be offered further investigations such as an ECG (recording of the heart) or brain scan of the head to help with diagnosis. A follow up appointment would take place where the findings of assessments will be discussed with the patient.

Staff told us that showed memory tests were not always culturally appropriate for patients from black and minority communities and this was taken into consideration throughout the assessment process. Patients were offered an interpreter for the assessment. Managers had discussed at governance meetings information provided by the Race Equality Foundation around people living with dementia from South Asian Communities; and a toolkit and including the use of standardised tests.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Interventions included referral to locality social workers, and local registered charities specialised in support for older people. Some nurses attended a monthly Dementia forum to keep up to date with best practice.

Staff told us they signposted patients and carers to singing groups- Singing for the brain- in the Gedling area provided by a leading charity for older people. This is a group that had fun vocal warm-ups and sing a wide variety of familiar and new songs in a supported environment.

Community-based mental health services for older people

Diagnostic and cognitive assessment tools were used to rate severity and outcomes such as the geriatric depression scales, Addenbrooke's cognitive examination-III (ACE-III) which is a screening test used to assess cognitive performance. Some staff used the repeatable battery for the assessment of neuropsychological status. This is a test measuring attention, language, visuospatial/constructional abilities, and immediate and delayed memory and consists of 12 subtests.

Some staff used the assessment of motor and process skills an observational assessment that measures the performance quality of tasks related to activities of daily living in a natural environment. The assessment is designed to examine interplay between the patient, the activities of daily living task and the environment.

Occupational therapy staff told us about examples of assisted technology to improve care. Staff sign posted patients, families and carers to assisted technology, for example a bed sensor that provided a message if a patient moved out of bed. A movement detector with sensors placed around a home indicating which room the patient is in. A talking memo where you record a carers/family member's voice with a message as a prompt to remind the patient to take a medicine or make a drink. In addition, a global positioning system (GPS) tracker that could be slipped into a patients' pocket or shoe. Carers and families feedback was that the tracker had provided them with reassurance their relative were in their garden or walking around the local area, and not wandered off.

Staff told us one patient under the Rushcliffe community mental health team telephoned the team regularly when they were feeling very anxious. In response to a demand for support for patients with anxiety and depression, staff at the location started a anxiety groupwork programme for older people with functional problems.

The psychologist from the Gedling and Hucknall team provided compassion focus therapy. This was delivered on a one to one with patients who were destabilised after bereavement. The therapy could help patients manage their anxiety through compassionate behaviour. This was in line with National Institute for Health and Care Excellence guidance.

Clinical staff routinely participated in clinical audit including, health and safety, lone working devices, infection prevention and control environment, Mental Health Act, Mental Capacity Act, safeguarding, and ligature audit (for premises where patients were seen). The memory assessment team contributed to a national audit of dementia. Services contributed to a national audit of suicide and safety in mental health.

Team leaders commenced monthly audits of care records with feedback to the teams in order to continually drive up the standards of care plans. This was evident in care plans we reviewed.

Skilled staff to deliver care

The teams included or had access to a range of specialists required to meet the needs of patients under their care. However, there was a shortage of nurses across teams. There were gaps in management and support arrangements for staff such as for appraisals, clinical and management supervision. Managers made sure that staff had the range of skills needed to provide high quality care. Managers provided an induction programme for new staff.

The community mental health teams included a range of mental health disciplines required for the patient group, consultant psychiatrists, psychologists, physiotherapists, community psychiatric nurses, occupational therapists, community support workers and associate practitioners. Social workers were also available across some teams.

The intensive home treatment teams include advanced nurse practitioners, community psychiatric nurses, occupational therapists, physiotherapist and community support workers. They were being supported by a consultant psychiatrist.

The memory assessment teams included qualified nurses and non-medical prescribers' working closely with doctors and the multi-disciplinary team. Non-medical prescribers are specially trained health professionals such as nurses who can prescribe medicines.

All services were supported by medical secretary's and or administrators.

Staff were experienced and qualified and had access to training specific to their role. Most staff we spoke with were long serving staff.

New staff receive an appropriate induction including access to mandatory training and management and clinical supervision.

Staff told us they had received annual appraisals however, we found this was not the case for all staff. The trust's target rate for appraisals were 95%. The trust provided data for staff appraisals at 100%. The trust data was not accurately recorded. The average annual appraisal rate were 85%. All services we visited had compliance rates under 95%. The lowest compliance rate were at Bassetlaw intensive home treatment team at 50% followed by City community mental health team and Gedling and Hucknall community mental health team both at 86%. The highest compliance rates were all four memory assessment services at 94%.

The trust clinical supervision and management supervision compliance target rate were 80%. The trust provided data for clinical supervision and management supervision. Clinical supervision rates for March 2022 were at 82%. The average clinical supervision rate were 86%. The lowest rates were at City intensive home treatment team at 29%. The service manager of this service were off long-term sick. Two services with low staff supervision rates were Rushcliffe community mental health team 57%, and Bassetlaw community mental health team 60%. The highest compliance rate were the memory assessment services at 100%.

Management supervision rates for March 2022 were at 91%. The average management supervision rate were 88% The lowest rates were at City intensive home treatment team at 57%, followed by Rushcliffe intensive home treatment team at 80%. The compliance rates at all other services ranged from 92-100%

Poor staff performance was addressed during supervision. Team leaders described seeking support from human resources along with managerial support to improve performance.

Multidisciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

During inspection we observed two multidisciplinary team meetings and heard detailed discussion about patients care and treatment. Staff updated on patients' records during the meeting. The multidisciplinary teams worked closely with the crisis team, social services, speech therapy workers, GP practices, community nurses including pressure care teams and respiratory teams. Staff teams had developed effective working relationships with Admiral nurses, who are specialist *dementia nurses* who are supported and developed by an external national dementia organisation.

Community-based mental health services for older people

Memory assessment services had effective working relationships with local GP practices and dementia support workers from an third sector organisation to fully support patients and their carers from initial assessment through to the diagnosis process. Dementia support workers offer support and advice on issues such as driving with dementia, employment and benefits. Staff told us they had strong links with Young Onset Dementia groups for adults under 65 years.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff had a good working knowledge of the Mental Health Act, the code of practice and the guiding

principles. As of March 2022, community based mental health services for older people were 94**%** compliance against a target of 95% for the number of staff trained in the Mental Health Act. The renewal timeframe for this course were every two years. This course were mandatory for staff.

Consent to treatment and capacity assessments were recorded in patients' records. Staff had a good understanding of capacity and consent and sought guidance from specialist champions within the service if required.

Rights under the Mental Health Act and community treatment orders were explained to the people using the service and their families and carers.

Staff were able to seek support from the Mental Health Act office on the implementation of the Mental Health Act and the Code of Practice.

There were regular audits to ensure that the Mental Health Act was being applied correctly and evidence of learning from this was seen in team meeting minutes. Independent mental health advocacy posters and leaflets were displayed in the reception areas at all of the bases. This is a charity that helps people to be involved in decisions being made about their care. Staff knew how to refer to the advocate and were familiar with the scope of their role.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Mental Capacity Act training was mandatory for all staff. Compliance rate for this core service was 93% against a target of 95%. The trust had a Mental Capacity Act policy which staff were aware of and referred to. Staff had a good working knowledge of the Mental Capacity Act and were able to tell us about the five statutory principles.

Staff told us that they assumed capacity and if people who used the service may have impaired capacity this was assessed and recorded in the clinical notes and on a dedicated capacity assessment form.

Community-based mental health services for older people

Staff told us there were two trust mental capacity act advisors they would contact regularly for advice. A staff member told us they were unsure how to assess a patient in the community, as the patient was refusing visits to their home to be assessed. The mental capacity act advisor with the support of the patient's carer, suggested staff go the rotary club where the patient regularly attended to assess her.

Staff supported people to make decisions and involved families and carers in order to ascertain people's wishes, feelings culture and history. There were best interests' assessors within the teams who assisted with this process. Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Is the service caring?

Good

Our rating of caring went down. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff respected and treated patients as individuals, with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

We observed many positive interactions between staff and patients. There were a strong, visible person-centred culture. Patients told us that they felt understood and well cared for. We attended two home visits with a patient and observed staff had a detailed level of understanding of the patients' needs and those of the carer. Staff explained to patients different treatment options and individual needs were always reflected in how care were delivered.

We saw a patient in a consultation with the psychiatric consultant. The psychiatric consultant put the patient at ease, used plain and simple language and were sensitive and respectful. They provided pauses in the conversations and gave the patient plenty of time to reply and ask any questions.

Feedback from patients, those who were close to them were positive. Patients told us the service was wonderful, staff were kind, will go out of their way to help and support you, the service had been a lifesaver, enjoyed visits from the team. One staff member from the Gedling and Hucknall intensive home treatment team during a home visit stayed with a patient during an emergency and waited until midnight for the ambulance to arrive.

We saw confidentiality forms in patient records and staff sought permission for us to contact patients during the inspection. There was a confidentiality policy and patient records were stored electronically.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates. Staff informed and involved families and carers appropriately.

Involvement of patients

Staff were fully committed to working in partnership with people and making this a reality for each patient. We spoke with nine patients. Their feedback was continually positive about the way staff treated patients. Patients told us there

was a strong focus on holistic person-centred care. One patient said the service had sign posted them to a Parkinson nurse to support them. Another patient said the doctor had visited her at home about mobility problems and provided options and advice. A third patient told us they had knowledge about their medicines as staff always provided full explanations which gave them a better understanding of their condition. A fourth patient told us staff had spent time explaining their diagnosis and answering questions.

Staff recognised and respected the totality of people needs. They always take patients personal, cultural, social and religious needs into account. This were evident in patients care plans. Staff involved patients and gave them access to their care plans. Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. Staff always empower patients who use the service to have a voice and to realise their potential.

Patient individual preferences and needs are always reflected in how care is delivered. Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. Staff supported patients to make advanced decisions on their care

Staff made sure patients could access advocacy services.

Involvement of families and carers

We spoke with 11 families and carers who gave continually positive feedback about the service. They told us the service had transformed their lives, staff were very patient and took time to explain and never felt rushed, and all matters were discussed openly. One patient told us their husband was very much involved and he looked forward to the team visiting. Families and carers told us staff always explained about medicine usage and side effects.

Staff involved families and carers in discussions, options and decisions about the patient's holistic care. Staff helped families to give feedback on the service. Staff gave carers information on how to find the carer's assessment. Families and carers were able to access local carers groups and organisations. We saw carers support group information displayed around locations.

Is the service responsive?

Requires Improvement

Our rating of responsive went down. We rated it as requires improvement.

Access and waiting times

The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments.

The services we visited operated at different times to meet patient's needs. The community mental health teams operated Monday to Friday 8:30am until 4:30pm, with duty worker on until 5pm. The intensive home treatment team operated a seven day a week service, working within the hours of 8:00am to 8:00 pm to meet patient's needs. The memory assessment service team operated Monday to Friday 9:00 am until 5:00 pm and part day on Saturdays.

The service had clear criteria to describe which patients they would offer services to and offered patients a place on waiting lists. The community mental health and memory assessment service waiting time as of February 2022 from referral to assessment and assessment to treatment were 18 weeks.

The data provided but the trust was not accurately recorded so were unable to fully understand if the trust were meeting their targets. Whilst the data highlighted there were met we were not assured that they could have been due the low levels of staffing.

The data provided showed that the trust target for access and waiting times was 100%. At the time of the inspection the service compliance was 98%. The referral to waiting for treatment (18 weeks) was 97.5% against a trust target of 98%. The trust target for access and waiting times was 100%. At the time of the inspection the service compliance was 98%. The referral to waiting for treatment (18 weeks) was 97.5% against a trust target of 98%.

The intensive home treatment teams had no waiting lists and would respond within 24-72 hours. The service were usually delivered in a person's home and for usually up to 8-weeks. Managers confirmed they meet the 100% target rate. The memory service teams waiting list varied from none to up to 4 weeks wait at Bassetlaw memory service.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services.

Staff tried to contact people who did not attend appointments and offer support.

Patients had some flexibility and choice in the appointment times available. Patients were offered telephone, face to face and video appointments. One carer told us they asked the team to bring their appointment forward as their relative were deteriorating and an earlier appointment were arranged. One patient told us they needed to change their appointment and the service arranged this.

Staff worked hard to avoid cancelling appointments and when they had they gave patients clear explanations and offered new appointments as soon as possible. Appointments ran on time and staff informed patients when they did not.

The service used systems to help them monitor waiting lists/support patients.

Staff supported patients when they were referred, transferred between services, or needed physical health care. The service followed national standards for transfer.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

We visited four community mental health teams. Each team included an intensive home treatment team and memory assessment team. Each service had a full range of rooms and equipment to support treatment and care. Interview rooms in the service had sound proofing to protect privacy and confidentiality. There were a full range of interview rooms available. The receptionist at Gedling and Hucknall team arranged room bookings. We saw the receptionist maintain the reception area, wiping down chairs and tables at intervals throughout the day.

Community-based mental health services for older people

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. However, signage and access to the building door at one location did not meet patient's needs. Staff helped patients with communication, advocacy and cultural and spiritual support.

The Gedling and Hucknall community mental health team were based in Hazelwood House at the Highbury Hospital location. Two patients and carers told us the service were difficult to locate due to poor signage. The CQC inspection team also experienced difficulty locating the service.

At the Gedling and Hucknall location two patients and their carers with mobility issues told us they experienced difficulties entering the building. They described the automatic front door opened towards you. This meant you had to move out of the way of the door to avoid being hit. We observed patients arriving and saw the front door caused some patients difficulties.

We saw ramps to buildings, handrails and accessible toilets for patients visiting the services. We saw some trust staff wore high visible yellow name badges with black text which aided patients and visitors with visual impairments and cognitive impairment including dementia.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. We saw a wide range of written information available in-service waiting areas. The service provided information in a variety of accessible formats so the patients could understand more easily. Staff told us they used Recap a digital platform which enables staff working within the trust to send digital information for health, wellbeing and recovery. The patient and carer need to set up a log in with a password and could access the platform.

One staff member during a home visit arranged for Asian meals to be provided as part of an existing patients home care package. The service had information leaflets available in languages spoken by the patients and local community. Staff could access telephone interpreting and face to face interpreters. Managers made sure staff and patients could get hold of interpreters or signers when needed.

One patient who was hearing impaired told us a staff member from the Gedling and Hucknall memory assessment team wore a mask with a clear plastic window and used sign language. The patient was then able to lip read coupled with the sign language. The patient was pleased and said this allowed them to become fully involved in their care planning.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Complaints posters and leaflets were on display in all locations. Patients, relatives and carers knew how to complain or raise concerns. They told us they were able to talk informally to staff in the first instance if they had concerns.

In the last 12 months from March 2021 to March 2022 the service received five complaints. Two were resolved at a local level and three included a full investigation. One of the complaints were for the memory assessment team at Rushcliffe at Lings Bar Hospital and remains under investigation. Staff understood the policy on complaints and knew how to handle them. Staff told us they knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Team leaders investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Community-based mental health services for older people

Patients received feedback from managers after the investigation into their complaint.

Team leaders shared feedback from complaints with staff and learning was used to improve the service. We saw each location had a book of excellence where they saved any complements received from patients, families and carers and feedback to the teams.

Is the service well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Staff consistently told us that morale was high, teams were supportive of each other and their team leaders and they felt a high level of satisfaction within their roles.

Sickness and absence rates were high at some services, but managers had plans in place to cover any staffing shortfall. Staffing levels did not meet the required number to meet the needs of the patients. Team leaders told us they used agency staff to improve staffing levels as there were a limited use of bank staff. They preferred to cover each other rather than use temporary staff. Managers said they used limited bank and agency staff and requested staff familiar with the service.

Staff knew where to access the whistleblowing policy and told us that they would have no hesitation in using it if they needed to. Staff were able to make suggestions about the service with their team leaders.

There were opportunities for leadership development and staff said that there was a leadership training course available. We saw evidence of promotion within teams.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

The trust's vision and values were on display in reception and waiting areas across the locations. The vison was- trust, honesty, respect, compassion and teamwork. Staff were highly motivated, passionate and inspired to offer care that was kind and promoted people's dignity. We saw effective team working linked to the trusts vision and values.

Staff told us that they strived for the best care and quality of life for the patients and carers and sought to place them at the heart of everything that they do.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Community-based mental health services for older people

Staff felt respected, supported and valued by their team leaders and managers. There appeared to be a good culture developed within teams; and staff had a good understanding of the service they provided. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Team leaders informed staff when changes were planned within the trust. Staff knew who the most senior managers were but told us they rarely visited services. Staff said they could email senior managers directly to raise issues but felt they were not responsive.

We saw most patients were truly respected and valued as individuals and were empowered as partners in care.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not managed well.

We saw risks around access to the Gedling and Hucknall community mental health team with patients experiencing difficulties accessing the automatic front door; and poor signage to the location.

The trust did not have enough suitably qualified staff across services, the total nurse vacancies were 47. The number of other professional staff vacancies were 55. Not all staff were up to date with mandatory training, with compliance rates below 75% for infection prevention control level two and care programme approach training.

Supervision and appraisals compliance for two teams fell below 75%. The lowest appraisal compliance rates were at Bassetlaw intensive home treatment team at 50%; the lowest clinical supervision rate were at City intensive home treatment team at 29% and for the same team management supervision 57%.

Staff sickness levels were high at Bassetlaw intensive home treatment team with 21%. The trust target for sickness were 4%. At the inspection in March 2022 the overall sickness rate were 8%.

Managers had not ensured that fixed point alarms should be fitted in all interview rooms and places where staff need to interact with service users or the public as per the trusts policy.

Despite the issues staff provided a range of treatment and care for patients based on national guidance and best practice. They also participated in clinical audit, benchmarking and quality improvement initiatives. Audits included Safeguarding, Mental Capacity Act and Mental Health Act. There was regular discussion on these areas at the multidisciplinary team meeting and these were agenda items at the monthly staff meetings. Safeguarding, Mental Health Act and Mental Capacity Act champions were in place to provide additional support.

Incidents were reported and there were clear pathways for lessons learned to be fed back to staff along with changes arising from complaints, feedback and feedback from the patients.

Team leaders told us they had sufficient authority and administrative support, and this was evidenced in the tasks carried out by administrative staff to assist with the running of the teams.

Caseload numbers had been submitted and reviewed by team coordinators.

Community-based mental health services for older people

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Managers and team leaders used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Effective multidisciplinary meetings across the service helped to reduce patient risks and keep patients and staff safe.

Managers notified and shared information with external organisations. Staff were open and transparent and explained to patients when something went wrong. We saw staff had good rapport with patients, carers and families.

Managers ensured that staff were offered the opportunity to give feedback and input into service development. Staff did this through regular team meetings.

Managers used the trust governance systems and processes to measure key performance indicators and to gauge the performance of teams. Team leaders had information that supported them. Team leaders reported service risks to senior managers who would include this on the risk register.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff used electronic patient record systems. Information governance systems included policy on confidentiality of patient records.

Team leaders had access to dashboards with information that supported them. However, we found data supplied to CQC following our inspection were not always accurate; for example, data around waiting times, and urgent referrals and non-urgent referrals.

Staff notified and shared information with external organisations when necessary, seeking patient consent when required to do so.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Team leaders and staff actively and openly engaged with patients, carers and relatives and local organisations to plan and manage services. We saw that teams held regular team meetings and we reviewed the minutes of these. This meant there were opportunities for staff to meet formally to discuss issues relevant to the running and development of their service.

Community health inpatient services

Requires Improvement

Is the service safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff. However not all staff had completed this.

Overall staff received and kept up-to-date with their mandatory training. There was an overall compliance rate of 92% for staff training. However, training compliance had fallen below 75% on John Proctor ward. In some key areas only 67% of staff had completed manual handling, 61% of staff had completed Hospital Life support and 74% of staff had completed Fire Safety Awareness. Staff also told us that the training they had received following the implementation of their electronic notes system in May 2021 was not adequate.

The mandatory training was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers had access to ward dashboards which supported them in monitoring training compliance.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. Staff were compliant with their safeguarding training. Staff were clear about their responsibilities in respect of safeguarding. All staff received training in how to safeguard children and adults and overall training compliance was 91%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The ward manager took the lead for safeguarding on the wards.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff made referrals to safeguarding appropriately. We reviewed incidents and saw that safeguarding alerts were raised with local authority. Staff also provided us with examples of safeguarding actions they had taken.

Staff followed safe procedures for children visiting the ward.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and tidy and had suitable furnishings which were clean and well-maintained. We observed staff cleaning regularly and they made sure that items that were handled or touched frequently were regularly cleaned to reduce the spread of COVID-19

The service performed well for cleanliness. Each ward displayed their compliance level with cleanliness. All wards had achieved a compliance level of above 95%.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment. Staff had been trained in donning and doffing. We observed staff wore PPE properly. They followed guidance to reduce the spread of COVID-19. For example, when required patients were nursed in isolation. We saw wards were closed to new admissions and visitors where there were COVID-19 outbreaks. All staff were bare below the elbow and managers carried out regular checks of mask wearing, to ensure staff did this correctly.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw this taking place and the wards used clean stickers to indicate that items were clean and when cleaning had taken place.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. We observed that this took place when we inspected each of the three wards.

Staff carried out safety checks of specialist medical equipment. Equipment was calibrated and safe to use.

The service had suitable facilities to meet the needs of patients' families. Families could visit patients on the ward. This was being managed carefully because of the COVID-19 pandemic. We asked families about their experience of visiting the ward and the majority of families were happy with visiting arrangements, other families were upset about restrictions out in place due to the COVID-19 pandemic.

The service had enough suitable medical equipment which was easy to access to help them to safely care for patients. For example, pressure relieving mattresses, patient moving and handling equipment and assistive technology including sensor pressure mats, rotundas and bariatric equipment. Equipment had been tested to see if it worked safely and manual handling equipment was readily available and clean and safe to use. Where walking aids were required for specific patients, they were labelled to avoid confusion. However, the bath on Castle ward was broken. We spoke to the trust about this and after our inspection the trust ordered a new one, this was due to be replaced as soon as it could be in September 2022.

There was access to lifesaving equipment which was in good order and checked regularly.

Staff disposed of clinical waste safely, processes for managing clinical waste, medicines disposal and sharps bins were effective.

Community health inpatient services

Assessing and responding to patient risk

Staff completed and updated most risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, staff did not complete falls risk assessments for all patients who were at risk.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the National Early Warning Scores to monitor patients, they scored these and acted when required in response to elevated scores.

We saw a range of care plans for patients' needs, these included night time care plans, moving and handling, continence, skin management, confusion, cultural and religious beliefs, and physiotherapy.

The service used standardised assessment tools to assess risk on admission including nutrition and hydration, venous thromboembolism (VTE), falls, bed rails, skin integrity and moving and handling. However, we found that staff did not always complete the falls risk assessment and care planning tool called 'Guide to Action.' We looked at 16 patient's records with specific falls risks and found that the falls risk assessment questionnaire and planning tool had not been completed in 10 of these 16 records. The trust had recently completed an audit of care records and identified that just over half of the patients that required a falls risk assessment had one. This meant staff were not best placed to understand and reduce risk for patients at risk of falls.

Managers had noticed that falls had increased on the wards and was completing a review of falls and how they were managed. They identified that the 'Guide to Action' tool was complex and did not include all the information required for staff to assess and manage the risk of falls. They planned to adopt the 'Avoiding Falls Level of Observation Assessment Tool' AFLOAT which had been developed by another NHS trust and had been shared as good practice by commissioners. This was due to be introduced along with other changes to practice, initially as a pilot on John Proctor ward. The aim was to increase learning from falls and improved assessment and risk reduction for patients in relation to falls. We saw all wards displayed the number of falls that had taken place in the month before our inspection and that falls had reduced.

Staff routinely carried out bed rails assessments and provided equipment to reduce falls, such as walking aids and bed rails. They positioned falls sensor mats near to patient risk areas, such as their chairs and beds and identified patients who were at high risk of falls. They made sure that patients who were at higher risks of falls were visible to staff and located staff in areas near these patients to ensure they were supervised.

Patients' bed boards provided key information for staff. The consent of the patient was sought regarding what staff included in information on boards where possible. Sensitive information was coded to maintain patient's privacy whilst making sure staff knew important information about patients that related to their care.

Staff knew about and dealt with specific risk issues. For example, records overall showed that staff identified risk and put measures in place to manage it effectively. For example, in relation to sepsis and pressure ulcers. They made sure specialised assessments were completed when required, such as speech and language therapy assessments to identify swallowing risks.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. Staff completed handovers throughout the day. Staff used these to share key patient information such as admission data, risk, progress, observation levels and discharge plans. We reviewed handover records which indicated that staff shared information effectively about patients.

Community health inpatient services

Staffing

The service did not always have enough nursing and support staff. Staff did not always keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Nurse staffing

The service did not always have enough staff. Most staff said they had enough staff to keep patients safe, but they said that the biggest impact of low staffing on the quality of care delivered. Staff consistently told us that staffing was a challenge.

Staff told us that there were system pressures and there was therefore sometimes pressure for them to take patients when they did not have enough staff. We reviewed an incident where a patient had fallen as there were not enough staff to observe them. This incident was being investigated by the trust. However, this appeared to be an isolated incident as we did not find evidence of similar incidents.

Fourteen staff told us staffing affected the quality of care they could give patients and some staff referred to personal care. After our inspection a senior leader spent time on the wards and spoke to both staff and patients about the impact of staffing to check patients were not missing out on personal care. The patients did not report any concerns about the level of personal care offered to them by staff and only one staff member raised concerns about this.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance, but staff were not always available. We saw that managers had reviewed patient dependency using the safer nursing care tool to review staffing.

Ward managers supported staffing when numbers were low but they said this had an impact on the time the needed to complete non-clinical duties.

The planned staffing for day shifts was for two or three registered nurses and five or six unregistered nurses (depending on patient occupancy.) At night the planned staffing was for two registered nurses as a minimum.

The ward manager could adjust staffing levels daily according to the needs of patients, if there were staff available. However, there were not always bank and agency staff available to work, despite managers working hard to plan and being supported by senior managers to do so.

The number of nurses and healthcare assistants did not always match the planned numbers. During our inspection there were staff shortages for unregistered nurses on all wards. For example, on Forest ward there was a shortage of two unregistered nurses and on Castle ward there was a shortage of three unregistered nurses. The service was working hard to recruit staff but the service experienced challenges with recruitment.

The service had reduced their registered nursing vacancies during the last year. In February 2022 before there were 5.5 full time equivalent nursing vacancies across the service. This meant vacancy rates were at 14%. The ward with the most nursing vacancies at 2.3 full time equivalent was John Proctor ward. The service had also reduced their non-registered nursing vacancies throughout the year. In February 2022 there was only 0.2 full time equivalent vacancies across all three wards. Castle ward had over recruited to these roles. By the time of our inspection these vacancies had increased, and this situation had changed. There were several vacancies that had been agreed for advertisement including at least seven full time equivalent registered nurses and 10 full time equivalent unregistered nurses to work across the wards.

The service monitored staffing and identified where staffing had fallen below planned levels. The trust looked carefully at clinical need and patient acuity. The trust reported that that staffing had not fallen below the minimum staffing level and that where staffing had fallen below planned numbers it had not been clinically unsafe or been at a suboptimal level on any of the three wards during the period 1st October 2021 to 31st March 2022. However, there were shifts where there had only been one nurse on duty and where the registered nurse to unregistered ratio was lower than the trust aimed for it to be.

The service was not able to provide data for each month regarding staff turnover, the data that the trust did provide could not be used for the purpose of this report.

The service had high levels of staff sickness which had an impact on staffing. Between 1st September 2021 and 28th February 2022, the average rate of staff sickness was 11%. Long-term sickness impacted on this.

The service relied on bank and agency nurses to staff the wards. Between the 1st October 2021 and 31st March 2022 temporary staffing constituted 32% of staffing.

Managers requested staff familiar with the service. Managers tried hard to use bank staff whenever they were able to. Staff that worked on the wards were normally familiar with the wards

Managers made sure all bank and agency and medical locum staff had a full induction and understood the service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers were currently reviewing the medical model to make improvements.

The service had enough medical staff to keep patients safe. The service contracted consultant geriatricians to work on each of the three wards on a sessional basis. These doctors acted as the named consultant for each patient and saw patients after admission. The consultants medically supervised and supported the medical registrar and locum senior house officers in their work with patients. Consultants were responsible for seeing all new patients and supporting care for patients with complex needs. All doctors were contracted to work for this service from another care provider. The trust had Advanced Clinical Practitioners on the wards, but at the time of our inspection there was only one in post, in the interim locum doctors covered for this.

Staff expressed some concerns about medical cover. They explained that not all consultant geriatricians attended their sessions as planned. The trust had completed a detailed review of its medical staffing model and had a plan in place going forward which included changes to current arrangements to ensure the needs of the ward were met effectively. Some staff told us they were disappointed that there was only one advanced care practitioner in post as they had found this role to be effective

The service did not always have a consultant on call during evenings and weekends and used the local out of hours GP service after 19.00 and before 9.00 between Monday and Friday and at the weekend. The consultant could be called in normal working hours.

Records

Staff kept records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, except for missing or incomplete falls risk assessment and care plans. Staff could access them easily.

Staff also told us that there should have been handheld devices available to use when entering physical health observations and results. However, these were still not available. This meant staff had to use computers off the main ward and meant this was less time efficient.

Records were stored securely; the care records were kept on an electronic system and this was password protected.

Medicines

The service used systems and processes to safely prescribe and administer medicines. However, we did find two omissions in the recording of medicines and medicines were not stored securely Forest ward at the time of our inspection.

Overall staff followed systems and processes to prescribe and administer medicines safely. They were supported and advised by the trust's pharmacy team.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. For example, at discharge nurses completed a form with patients to help them to understand their medicines and how to take them. We observed a medicine round where staff explained clearly about the medicines administered to patients on Forest ward.

We saw that staff had not recorded that they had administered a critical medicine on one occasion. We also saw staff had not recorded when a diabetic patient who self-administered insulin had taken their blood sugars or whether they had administered insulin. Staff could not be sure in both cases that the patients had taken or been administered critical medicine.

Staff stored and managed all medicines and prescribing documents safely within the clinic rooms. on Castle and John Proctor ward. However, there was a problem which meant that the Forest ward clinic room door did not always lock properly. We pointed this out to staff, and the trust rectified the issue after our inspection so that this was secure.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. There were systems in place to make sure this was completed. For example, pharmacists completed medicines reconciliation.

Staff learned from safety alerts and incidents to improve practice. Staff reported medicines errors and they recorded learning and subsequent changes following these. However, the wards audited controlled drugs only. There were plans for staff to complete medicines audits, but this was not in place at the time of our inspection.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. We did not see any evidence of inappropriate use of medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Community health inpatient services

All staff knew what incidents to report and how to report them. Staff reported a range of incidents Managers provided feedback about incidents. They raised concerns and reported incidents and near misses in line with trust policy.

The service had not had any never events on the wards.

Managers shared learning with their staff and across the trust. We saw information updates that had been made available to staff. There was a staff bulletin available with recent lessons learned clearly described.

Staff reported serious incidents clearly and in line with trust policy. Managers reviewed and ensured there was learning from any serious incidents.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We were given an example of when this had taken place.

Staff received feedback from investigation of incidents, both internal and external to the service. Ward managers fed back by email, at meetings and in supervision.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers gave us examples of where this had taken place

Managers debriefed and supported staff after any serious incident. Staff gave us an example of when this had taken place following an incident of patient self-harm.

Is the service effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

Staff provided care and treatment based on national guidance and best practice. They were able to tell us which National Institute for Health and Care Excellence (NICE) guidance they used and why they used it, for example for the prevention and management of pressure ulcers and guidance in relation to prescribing. The trust supported managers sharing updated guidance from NICE.

Staff used nationally recognised tools to assess and monitor risk and the functional ability of all patients admitted to the service, for example for malnutrition and wound management.

The wards had employed activity coordinators to ensure patients could access individual and group activities that were suitable for their individual needs. This included craft and reminiscence groups, exercise classes, sensory activities and karaoke and films.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff recorded patients' weight when they were admitted to the wards and weekly at review meetings. We observed that staff looked after patients' needs well.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The service used the Malnutrition Universal Screening Tool to identify and prevent malnutrition.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff were responsive to individual patients' need with respect to nutrition and hydration. They assessed patients when they were admitted, so they knew which patients required support and how much support they needed. Staff made sure that patients who needed assistance were provided with it. Staff ensured they placed drinks within the patient's reach.

Patients could access support from dietitians and speech and language therapists. We saw that patients had diets planned that suited their individual needs such as pureed food.

Staff gave us examples of how they met patient's individual cultural, religious and dietary needs, including Halal and gluten free diets.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain and gave pain relief in line with individual needs and best practice. Staff used a pain assessment tool and supported patients to help manage their pain.

Patients received pain relief soon after requesting it. Families and carers told us pain was well managed.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in the Royal College of Physicians National Falls and Fragility Fractures National Audit Programme.

Managers and staff used results of audits to improve patients' outcomes. There was a structured quality improvement plan for the service and there were many examples of learning taking place and changes being made to improve outcomes for patients. For example, changes in falls management, ceasing using abbreviations in clinical notes and an open offer to staff to be involved in reviewing National Institute of Care Excellence Guidance in relation to the service.

Staff used the Barthel Scale to assess patients' ability to complete activities of daily life and their readiness for discharge.

Managers and staff carried out a programme of repeated audits to check improvement over time. Several trust wide audits took place. For example, Forest and John Proctor ward had participated in a trust wide Infection Prevention and Control Environmental Audit. There were audits specific to the Community health services including documentation, wound assessments and mental capacity audits.

Managers used information from the audits to improve care and treatment, an example of this was increased support from the Mental Capacity Act legislation team following concerns raised in the Mental Capacity Act audit.

Managers shared and made sure staff understood information from audits and improvement was checked and monitored in the Lings bar quality improvement. This was a clear framework for ongoing improvement. Staff were kept up to date about the progress of this document.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance but not all staff received regular supervision and team meetings did not always take place regularly.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Many staff had worked on the wards for a number of years and were skilled in working with the patient group.

Managers gave all new staff a full induction tailored to their role before they started work. This included bank and agency staff.

Managers supported staff to develop through yearly, constructive appraisals of their work. The compliance rate for appraisals in February 2022 was 93% this was just below the trust target of 95%.

Staff told us they received both management and clinical supervision and we reviewed supervision records from Castle ward. A mix of one to one and group supervision took place and specific safeguarding supervision. We reviewed supervision data for both management and clinical supervision for six months between the 1st October and 31st March 2022. The trust aimed for supervision compliance to be at 80% or above, but the service did not always achieve this. Clinical supervision compliance was at 81% across the three wards although compliance was at 75% on Castle ward. We saw that management supervision compliance on Forest Ward was at 25% and on John Proctor ware was at 63%. This meant the average over the three wards was at 59%.

Medical staff received supervision from the provider they were employed by so that they developed through regular, constructive clinical supervision of their work.

The clinical educator and practice development nurse supported the leaning and development needs of staff.

Team meetings had not consistently taken place across the three wards. We could see that meetings had taken place on occasion, but that these meetings had not been consistently planned or recorded. This was a missed opportunity for staff to share information and learn.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers said that the COVID-19 pandemic had reduced the availability of face to face training, but there was specialist training available for staff specifically for their roles. For example, staff completed dementia training 78% of staff were compliant with this and staff had been booked onto training who had not yet completed this. There was external training facilitated by another care provider for training for intravenous cannulation and training in relation to patient's physical health.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers identified poor staff performance promptly and supported staff to improve.

Managers recruited, trained and supported volunteers to support patients in the service. There had been less volunteer involvement due to the COVID-19 pandemic, but the trust was now seeking to increase this again.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff worked with and made referrals to dieticians and speech and language therapists. They worked with therapy staff on the wards including occupational therapists, physiotherapists and activity coordinators. Staff worked with social workers and other professionals in the community to aid successful patient discharges.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. However, we were told that these meetings were not always attended by doctors who worked on the wards; the doctors carried out ward rounds and this information was share in the multidisciplinary meetings. These meetings were attended by nurses, occupational therapists, physiotherapists and admission and discharge facilitators. In addition, the Mental Capacity Act team members had been attending these meetings.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. There was information readily available for patients.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. The wards ensure that they supported patients to live healthier lives. Staff were trained to offer brief interventions to patients. Activity coordinators offered exercise classes and there were healthy living reviews. For example, staff supported patients with information and support about reducing or stopping alcohol consumption and smoking.

Community health inpatient services

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The service had made improvements since our last inspection, but there was further work to be done. Staff better supported patients to make informed decisions about their care and treatment. They had improved how they supported patients who lacked capacity to make their own decisions. However, the pace of improvement had been slow

Staff understood how to assess whether a patient had the capacity to make decisions about their care, staff could describe this to us when asked, however it was not clear in practice that staff understood capacity was decision specific.

Staff gained consent from patients for their care and treatment in line with legislation and guidance for their overall care and treatment. It was recorded in care records whether patients had consented to this. However, we did not see that consent had been sought for any specific decisions about specific aspects of care and treatment. We also noted on a ward handover document that patients' capacity was marked as a simple yes or no. This could be misleading as capacity is decision specific, meaning that patients may not have capacity to understand and consent to specific elements of their treatment or other specific decisions, but they may be able to consent to others.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. We saw that where patients lacked capacity, there had been best interest assessments that had considered their wishes.

Staff made sure patients consented to treatment based on all the information available. They clearly recorded consent in the patients' records.

Nursing and clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The overall compliance for Mental Capacity Act training was high at 96% and no ward fell below 94% compliance.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Deprivation of Liberty Safeguards were monitored and where there were delays in patients being assessed by the local authority the Mental Capacity Act Legislation team followed these up and monitored them.

The Mental Capacity Act Legislation team supported staff on the wards. The team spent time on the ward and staff knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. They had supported the wards with training and helped staff to understand better their responsibilities in relation to the Mental Capacity Act. The team were able to describe where improvements had been made and where further improvement was required.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. This was on the service's risk register and there had been a programme of quality improvement to improve the way staff applied the Mental Capacity Act. There were audits completed to assess whether the Mental Capacity Act was being implemented effectively. The last audit completed by the Trust of the service in November 2021 indicated there were inconsistencies in the way the Mental Capacity Act was applied and that there was no assurance that enough progress had been made. There was however a clear action plan and a new audit was due to be commenced after the inspection period.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. There were 15 patients subject to Deprivation of Liberty Safeguards across the three wards at the time of our inspection.

Community health inpatient services

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Overall staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We observed staff interacting with patients and families and saw staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We spoke to 12 family members, overall families told us that staff were responsive to patient's and respected their privacy and dignity.

Many of the staff that worked for the service had worked for the service for a number of years and were clearly passionate about their work and enjoyed their roles.

Patients said staff treated them well and with kindness. We spoke to three patients who were happy with the care they received and said staff were kind. Overall families who had been on the ward agreed with this and we completed two observations on Castle and John Proctor ward. We observed staff treated patients with kindness and were caring in their interactions with them.

Staff followed policy to keep patient care and treatment confidential. We observed that staff kept patients' information confidential when they were discussing patients and staff logged out of computers after use.

The wards had devices to measure sound levels so that staff could clearly see when activity was becoming too loud for patients.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff doing this in their interactions with patients.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff demonstrated a high level of empathy and dedication when we spoke to them and understood patient's individual needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff were able to provide us with examples of how they had met a patient's individual religious needs. There was information about the hospital chaplain displayed on the ward and staff could describe patients' different cultural needs and how they had met these.

Community health inpatient services

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. However, some families told us that they thought that communication from the wards could be improved.

Staff made sure patients and those close to them understood their care and treatment in most cases but not all. Feedback about this from families was mixed. Four families told us that communication with staff could be improved, as they did not all feel involved with the treatment of their family members.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff gave us examples of when they had used easy read symbols and there was evidence that the service ensured that patients were able to communicate in the way that they preferred.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service had introduced 'Feedback Fridays' where patients could feedback on their care and treatment, the service ensured they responded to patient's comments and sought the feedback of families. The trust used the care opinion survey for families. There was a quality improvement plan in place to increase feedback from families and patients as this had reduced due to the impact of the COVID-19 pandemic. Overall, the feedback that the trust had received form families and carers in the six months prior to our inspection was positive. In the patient survey all key areas had scored between 90% and 95%. The three patients that we spoke to provided us with positive feedback and each of them was happy with the care and treatment they received.

The trust had recent signed up to the Resuscitation Council (UK) ReSPECT process. ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) is an approach to encourage people to have an individual plan to try to ensure that they get the right care and treatment in an anticipated future emergency, where they may no longer have the capacity to make or express choices.

Is the service responsive?

Requires Improvement

Our rating of responsive went down. We rated it as requires improvement.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service had a clear referrals criterion for admission. The service did not take patients who were acutely physically unwell, patients had to be 'medically fit', staff understood the care pathways and discharge goals for patients. Managers planned and organised services, so they met the needs of the local population. They monitored the needs of the patient group so that they could adapt to the care they required.

Staff told us that there were system pressures and there was therefore sometimes pressure for them to take patients when they did not have enough staff. We reviewed an incident where a patient had fallen as there were not enough staff to observe them. This incident was being investigated by the trust. However, this appeared to be an isolated incident as we did not find evidence of similar incidents.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Male and female patients were nursed in gender specific bays or single rooms in line with Department of Health guidance on delivering mixed sex accommodation.

Facilities and premises were appropriate for the services being delivered.

The trust were able to support patients with a learning disability, mental ill health and dementia. There were staff with the right skills and expertise to do this. The service had recruited registered mental health nurses and a support worker to support patients who required support with their mental health. However, when there was an emergency staff said that they could not always easily access emergency mental health support 24 hours a day 7 days from within the trust. These concerns had been highlighted to senior leaders within the trust and staff were awaiting feedback.

The service had systems to help care for patients in need of additional support or specialist interventions. Where patients required a doctor out of hours, they used the local GP out of hours system for support. Staff told us that this service usually advised that the patient should go the local hospital for urgent care, however the out of hours GP did sometimes provide advice or see the patient face to face. The service had reviewed its medical model and in April 2022 there was to be an on-call doctor that was contracted by the trust in addition to the trust's current out of hours arrangements.

Meeting people's individual needs

The service aimed to be inclusive and to take account of patients' individual needs and preferences but needed to make further improvements. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Wards were designed to meet the needs of patients living with dementia. The service had completed an environmental audit in December 2021 to assess whether the wards were dementia friendly. They had reviewed the ward environments against the Kings Fund Guidance for Dementia Friendly Environments. Overall, the wards had scored 80% for compliance but the trust wanted to improve this further and had a quality improvement plan with specific areas for improvement. We saw that there were actions taking place. For example, the nursing stations had been removed and replaced with lower level desks. There was a clear timeframe embedded in the plan for completion.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss, the service was able to meet accessible communication standards. For example, the occupational therapists worked with patients and supported them with visual aids where they were required.

The service could produce information leaflets available in languages spoken by the patients and local community. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff gave examples of where this had been facilitated for patients.

Patients were given a choice of food and drink to meet their cultural and religious preferences and staff could describe when this had taken place.

The ward door was locked all the time, despite most patients not being subject to Deprivation of Liberty Safeguards. There was no information telling patients how they could leave the ward, the ward could not be exited without a door code which was not shared with patients. This was restrictive.

The wards did not use their dining rooms – they had either repurposed these spaces for staff to use or for families to visit. Staff explained that they did not use dining rooms due to COVID-19 restrictions for social distancing. However, this meant that patients had to eat in their bed space and the approach to dining was not rehabilitative and was restrictive.

Staff did not always support patients to make advanced and informed decisions about their care. For example, whilst we were on our inspection, we spoke to staff about the use of the reSPECT forms. The trust policy recommends the use of reSPECT forms but, accepts that Do Not Attend Cardiopulmonary resuscitation forms (DNACPR) may still be in place for some patients. Staff told us that doctors preferred not to use the reSPECT form and instead continued to use DNACPR forms. When we reviewed an audit that we asked the trust to complete we found that 58% of patients had neither a DNACPR or reSPECT form in place and that only 10% had a reSPECT form in place. This was not in line with trust policy and staff told us that they thought that there were missed opportunities therefore to support patients to make advanced decisions in line with their wishes.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Managers monitored the time it took between referral, acceptance of referral and admission. The service accepted referrals promptly and made sure patients could access services when needed and received treatment within agreed timeframes.

Managers and staff worked to make sure patients did not stay longer than they needed to. Patients were regularly reviewed in preparation for discharge.

The service moved patients only when there was a clear medical reason or in their best interest. Staff did not move patients between wards at night.

The service moved patients only when there was a clear medical reason or in their best interest and they monitored when this happened.

Staff did not move patients between wards at night.

Managers and staff started planning each patient's discharge as early as possible. Patients' discharge planning was started as soon as they were admitted to the ward.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Some staff said that capacity for occupational therapy was an issue and if an occupational therapist was not available this could slow down discharge. However, trust data for delayed discharges indicated that where discharges were delayed this usually related to the availability of resources in the community. The wards each had information about the length of stay for patients on their ward. The aim was for patients to be on the ward for no

more than 28 days. There were cases where patients discharge took longer but this was monitored by managers and staff were proactive in managing discharges effectively. At the time of our inspection the average length of stay was longer than 28 days, but this was because there were specific patients who had been waiting for community support before they could be discharged.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Not all relatives and carers knew how to complain or raise concerns. Five of the 12 families we spoke to told us they were not clear about how to complain, but overall, they felt confident that they could speak to staff about concerns if they needed to.

The service clearly displayed information about how to raise a concern in the ward area. This was displayed on ward notice boards.

Staff understood the policy on complaints and knew how to handle them. Staff understood how to manage a complaint and managers talked to us about how they handled complaints. There was evidence that staff sought to find local resolutions for complaints where this was appropriate.

Managers investigated complaints and identified themes, however there had been a low number of complaints made about the service. In the last three months there had been one complaint made, which had been investigated. Over the last 12 months there had been five complaints received, two of these had been resolved locally. Detailed investigations had taken place when required.

Staff knew how to acknowledge complaints and patients received feedback from managers after investigation of their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. These were discussed in team meetings and in supervision.

The service received regular compliments, and there were many displayed on the wards.

The wards demonstrated they responded to feedback to improve daily practice and patient experience on the 'you said, we did' boards displayed in the wards. For example, changes had been made to improve the menu.

Is the service well-led?

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

Community health inpatient services

WELL-LED

Leaders had the skills and abilities to run the service. They understood and the priorities and issues the service faced but had not managed to make all required changes needed. Governance systems were not robust to ensure positive sustained changes had been implemented.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. Leaders were experienced and qualified for their roles.

Leaders had a good understanding of the services they managed. They could explain how the teams were working to provide high quality care. Leaders were working to improve the service. The three wards had been identified as an area that required improvement. The improvement programme had been in place for 18 months and senior leaders told us that this was 80% complete, this meant that there were areas where the service still had improvements to make.

Leaders were visible in the service and approachable for patients and staff. Overall staff fed back that leaders spent time on the wards and were available for staff and patients. A minority of staff said they would like to see senior leaders on the ward. All teams felt supported by ward managers.

Leadership development opportunities were available, including opportunities for staff below team manager level. For example, there were nurse associate roles and training opportunities for unregistered nurses to develop.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The values of the provider were embedded into staff appraisals and managers described how staff embodied the trust values in their work.

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. Staff understood the values of the organisation.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. There was a quality improvement programme for the service and staff contributed to this. Staff told they were listened to.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. However, staffing pressures continued to be an issue for staff.

Overall staff told us they felt respected, supported and valued. The 2021 staff survey for this core service highlighted that staff were not happy with several areas of their working life. A significant part of their concerns related to work being tiring and feeling burnt out. They did not always feel recognised for the work they did and did not feel that their time pressures were realistic. Only 16% of staff thought there was enough staff for them to do their job. At our inspection staff continued to identify staffing as an issue.

Staff felt positive and proud about working for the provider and their team. They were passionate about the work they did with patients.

Staff felt able to raise concerns without fear of retribution. Overall staff said they could speak up and be open.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. Staff knew who the guardian was and how they could contact them. There was information throughout the wards about the role and how to contact them.

Managers dealt with poor staff performance when needed and we heard examples of how staff managed specific issues.

Teams worked well together and where there were difficulties managers dealt with them appropriately. Many staff told us they had worked for the service for several years and that they valued the people they worked with highly.

Staff appraisals included conversations about career development and how it could be supported.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. There were staff networks, forums and steering groups for staff.

The service's staff sickness and absence were high, this was linked to long term sickness.

Staff had access to support for their own physical and emotional health needs through an occupational health service, staffing health and wellbeing service and a staff counselling service.

The provider recognised staff success within the service – for example, through staff awards. There were many examples of staff who had been put forward for the Recognition of Outstanding Care Courage, compassion, commitment, competence and communication awards.

Governance

Leaders did not operate fully effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Although they have not been able to make the improvements in a timely way.

Staff told us that there had been a lot of improvements required in the service. Mangers and staff had worked hard to make these. There had already been 35 actions completed in the quality improvement plan. However, there were still 16 actions that were incomplete six overdue.

Governance structures were not robust, and this meant that there were gaps in training and supervision. There were missed opportunities to come together and meet to learn and share information as ward team meetings did not take place regularly and this was a missed opportunity for sharing important information that came from senior leaders' meetings that took place in the division and there was no meeting frame work to ensure the important things were discussed that came from the governance meetings that took place in the division.

Since our last inspection in 2017 it was clear that the trust had made improvements in several areas and the majority of the issues identified at this inspection had been resolved. However, there were still areas that we identified over four years ago that had not been rectified, where governance had been lacking. The trust had not made sufficient progress in respect of how they implemented the Mental Capacity Act and neither had they ensured that their medical staff followed trust policy and used the reSPECT form when discussing advanced decisions with patients.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.

Staff undertook or participated in local clinical audits. The audits provided assurance. However, there was an absence of audits of medicines, apart from controlled drugs.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Management of risk, issues and performance

Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required. Staff concerns matched those on the risk register.

The service had plans for emergencies – there were contingency plans for adverse weather or and infectious diseases.

Information management

The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required. However, staff did not always have access to equipment and information technology they required.

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.

Staff did not always have the access to the equipment and information technology needed to do their work. For example, staff did not have access to handheld devices that were meant to be in place for them to enter patients' health observations whilst they were on the wards. There was no system on the three wards for staff to open the door unless they walked to the door to open it, this was time consuming for staff.

Information governance systems included confidentiality of patient records.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Information was in an accessible format, and was timely, accurate and identified areas for improvement. The Quality improvement plan for the service was clear and progress was regularly communicated with staff.

Staff made notifications to external bodies as needed. For example, staff communicated with the local authority safeguarding teams.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used – for example, through the intranet, bulletins, newsletters and so on. There were update bulletins for staff and information across the wards about improvements and progress in the service.

Community health inpatient services

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The service was trying hard to increase the feedback it received from patients and families. There were initiatives such as feedback Friday to encourage feedback from patients about their experience of the service. There were patient and carer surveys and they could also feedback through care opinion.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. We saw a range of feedback and comments from families. The trust actively sought information to help them improve.

Directorate leaders engaged with external stakeholders – such as commissioners and Healthwatch.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. Staff had been involved in quality work about what a good ward environment looks like and in the innovation of a checklist to improve the culture on the wards as part of the 'what does good look like' focus.

Staff used quality improvement methods and knew how to apply them; some staff had been given the opportunity to complete quality improvement training. The trust had a

Staff participated in national audits relevant to the service and learned from them.

Community health services for adults

Good

Is the service safe?

Good

We rated it as good.

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Most staff had received and were up to date with their mandatory training. Across the services visited, compliance rates per month varied between 77% and 100%. Staff from four teams (Larwood and Bawry; Urgent response and hospital at home; Rushcliffe and Dietetics) had consistently ensured training compliance of staff was above 94%. The Newark team had compliance rates between 77% and 100%. Only 68% of staff within this team had completed and were up to date with mandatory fire training.

The mandatory training was comprehensive and met the needs of patients and staff. Examples of mandatory training included the safeguarding of adults and children; basic life support; infection prevention and control and manual handling.

Managers held staff training data electronically and informed staff when training was due. Staff told us that they had time to undertake their training during working hours and did not have to complete in their own time.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. All clinical staff received level three training in line with national guidance. Staff compliance for this training across the teams varied between 81% and 100%.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff identified and assessed the need for providing early help for different vulnerable groups, to include those with learning disabilities, mental health issues, female genital mutilation and individuals with mobility issues.

Staff knew the trust had a safeguarding team they could contact for advice if required. Staff from across the teams visited had made safeguarding referrals to the Local Authority where this had been necessary. During one patient visit, the staff member made a referral to the Local Authority directly after the appointment. Staff were confident with escalating concerns to minimise the risk of harm.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Most staff were up to date with training on equality and diversity.

Cleanliness, infection control and hygiene

Community health services for adults

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and their work areas visibly clean.

Team offices were suitably furnished, clean and well-maintained. Staff cleaned all areas regularly. Staff cleaned equipment such as thermometers after each patient contact. At locations where equipment was stored, staff had labelled to show when it was last cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE) and regular hand washing. The teams had not had any instances where they reported infection prevention and control to be an issue. The trust had required all PPE in line with national guidance throughout the Covid-19 pandemic.

Staff were adhering to national guidance with regards to COVID-19 infection prevention and control precautions. Staff adhered to local protocols when providing care and treatment in patient's homes, to ensure all appropriate PPE was available, worn and safely disposed of.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. When providing care in patients' homes staff took precautions and actions to protect themselves and patients.

Teams had a process in place to ensure that any equipment provided to patients was safe and in full working order. Staff carried out regular visual checks of specialist equipment and ensured that all necessary equipment was checked through a contractor on an annual basis to ensure all equipment was fit for purpose.

All staff had received and were up to date with manual handling training to ensure that care and treatment provided in a patient's home was safe. The trust worked with a local charity to ensure that appropriate equipment was provided, such as mobility aids, in a timely way.

The trust cascaded any device alerts to all the community teams who ensured these were discussed during team meetings. Team leaders also received these electronically, who in turn communicated these to the wider teams. Any required actions were recorded within each clinical area.

The service had adequate space within clinics offered to meet the needs of patients' families or accompanying carers. Clinics were easily accessible for those who may have mobility difficulties.

The service had enough suitable equipment to help them to safely care for patients. As and when additional equipment was needed for patients, staff could order this through a charitable organisation and get this delivered quickly.

Staff disposed of clinical waste safely, in line with trust policy.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff recorded all clinical observations, such as temperature; pulse; blood pressure and oxygen levels within patient's records.

The service had clinical staff who could undertake medical assessments which needed completed urgently such as the taking of bloods and an electrocardiogram (ECG). Senior clinical staff could access the results of tests in a timely way. Staff maintained communications with each patient consultant or GP to discuss any deterioration or concerns as they became evident to ensure patients received the correct care in a timely way.

Staff completed a risk assessment for each patient using a trust tool. We reviewed 20 patient records and found that staff had completed, regularly reviewed and updated these. Staff put flagged alerts onto the system so that these were highlighted to staff accessing records.

Staff knew about and dealt with any specific risk issues, such as pressure ulcers or risks of falls. Staff used nationally recognised tools to assess specific risk areas.

Staff shared key information to keep patients safe when handing over their care between internal staff, and to other healthcare agencies.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and locum staff a full induction.

The service had enough staff to keep patients safe. The number of staff on duty matched the planned numbers by using bank and agency staff. Managers accurately calculated and reviewed the number and grades of staff needed for each shift, dependent upon the number of visits or appointments required. Staff were flexible with their visits and would regularly help each other to ensure the patients received the care needed.

Managers and team leaders across the service had been looking into a safe staffing standard operating procedure, which incorporated travel and visit time. This was a work in progress and had been ongoing since January 2022. The service strived to provide a benchmark for staffing rota's and provide staff with an escalation route should minimum staffing levels not be met.

The service had low vacancy rates. At the time of inspection, we noted there was one post in dietetics; one in the Rushcliffe team; three in the Sherwood team, and one at the urgent response team.

The service had lower than average staff turnover rates. The Rushcliffe team had a higher than average turnover rate in August 2021 and in February 2022 (5.9%). Some staff had left the service to take up new opportunities. Aside from this, staff teams across this service had remained stable.

The service had high sickness rates across five of the six teams inspected. Sickness levels over the last 12 months at the dietetics services had remained at 0%, below the national average of 4.6%. The remaining teams had a higher than average sickness rate. Month on month this varied between 0% and 22%. Teams affected most by sickness had been Sherwood and Newark integrated care teams. COVID-19 and staff isolating in line with national guidance had contributed to this.

The only teams who required the use of agency staff were the Newark and Sherwood integrated care teams. Between April 2021 and March 2022, these services used agency staff to cover 255 shifts. This was to cover sickness, training, leave and other absences.

Across the service, some regular staff chose to work additional shifts to help cover. The service used regular bank staff across the teams to cover any gaps in staffing. Between April 2021 and March 2022, the teams had used bank staff to cover 283 shifts. Team managers made sure all bank staff had received a full induction and understood the service.

Medical staffing

The teams worked closely with acute hospital consultants and GP's to determine what treatments and interventions are required from each patient. Staff could contact a consultant for advice as and when required, along with the patient's GP, who attended monthly multi-disciplinary meetings.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Most records were held electronically. Some staff had a laptop so that they could record information as they visited. Some patients had some paper records in their homes, related to medicines or communication for carers. Staff updated these as necessary during individual visits, as well as recording electronically.

All 20 care records we reviewed were up to date and gave a clear chronology of interventions provided by staff.

When patients transferred between teams, there were generally no delays in staff accessing their records. Local general hospitals used a different electronic notes system. However, staff had not found this to be problematic. Most patients had consented to share medical information and so the hospitals usually communicated with the teams to ensure a safe handover of care.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Due to the nature of the services visited, staff were more likely to administer medicines as opposed to prescribe. Staff followed trust systems and processes to prescribe and administer medicines safely as and when required.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Visiting staff enquired with patients how they were getting on with prescribed treatment and asked if they had encountered any problems.

Staff completed medicines records accurately and kept them up to date where applicable. Many patients held blister packs of medicines which staff checked against the prescription when they were administering to the patient in their own home.

Staff stored and managed prescribing documents in line with the provider's policy and national guidance. The service had systems to ensure staff knew about safety alerts and incidents. The service had five medical prescribers at the time of inspection.

Community health services for adults

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff we spoke with were able to give examples of incidents which they would be required to report and were familiar with the electronic reporting system. Staff raised concerns and reported incidents in line with trust policy.

Team leaders analysed all incidents regularly to review any themes and identify areas of risk. Staff met to discuss the feedback and looked for areas for improvement. The most common themes of incidents recorded across the integrated care teams related to new or existing pressure ulcers and deaths.

The service had not reported any serious incident or never events over the last twelve months. The trust had a policy in place which clearly identified what staff should do if such incidents occurred. Staff were aware of this policy. There were processes in place to support staff following any serious incidents, which included a de-brief and additional support if needed.

Managers shared learning with their staff about never events that happened elsewhere during meetings. Staff received feedback from investigation of incidents, both internal and external to the service. The trust had a monthly 'learning the lessons and sharing good practice' bulletin. Staff met to discuss the feedback and look at improvements to patient care during monthly local governance team meetings.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. All staff undertook duty of candour training as part of their induction.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations where appropriate.

Is the service effective?

Requires Improvement 

We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

Staff provided a range of care and treatments suitable for the patients in the service. Staff delivered care in line with best practice and national guidance, such as the National Institute for Health and Care Excellence (NICE).

Teams participated in local and national audits to review quality and patient outcomes. Locally, staff were undertaking numerous audits such as wound assessment; environmental audits; pharmacy; Venous thromboembolism (VTE) and Infection Prevention and control.

Staff used technology to support patients. Two nursing teams had been using an electronic referrals system with care homes. This system also enabled photographs to be taken of patient's wounds or skin damage for the teams for review. The receiving team then reviewed the photographs and assessed if advice could be given over the telephone, or if a visit to the patient was required. Staff reported that this had been working well and there were plans to trial across other areas.

Staff had ordered some new doppler probes in the Newark integrated care team, in line with best practice recommendations.

Nutrition and hydration

Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery. They worked with other agencies to support patients who could not cook or feed themselves.

During home visits, staff asked patients if they had enough to eat and drink, including those with specialist nutrition and hydration needs. Some staff working within rapid response and hospital at home teams facilitated care visits for a short period of time while an appropriate care package was being set up with the local authority. Some staff assisted patients with light meal preparation where needed. Staff recorded patients' fluid and nutrition intake where appropriate.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition, which they reviewed regularly.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Team members communicated with other healthcare professionals when necessary to discuss pain relief and effectiveness. For example, the patients GP, or palliative specialist teams. Where appropriate, staff administered and recorded pain relief accurately. An out of hours service enabled palliative patients experiencing pain to call, where staff were able to facilitate an urgent visit.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. Relevant teams were involved in some national audits to include areas of stroke, asthma, Chronic Obstructive Pulmonary Disease and Parkinson's disease.

Managers used information from the local audits to improve care and treatment. In one rapid response team, after an audit of the number of calls received, staff identified that an additional staff member was required in the afternoons to ensure all calls could be actioned. This resulted in a further staff member being available in the afternoons, to meet patient needs.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time, which the teams adhered too. Results of audits were discussed within the local governance team meetings which were held monthly. For staff who could not attend, a written report was produced and left available for staff to read.

Competent staff

The service had practises in place to ensure staff were competent for their roles. Managers appraised staff's work performance regularly, which provided support and development opportunities.

Most staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Many staff had a wealth of experience from working in different areas of specialisms, such as palliative care, practice teachers or district nurses.

Managers gave all new staff a full induction tailored to their role before they started work. This consisted of a trust induction, followed by a local induction. The local induction offered staff the opportunities to shadow other staff as part of getting to know the service in which they would work.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. All staff received an annual constructive appraisal of their work.

Managers told us they supported staff to develop through regular clinical supervision of their work. Compliance rates for clinical supervision were variable across the teams visited.

The Urgent community response and hospital at home team demonstrated how they undertook clinical supervision. The team leader scheduled this and prepared for each session in advance. Case studies could be included for discussion, as well as incidents which had occurred which staff could learn from. Sessions were well attended by staff, well received and recorded. Compliance within this team was 100%.

Many staff we interviewed across the care teams referred to a handover as being clinical supervision. Several staff we spoke with told us that clinical supervision was not being recorded.

Whilst managers ensured that staff had access to clinical supervision on a monthly basis the supervision offered was not line with the trusts policy. Staff told us that they recorded handover and multidisciplinary meetings as supervision. In addition, staff did not meet the compliance rates for clinical supervision. From April 2021 to March 2022 the average compliance rate for all teams was 85%. In the same year there were six times that the compliance rates fell below 50% within the Newark Integrated Care Team and the Sherwood Integrated Care Team.

The clinical educators across the service supported the learning and development needs of staff. For example, within the dietetics team, staff had implemented an E-learning module for diabetes for the trust. Staff put regular newsletters together and circulated to GP surgeries. Clinical educators had developed information leaflets, posters and videos which were available to care homes.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The rapid response and hospital at home team had set up a forum online for the cascading of relevant information to all staff. Staff said that this had worked well and they checked regularly for information they may have missed.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We were aware of ample opportunities for staff. We heard of several staff who had started as a band 2 health care assistant, had worked up to band 4, and then had gone on to qualify as a nurse (band 5). The trust had supported some nurses to complete their district nurse training. One staff member was being supported to undertake a master's degree. Other nurses were going to undertake the nurse prescribers' course.

Managers made sure staff received any specialist training for their role. We saw numerous different nursing clinical competencies staff were assessed on. These included suture and clip removal; packing a wound; toe to knee bandaging; tissue viability; continence management and end of life care.

Whilst managers had systems in place to identify poor staff performance this was not effective as it could be. For example, during a leg ulcer clinic, we observed a nurse undertake an assessment of a patient but did not follow best practice in doing so. The patient should have been lying in a flat position and was not. A piece of equipment (cuff) was placed in the wrong position on the patient's leg. This could have potentially given an inaccurate diagnosis, which could have resulted in incorrect treatment. On this occasion it did not.

We spoke with the nurses who were in the clinic who had admitted they had not been regularly running these. Both nurses identified that the actions were incorrect but could not explain why the assessment had been undertaken in that way. Both nurses confirmed that they had undertaken the correct competencies relating to this clinic. However, when asked about the difference between different bandages used for compression, it was clear that there were gaps in knowledge.

We fed this back to the service manager at the time of inspection who was not aware of this issue. However, when they were made aware of this issue and others they had identifies for themselves they to action, which included had found issues with staff holding regular support meetings; looking at flexible ways of working; training, accessing counselling, or a referral to the trust health and wellbeing team.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Teams held monthly MDT meetings which were well attended by a variety of healthcare professionals such as GP's, tissue viability nurses; staff from the palliative care team, social worker, local authority, clinical commissioning group and other professionals as relevant. Staff discussed the holistic needs of each patient.

Each team visited had comprehensive handovers between shifts. Some staff attended these within the office, while others attended virtually. Attendance was very good. Every staff member contributed, gave an update of where they had been and interventions undertaken, as well as discussing any concerns which had arisen. This enabled the whole team to problem solve and work together to ensure each patient got what they needed.

Staff knew they could refer patients for mental health assessments when they showed signs of mental ill health. We saw that one team had made a referral to a local drug and alcohol support service for one patient, who had begun working with the patient. Staff were also aware of the local improving access to psychology services (IAPT), which they could signpost patient to.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant written information promoting healthy lifestyles and support in offices and in clinics provided.

Staff assessed each patient's health holistically when admitted to the service and provided support for any individual needs to live a healthier lifestyle. For example, one nurse who was dressing a wound spoke to the patient about how eating a healthy diet could aid healing. Another staff member offered dietary advice to a patient who was diabetic.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. All staff upon induction received appropriate training about the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLs). This included the five key principles of the Act.

Staff we spoke with explained the importance of gaining patient consent prior to any treatment or interventions given. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Upon admission to the service, patients consented to care and treatment. Visiting staff always explained the purpose of their visits and ensured the patients agreed to any interventions before proceeding.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. During a visit to a patient, the nurse explained that the team had recommended the patient use a specialist mattress to reduce the risk of further skin damage. The patient had declined this. We saw that a capacity assessment had been undertaken. The patient had been assessed as having the capacity to make this particular decision. Staff felt that this was an unwise decision but respected this.

Staff could describe and knew how to access the trusts policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. When patients could not give consent, staff made decisions in their best interests, taking into account patients' wishes, culture and traditions.

Is the service caring?

Outstanding ☆ ↑

We rated it as outstanding.

Community health services for adults

Compassionate care

Staff truly respected and valued patients as individuals and empowered them to be partners in their care, practically and emotionally. Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs

There is a strong, visible person-centred culture. We observed, during home visits that staff were highly motivated and inspired to offer care that is kind and promotes people's dignity Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Throughout the inspection the feedback from people who use the service, those who are close to them was continually positive about the way staff treat people. Patients told us that they did not feel hurried in any way. Staff extended visits if additional support was identified, even if this meant that further planned visits that day may have been delayed for a short time.

All 13 patients and three carers we spoke with talked about staff in a positive way and had lots of praise for them. All patients and carers told us that staff always treated them with kindness and respect. We observed staff providing care in patients homes in a way which ensured their privacy and dignity was maintained as much as was practically possible during care and treatment.

Staff recognised and respected the totality of people's needs. They always take people's personal, cultural, social and religious needs into account, and find innovative ways to meet them. Several staff in one team talked to us about one patient who would not always adhere to prescribed medicines or follow dietary recommendations. Staff recognised that social factors and regular consumption of alcohol was having an impact. Although this had been difficult for staff to manage on occasions, staff continued to speak respectfully about the patient and continued to look for ways to help them.

Staff understood people's emotional and social needs are seen as being as important as their physical needs and were fully committed to working in partnership with people. Staff showed determination and creativity to overcome obstacles to delivering care to one patient who was receiving end of life care in hospital said that they wanted to be discharged home to spend their final days in familiar surroundings. The hospital at home team felt concerned that this patient would be spending lots of time alone. The patient had no partner or children. Medical records had no next of kin. One of the staff members spent his own time going through various notes to see if they could locate a friend or relative who may have been able to spend some time with the patient. Although it took some time and effort, staff identified and located a relative, who provided care and company for the patient at the end of their life. Staff felt genuinely pleased that they had achieved this for the patient.

A patient recalled a time when staff went 'the extra mile' for them to provid care and support. They explained that on one occasion, the weather was poor, it had been snowing. The patient lived in a rural location. The roads were dangerous, and some villagers had been snowed in. The patient recalled that despite this, a staff member from the Newark integrated care team walked through the village in a warm coat and wellington boots to ensure that the patient was visited. The patient had not expected them to do this and stated "they didn't have too".

All staff consistently followed the trust policy to keep patient care and treatment confidential. Patient details were maintained on a secure electronic system.

Community health services for adults

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

We saw from assessments that staff considered the patient's family dynamics and used a person-centred approach to providing care. Staff understood that some illnesses and treatments could emotionally affect a patient's wellbeing and those close to them.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff consistently gave patients time during visits for the patient to express how they were, and to voice any specific concerns. All patients and carers we spoke with told us the staff were supportive and talked to them about many aspects of their life and not just the treatments they were receiving or their illness.

During one visit, we observed staff talking to a patient who felt lonely. The staff member promised to have a look online later in the day to see if they could find any local clubs or groups the patient might like to attend. The patient said that they would appreciate this and would consider attending something nearby. The staff member was going to do this after their shift when they got home.

One patient we spoke with told us that the staff helped them emotionally and spoke of the integrated care teams very positively.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. With the patients' consent, staff explained care and treatment to carers as well as patients. Staff provided relevant written information where appropriate and signposted patients to relevant organisations, such as charities who offered support, day centres and meal services.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families and carers could give feedback on the service and their treatment and staff supported them to do this. The trust had two different leaflets which the teams handed out to patients and carers. One was titled "how was your care?". It was straightforward to complete, with six questions, answers ranged from very good to I don't know". There was space for comments on what was good and what could have been better. It could then be sealed and posted free of charge.

The second leaflet gave information on how to complain, time scales; advocacy support available and how to do this (via telephone, in writing or online). It also gave the contact details of the Parliamentary and Health Service Ombudsman (PHSO).

Community health services for adults

Is the service responsive?

Good

Our rating of responsive had improved. We rated it as good.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The Urgent community response team had been funded to assist with the Avian flu in 2022 and had also been supporting an oxygen monitoring service (remote) for patients who had COVID-19.

Facilities and premises were appropriate for appointments offered to patients, had appropriate signage and were accessible.

The service had systems to help care for patients in need of additional support or specialist intervention. Senior staff met regularly to discuss patients who had complex needs.

Managers monitored and took action to minimise missed appointments. While the service had cancelled appointments on occasions, patients were offered an appointment the next day where possible. There were no patients awaiting appointments, all had been scheduled. Managers ensured that patients who did not attend clinic appointments were contacted.

The service relieved pressure on other departments when they could treat patients in a day. We heard of numerous examples when staff from the rapid response and hospital at home teams had taken urgent referrals from local palliative care teams or the ambulance service when they did not have capacity to visit. If this service had not been available, it is likely that further patients would go to the local hospital for assessment and treatment.

Wherever possible, staff would plan visits at the patients preferred time of day, being morning or afternoon.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents. Briefly, this informs the reader what it is the patient likes and dislikes, can aid communication and explain some behaviours.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff were able to retrieve various communication aids through speech and language therapy to aid communication with patients.

The service could source information leaflets in languages other than English spoken by the patients and local community. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. All staff carried mobile telephones. If a situation unexpectantly arose which required some translation, staff explained they would access translation websites if required through their phones.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets where possible.

The service had a target of assessing and treating new patients within 13 weeks. The dietetics team and met this target every month from April 2021 to March 2022.

The urgent care team had two targets to meet. The first target was for staff to have contact with patients within two hours, the team had 1077 patients who required this and this was met for 917 patients. The second was for staff to see patients within two days, the team had 962 patients who required this service and staff met this target for 903 patients.

For the other teams across this service they only 3 patients had not been seen with the target of 13 weeks. Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets where possible.

Teams who had specific targets to meet included the dietetics service and the rapid response teams.

Within the dietetics team, all four practice educators previously moved and worked to provide COVID-19 vaccines for children and young people. Because of this, the waiting lists for dietetics appointments had increased. The practice educators at the time of inspection had returned and were working their way through the waiting lists. As of 30 April 2022, there were a total of 109 patient on their waiting list. No patients had been waiting beyond the target of 13 weeks.

Similarly, due to staff responding to COVID-19 help, the diabetic group held an increased waiting list. At the time of inspection this was around 412 patients. The team were working hard to bring this down to acceptable levels.

Managers and staff across the rapid response and hospital at home teams worked to make sure patients did not stay on caseloads longer than they needed to. Typically, those patients who had been referred in for urgent help, were discharged as soon as the patient was safe. This was usually within a 72-hour period. The hospital at home teams held patients on their caseloads typically between one week and two.

The integrated care teams did not have any waiting lists. The number of patient's staff seen per day depended upon the complexity of visits. Staff confirmed that they would make anything between eight and fourteen visits per day.

Caseloads between the community nursing teams varied from between 119 and 160 patients. Staff felt that caseloads were manageable and felt confident they met patient's needs.

Managers worked to keep the number of postponed or cancelled appointments to a minimum. When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible. Of the 13 patients we spoke with, only one had experienced a cancelled visit. The staff had contacted them to advise the patient would be visited the next day.

Staff supported patients when they were referred or transferred between services. Staff ensured that all patient information was up to date so that the receiving healthcare provider had all relevant information available.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Across the services visited, in the last 12 months, there had been only nine complaints. Most were themed around care and treatment. Each team received far more compliments via cards and letters than complaints.

Staff could give examples of how they used patient feedback to improve daily practice. One example staff gave was around communication. Following an investigation, additional communication documents were introduced into some patient homes, in the hope to prevent any future lapses in communications between staff and carers.

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with said they would speak to the staff or call the office. The service clearly displayed information about how to raise a concern in patient areas. Leaflets on how to make a complaint were given to patients and carers.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints, monitored for themes and fed back to staff during the local monthly governance meetings.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We viewed two complaint responses which demonstrated this.

Is the service well-led?

Good 

We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

There was compassionate, inclusive and effective leadership within the service. Leaders had the skills knowledge and experience to consistently deliver high quality personalised care. Leadership development was embedded into the service and there was a strong culture of staff development across all levels of the service.

Leaders had a clear in-depth knowledge of the priorities, risks and challenges within the service and used this to continuously develop and improve service delivery. Challenges and risks staff relayed to us were present on the trust risk registers.

Community health services for adults

It was clear that staff wanted the best possible care and outcomes for patients. Staff spoke passionately about their roles and the satisfaction it gave them.

The leadership teams met regularly to review compliance, quality, governance and areas of risk and how to reduce and manage these.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against future plans and strategy.

There were clear shared goals that were known to staff. Senior staff attended regular meetings where the ongoing performance of the teams and future aspirations were discussed. Leaders we met were energetic, forward thinking and happy in their roles.

Staff knew and understood the provider's vision and values and how they were applied to their work. All staff we spoke with truly wanted to make a difference and believed in the trust's values. These were around trust; honesty; respect; compassion and teamwork. Senior staff considered these to be important and expected to see such values in action across the workforce. Some staff told us of their saying "in it together".

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff that we spoke with were very proud of the service and spoke highly of colleagues and managers at all levels. Teams were collaborative and cohesive and shared a vision and determination to deliver consistently high-quality care. There was a strong organisational commitment and effective systems and processes in place to ensure that equality and inclusion underpinned the service.

There were no cases of bullying or harassment reported within the service. Staff we spoke with said they could raise concerns without the fear of repercussions. The trust had a whistle blowing policy which staff could access. Managers covered whistle blowing during staff induction to the service. The trust had freedom to speak up champions across the trust. Staff were aware of how to contact them if needed. The trust encouraged staff to speak up and were striving for a culture where raising concerns is "the norm".

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Senior staff routinely reviewed the quality of the service through various meetings which staff recorded. Senior staff cascaded required actions and learning to relevant staff and teams through team meetings; emails; bulletins and through supervision.

The service used key performance indicators to drive performance, as well as keeping relevant stakeholders informed of progress. Teams used technology to help capture data, for example the number of calls received in the rapid response teams. This enabled data to be collated and reviewed in a prompt way.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The trust had effective governance systems and processes in place to manage current and future performance of services. Where challenges arose, leaders dealt with them quickly and effectively. The trust had policies and procedures in place in the event of unexpected events.

The service had a risk register that staff could submit items to, through their line manager or the senior management team. There were no examples where financial pressures compromised care. Staff were aware of the risk registers and the areas of risks within their teams.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Collated data was available to relevant staff electronically. This enabled regular monitoring of team performance, to include staffing; sickness; training; appraisals and number and themes of incidents. Team leaders could discuss current, ongoing and future risks with more senior staff, as well as discuss ideas around further improvements to enhance patient care. There was a demonstrated commitment to sharing data and information proactively to drive and support internal decision making as well as system-wide working and improvement.

In the rapid response team, staff had used collected data to demonstrate that an additional triage staff member was required in the afternoons. With the additional staff member taking calls, this ensured that all calls could be answered as expected. The staff team were pleased that this had been recognised and acted upon.

Staff submitted required data or notifications to external organisations as and when required, for example to the Care Quality Commission.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff felt that they could give feedback leading to service development. Staff we spoke with said that senior management was always open to listening to suggestions on how to improve the service provided.

The Chief Executive Officer communicated regularly with all staff through electronic bulletins. At the outset of COVID-19, these communications had been daily, which staff had appreciated. At the time of inspection, these were circulated weekly.

Staff we spoke with knew who the senior leadership team were and what roles they had within the trust. One staff member told us that they had requested to observe certain senior leadership management meetings, which had been welcomed.

Teams worked with various local external agencies, such as GP surgeries, care homes, charities and ambulance services to try to meet the needs of patients in a prompt way.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service actively encouraged celebrations and success. Each team voted internally for an employee of the month, who received a gift in a hamper basket. At trust level, there were annual staff awards, referred to as 'The Oscars'. – Outstanding service contribution and recognition scheme. Nominations were open from patients, staff and carers. In 2021, one staff member within the dietetics service was nominated for the leadership award, a nurse associate was nominated for the care and compassion aware from the West Bridgeford health centre, and another staff member from West Bridgeford health centre was nominated for the leadership award. Staff we spoke with valued this recognition and looked forward to an award ceremony later in 2022.

Each team held a 'book of brilliance' within the team base, which was full of recent innovations, individual staff members successes, such as completing specialised training; compliments received by the team and general recognition of how the teams were performing.

There were organisational systems to support improvement and innovation across the service. These included individual and team staff objectives, various data systems, and communications to aid the sharing of learning.

Wards for older people with mental health problems

Requires Improvement

Is the service safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained but the environments were not fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. There were up to date ligature risk assessments on file and staff completed regular ligature audits. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

Staff could observe patients in all parts of the wards. Staff ensured that patients had the appropriate levels of observation to ensure their safety.

The ward did not comply with guidance on NHS England guidance on delivering same sex accommodation. The female lounges at both Amber ward and Cherry ward were not currently in use. The female lounge on Amber ward was used as a staff changing room to enable staff to change into personal protective equipment. The female lounge on Silver Birch ward was located on a four bed corridor that was being used as a Covid-19 isolation area for patients following admission. In both cases, staff had not put alternative arrangements in place.

The service did not comply with national guidance regarding shared sleeping arrangements and some wards had dormitories for between four and six patients. The dormitories contained lockable storage facilities for patients to store personal possessions. Staff and patients used privacy curtains to ensure patients privacy and dignity when using the bathrooms located on corridors. There were plans in place to eradicate dormitories. Improvements to the Millbrook Hospital site will be made to accommodate three older adults' wards in single room accommodation. This is planned for completion in 2024.

Staff had access to alarms. However, on Amber ward, there were no additional alarms other than those that were being used by the staff currently on shift. It was unclear whether additional staff would have access to an alarm if staffing numbers needed to be increased. Patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, and well- furnished. Staff completed a monthly infection, cleanliness and environmental audit. The audits we reviewed had been completed in a timely manner and showed that the service was compliant with infection prevention and control standards.

Staff made sure cleaning records were up-to-date and the premises were clean. We reviewed the trusts' touch point cleaning schedule which showed that cleaning of all ward areas had taken place and that the documents had been signed and dated appropriately.

Staff followed infection control policy, including handwashing. The wards we inspected had sufficient supplies of hand wash and personal protective equipment. We observed staffing regularly handwashing during the inspection.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment and the cleaning records we reviewed were complete and in order.

Safe staffing

The service did not have enough nursing and medical staff, who knew the patients well. However staff received basic training to keep people safe from avoidable harm.

Nursing staff

The service had assessed how many staff they needed to deliver care and keep patients safe on the ward. However, staffing did not always meet the identified numbers required and wards regularly fell below safe staffing levels. In the six months prior to the inspection, 23.5% of shifts were understaffed.

Some staff told us they felt unsafe on the wards and did not have time to support patients or meet their needs. Other staff said that they felt able to keep patients safe but otherwise did not have time to engage with patients, or complete one-to ones.

The service had high vacancy rates. There were multiple vacancies at each of the wards we inspected. At the time of the inspection there had been a total of 18 nursing vacancies and 24 nursing assistant vacancies during the last 12 months. This meant the service regularly used bank and agency nurses and nursing assistants.

Where bank and agency staff were needed, managers requested staff familiar with the service where possible and some ward managers told us there were bank and agency staff who regularly worked on the wards. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. This included during handovers.

Seven out of the 12 staff we spoke with (excluding managers and doctors) described significant staffing issues with four of those staff stating that the wards were unsafe. They cited not being able to meet patient clinical needs or not being able to complete observations. Nevertheless, the records we reviewed showed that observations were completed in a timely manner.

The service had average turnover rates, although it had seen an increase in turnover in the three months prior to the inspection. Staff turnover during the previous 12 months averaged at 8.4%.

Managers supported staff who needed time off for ill health. However, levels of sickness were high and averaged at 7.7% for qualified and non-qualified staff. Manager said this was mainly due to the impact of Covid-19.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. However, they could not always adjust staffing levels according to the needs of the patients due to staffing shortages across the older adult wards.

Patients had regular one- to-one sessions with their named nurse and there was evidence that these were taking place in most of the records we reviewed. No patients reported that their escorted leave or activities cancelled.

Wards for older people with mental health problems

Patients often required support with personal care and mobility. The service ensured that staff on

each shift prioritised physical interventions and ensures these were carried out safely.

Staff shared key information to keep patients safe when handing over their care to others. We had

sight of handovers which contained specific alerts, summaries of risk and patient updates

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff mostly completed and kept up-to-date with their mandatory training although there were some areas of non-compliance. We reviewed mandatory training figures and saw that most training modules had a 100% compliance rate for completion. However, manual handling training compliance was 71% across the service.

The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training. Managers used a dashboard to monitor training compliance and flagged overdue training with individual staff.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.

We reviewed nine patient care records. The assessments were completed thoroughly and were up to date.

The service set a 24- hour timescale for the completion of falls risks assessments and this timescale was met in the records we reviewed. Staff could access support from the trusts' dedicated falls lead and falls link nurse where required

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Some patients were identified as a risk of falling and the records we reviewed showed that staff took appropriate action to safeguard against the risks. Staff also monitored patients' risks of developing pressure ulcers regularly using the Braden scale.

Wards for older people with mental health problems

We found that staff had placed some blanket restrictions on the wards. These included access to the kitchen, knives, protected meal times, and no visitors being allowed in dormitories. However these were documented in a blanket restrictions folder and subject to regular review within meetings and the service and overall trust governance systems as outlined in the Mental Health Act Code of Practice.

Staff identified and responded to any changes in risks to, or posed by, patients. The care plans we reviewed set out patient risks including individualised de-escalation techniques

Staff followed procedures to minimise risks where they could not easily observe patients. This included regularly reviewing observation levels. The records we inspected showed that staff completed reviews and observation levels and documented the required level including the rationale.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. For example, on Cherry ward, staff completed weekly wardrobe checks to make sure that these did not contain items that could be used for ligatures or that family/ carers had not brought items of risk onto the ward.

Use of restrictive interventions

Levels of restrictive interventions were low. During the three- month period prior to the inspection the trust reported a total of 33 restraints and 13 restraints ending in rapid tranquillisation. Staff . followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff had access to policies and had an awareness of the use of restraint with older people. If required they had access to specifically trained staff that would support them to write care plans for specific individual patients to support the patients if they need staff intervention.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff understood the Mental Capacity Act definition of restraint and worked within it. For example, in one record we saw that staff had used restraint to administer rapid tranquillisation. There were ongoing reviews of the patients' capacity to consent on file and staff had recorded a clear rationale for the use of restraint.

Safeguarding

Staff mostly understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and in most cases, they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff mostly kept up-to-date with their safeguarding training. Training compliance was 89% for Safeguarding Adults Level 3, and 93% for Safeguarding Children Level 3. Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Wards for older people with mental health problems

Staff followed clear procedures to keep children visiting the ward safe. Children and young people could not go on the ward due to the patient group but there was a visitors' room outside the ward where visits took place.

Staff mostly knew how to make a safeguarding referral and who to inform if they had concerns. Actions were appropriate and investigated when required.

However, in one record, there were three patient-related safeguarding incidents. Staff had reported these incidents using the trusts' incident reporting system, but they had not completed safeguarding referrals in line with trust policy.

Staff told us they felt that the process for submitting safeguarding referrals was complex and time-consuming. They said this meant that safeguarding referrals were either not always submitted in a timely manner or that staff would fail to complete these altogether. Staff also said that ongoing staffing issues further impacted their ability to make safeguarding referrals

In addition, managers did not review or monitor safeguarding alerts at ward level. Some of the managers we spoke with could not tell us how many recent safeguarding referrals had been made or where this information was stored. Managers said there was not a clear process for identifying themes or trend from safeguarding alerts, or to implement learning from these.

Managers took part in serious case reviews. Managers developed action plans following serious incidents and these were added to the trusts' quality improvement plans. This enabled managers to review these and make changes based on the outcomes.

Staff access to essential information

Staff did not always have easy access to clinical information which meant it was not always easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and the trust used an electronic records system to store and update patients' records. When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely, however, not all staff could access patients notes easily. Staff told us that some long- term agency nurses did not have access to the electronic patient notes. This meant they were unable to view or update documents including care plans and risk assessments without assistance. Staff also told us this placed additional work on those staff with access to the system, to complete and update patients notes. However, the Trust had a 'Break Glass' process which enabled urgent access to records.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. We saw that store cupboards and drugs trolleys were in order and that staff had completed medication reconciliations. Staff used an electronic system to record and monitor fridge and room temperatures and the records we reviewed were in order.

Staff reviewed each patient's medicines regularly. Medication was an agenda item at patients' weekly multidisciplinary team meetings. Carers attended multidisciplinary team meetings where appropriate and staff gave advice to patients and carers about their medicines during these. We saw evidence that carers could contribute their views around medication.

Staff completed medicines records accurately and kept them up-to-date. Staff also completed daily cleaning of clinic room equipment and made a record of this.

Staff stored and managed all medicines and prescribing documents safely. Clinic rooms contained grab bags which contained emergency equipment and medication. We saw these were in order and displayed containing expiry dates and photos of contents.

Staff followed national practice to check patients had the correct medicines when they were admitted or when they moved between services. We saw that the rapid tranquillisation policy was present and accessible in the clinic room

Staff learned from safety alerts and incidents to improve practice. For example, staff follow a process to raise system alerts in response to concerns with fridge or room temperatures.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. The side effects of medication were documented in patient records and there was evidence that staff offered alternative medication where appropriate

Track record on safety

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them using the trusts' incident reporting form. Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

Staff understood the duty of candour and gave patients and families a full explanation if and when things went wrong. . We reviewed complaints records and saw when duty of candour discussions had taken place with patients. The inpatient manager had written to the families giving a clear apology and explaining what action they had taken to out things right.

Managers investigated incidents, gave feedback to staff and shared feedback from incidents outside the service. This included at divisional meetings, learning forums, and violence reduction, challenging behaviour and blanket restrictions meetings.

Staff met to discuss the feedback and look at improvements to patient care. For example, the trust was in the process of developing a pool of specialist clinicians in response to violence and aggression- related incidents, with those staff having specialist knowledge and being trained diffusers

Managers debriefed and supported staff after any serious incident. The managers we spoke with understood and had access to the trusts' de-brief tool and protocol

Wards for older people with mental health problems

Is the service effective?

Requires Improvement

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We reviewed nine care plans and saw that these were completed to a good standard. Staff had considered and implemented the least restrictive option. There was evidence within care plans that staff had liaised with outside agencies where appropriate. Care plans also showed evidence of involvement and input from family/ carers. Staff regularly reviewed and updated care plans when patients' needs changed

Care plans were personalised, holistic and recovery- orientated. The care plans we inspected set out individual care needs, and specified patients' wishes and preferences where appropriate. Staff documented the rationale for not providing patients with copies of care plans where appropriate.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. The records we inspected showed that medical staff routinely completed physical health checks and physical health risk assessments and that specific physical health conditions were subject to ongoing monitoring.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service.

Staff delivered care in line with best practice and national guidance. (from relevant bodies e.g. National Institute for Health and Care Excellence. Managers said they shared latest NICE guidelines and other updates in newsletters, general communication and during ward meetings.

Staff identified patients' physical health needs and recorded these in care plans. Staff used National Early Warning Scores (2) effectively to monitor physical health and identify if where patients' physical health was deteriorating.

Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. We saw that patients had involvement from speech and language therapists and dieticians where appropriate. Some patients required thickening fluids or had choking risks. The staff we spoke with knew which patients had specific needs and what support they required. Specific dietary requirements were also shared during handovers. Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. This included the Malnutrition Universal Screening Tool, and the Venous Thromboembolism risk assessment, the FRAX falls risk assessment, In addition, staff completed the Braden scale, which measured the risk of developing pressure ulcers for patients on the wards.

Staff took part in clinical audits, benchmarking and quality improvement initiatives and used results from audits to make improvements.

Skilled staff to deliver care

The ward teams did not always have access to the full range of specialists required to meet the needs of patients on the wards. Due to staffing issues across the services managers could not always make sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals and supervision but not all staff received these in a timely manner. Some staff had opportunities to update and further develop their skills but other staff described a lack of developmental learning due to the impact of Covid-19. Managers provided an induction programme for new staff.

There were staffing gaps within clinical teams. For example, B1 ward did not have an occupational therapist, or a dedicated physiotherapist or psychologist'. If patients required access physiotherapy and clinical psychology, they would access the 'in reach' community mental health team. Staff told us they needed to make requests for these where they felt patients needed this input. On Amber ward the psychologist and activities coordinator posts were vacant. We reviewed nine sets of patient records and saw that multidisciplinary team meetings confirmed that these often took place by without staff present from other clinical disciplines.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through appraisals of their work, although the appraisal data we inspected showed that annual appraisals did not always take place in a timely manner. The trust set target of 95% for completion of appraisals but only B1 ward regular met their monthly target. In the month prior to the inspection, Cherry ward had the lowest compliance rate of 60%, in addition to Kingsley ward at 81% and Amber ward at 82%

Managers did not always support staff through regular, constructive clinical supervision of their work. The clinical supervision compliance rate for the service in the three months prior to the inspection was 48%. For managerial supervision, this was 39% Staff described the impact of Covid-19 on their ability to provide supervision and said that the figures did not capture those staff who were unable to attend supervision, for example due to leave. The trust had a trust-wide supervision database for staff and managers to record and monitor when supervision, including safeguarding supervision has taken place.

Wards for older people with mental health problems

Managers did not always ensure staff attended regular team meetings or gave information from those they could not attend. We had sight of team meeting minutes for Silver Birch which confirmed that team meetings were mostly taking place on a monthly basis although there had been several instances where these had not gone ahead. However, staff told us that team meetings at B1 ward did not always go ahead and that there had been no team meetings in the three months prior to the inspection.

The team meeting minutes we reviewed showed that wards used different templates and that agenda items were not standardised. For example, complaints were an agenda item on Kingsley ward, but not for Silver Birch, Amber ward or Cherry ward. In some cases, meeting minutes were very brief and consisted of only several paragraphs without a set agenda.

Managers identified any training needs their staff had but staff did not always have the time and opportunity to develop their skills and knowledge. Some staff described role-specific training they had attended, whereas other staff told us they had been unable to undertake developmental projects or professional learning due to their workload and the impact of Covid-19. Staff told us that some health care assistants had completed phlebotomy courses. Others were trained to test for Covid-19 or to complete ECGs.

There was training in place to ensure staff received any specialist training for their role, but the Covid-19 pandemic meant that some training had been impacted and put on hold.

For example, managers described a “development in skills and knowledge” face to face training course which included dementia specific training. However, they said that staff had been unable to attend the course throughout the pandemic. Managers also told us that some staff had completed the national certificate for health care assistants, which also included aspects of dementia care. They confirmed that this course had also been impacted by Covid-19. Managers had booked staff on to additional training dates in order to increase the attendance at these session moving forward.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers recruited, trained and supported volunteers to work with patients in the service. This included planning and assisting with activities, pet therapy, and group or individual engagement with patients. Managers said they liaised with voluntary services where appropriate but described how Covid-19 had impacted their ability to facilitate volunteers on the ward.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care and made sure they shared clear information about patients and any changes in their care, including during handover meetings. Staff described how handovers included updates on risk, observations level, physical health needs and do not attempt resuscitation status.

Ward teams had effective working relationships with other teams in the organisation. There was evidence of joint working with the home treatment and community mental health teams. We also saw effective working relationships with external teams and organisations.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients’ rights to them.

Wards for older people with mental health problems

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Mental Health Act training compliance was 91%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice and confirmed that this support came from the trusts' Mental Health legislation team.

Staff knew who their Mental Health Act administrators were and when to ask them for support, although one member of staff told us they did not know how to access this support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. There was information on display in wards areas about independent mental health advocates (IMHA) and how to access the advocacy service. Staff recorded whether a refer to advocacy had been made.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. There was a system in place to flag patients' rights' and ensure these were revisited at regular intervals.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them electronically when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Mental Capacity Act training compliance was 90%. Staff described examples of how patients' capacity was assessed and recorded. This included specific decisions around medication or nutrition.

Wards for older people with mental health problems

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us they could access support and advice from the trusts' mental health legislation team.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. The records we inspected contained evidence that capacity for specific care and treatment decisions was routinely assessed, recorded and revisited.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. There was also evidence that staff held best interests' meetings where necessary.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve. Managers told us they completed regular audits of Mental Capacity Act compliance.

Is the service caring?

Good

Our rating of caring went down. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. Staff utilised privacy screens in the bedroom corridors to ensure that patients could access the toilet or bathroom in a way that maintained the privacy and dignity. Patients also told us that staff knocked on their bedroom doors prior to entering.

Staff gave patients help, emotional support and advice when they needed it. Patients said staff treated them well and behaved kindly.

Staff supported patients to understand and manage their own care, treatment or condition. The patients we spoke with mainly told us staff explained their medication to them, including the purpose and side effects of the medication.

Staff directed patients to other services and supported them to access those services if they needed help.

Wards for older people with mental health problems

Staff understood and respected the individual needs of each patient. The staff we spoke with had a good understanding of patient's communication needs, likes and dislikes, sleep cognition, and needs associated with activities of daily living.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential. This included using passwords to access electronic records.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. **They ensured that patients had easy access to independent advocates.**

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients received a ward orientation which staff said was tailored the patient group and their ability to understand the ward layout and environment.

Staff involved patients in care planning and risk assessments wherever possible. Care plans were holistic, personalised, and included patients' views. Where appropriate patients were offered copies of their care plan.

The records we inspected set out patients' likes, dislikes and preferences. There was also evidence that staff also had gathered and recorded historical information from patients' and carers to help individualise care and treatment. Each patient had an "All About Me" document and staff said this was a useful tool for engaging with patients.

Patients could give feedback on the service and their treatment and staff supported them to do this. Staff reminded patients that they could feed back individually and there were also poster explaining that they could do so

Staff supported patients to make decisions on their care. There were up to date capacity decisions present in the records we reviewed.

Staff made sure patients could access advocacy services. There was information on display about how to contact the service. We saw evidence of referrals to the independent mental health advocates and independent mental capacity advocates and staff made automatic referrals for patients who lacked capacity to instruct these

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. This included weekly carers contact calls, whereby staff provided family and carers with updates and invited them to contribute their views. We saw that carers were invited to meetings including ward rounds, care programme approach meetings and discharge planning meetings.

Staff helped families to give feedback on the service. Staff gave carers a feedback form on admission and there was a process in place for monitoring and reviewing carer feedback at ward level. The carers we spoke with said they felt listened to and gave examples of how were responsive to their views or requests regarding care and treatment.

Staff gave carers information on how to find the carer's assessment.

Wards for older people with mental health problems

Is the service responsive?

Requires Improvement

Our rating of responsive went down. We rated it as requires improvement.

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. However, patients often had to stay in hospital when they were well enough to leave.

Bed management

The service had a low out-of-area placements and there had not been any patients placed out of area in the 12 months prior to the inspection. Managers told us that out of area placements were very rare. There was a trust out of area protocol in place for staff to follow in the event staff needed to place patients out of area.

The service used a standardised document to record and monitor patients' progress and development in preparation for discharge and staff worked to make sure they did not discharge patients before they were ready. This included completing placement assessments and continuing health checks to assess and record that patients were ready for discharge.

There was a daily meeting which was attended by the trusts' transfer of care team which included reviewing pending discharges and developing actions to help facilitate discharge.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interest of the patient. Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

We found that patients stayed in hospital longer than they needed and there were large numbers of delayed discharges across the service. For example, at the time of the inspection, eight out of 19 patients on Silver Birch ward had delayed discharges. On Amber ward, seven out 13 patients had delayed discharges. On B1 there was only one patient whose discharge was delayed.

Staff cited multiple reasons for the high number of delayed discharges. These included the impact of Covid-19, the capacity of and engagement with social workers, and there being a lack of

available staff to facilitate discharge. Nevertheless, there was a robust discharge process in place and staff supported patients when they were referred or transferred between services

We had sight of the weekly discharge of care report and discharge actions document. We noted that whilst there were delayed discharges staff were regularly contacting onward services to discuss the delays and monitor progress. In addition, staff created and followed up discharge action plans and had regular liaison with external agencies. There were also two discharge facilitators within the service who oversaw the discharge process.

Wards for older people with mental health problems

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, but did not always promote privacy and dignity. Some patients did not have their own bedroom with an en-suite bathroom. Patients could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

The multiple occupancy dormitories impacted patients' privacy and dignity, although there were curtains separating each bed and sleeping area. Some patients told us they did not like the shared sleeping arrangements and that they would prefer to have their own bedrooms. Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. The service had quiet areas and a room where patients could meet with visitors in private. There were visiting times on the ward. Visitors currently had to booked appointments for due to Covid-19 which family and carers described said was inconvenient.

If required staff could refer patients to specialised teams in order to get specialised equipment to support them during their admission. For example, bed rails or adapted feeding utensils.

Patients could make phone calls in private. The service had an outside space that patients could access easily.

The service offered a variety of good quality food including those with different types of food preferences, vegetarians or religious beliefs. Those patients who could make their own hot drinks and snacks without assistance could do so independently and were not reliant on staff. Staff ensured that those patients who needed assistance had regular access to hot drinks and snacks. Staff would support patients who had been assessed to need to specialised diet. For example, they would ensure that low sugar food was ordered at mealtimes or food was softened to the required consistency for patients with swallowing difficulties.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff helped patients to stay in contact with families and carers. Staff arrange telephone and video calls for patients to speak with family and carers on a regular basis. They also planned and facilitate regular visits on the wards.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support. However, the wards did not always have as much dementia friendly signage as they could have had,

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Wards were not always dementia friendly as they could be. Although there were dementia friendly signs on doors, Amber ward did not have clear signage to orientate patients to the ward. In addition, on Amber ward both clinical and patient areas contained dementia friendly signage. We were concerned that patients would not be able to differentia between these areas.

Wards for older people with mental health problems

Wards supported disabled patients. For example, there were handrails along corridors, wheelchairs, and other equipment to support.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. There was information visible on the wards letting patients know about the complaints' procedure.

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. The records we reviewed showed that staff monitored patients' weight, encouraged them to engage in healthy lifestyles and that dietician referrals were made where appropriate.

Patients had access to spiritual, religious and cultural support. This included a chaplaincy service which staff said carers requested on behalf of patients.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously and investigated them. However, the service did not always learn lessons from the results or shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns and the service clearly displayed information about how to raise a concern in patient areas. The service used compliments to learn, celebrate success and improve the quality of care. We had sight of some of the compliments the service had received, which managers said were shared with staff.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints in line with trust policy. There was a total of 16 complaints across the service during the previous 12 month period. 7 were locally resolved and 9 proceeded to a full Investigation.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Staff protected patients who raised concerns or complaints from discrimination and harassment. However, managers were not always able to identify themes from complaints. Some managers did not know how many recent complaints there had been on the ward and said this information was kept by the patient advice and liaison service (PALS). They said that PALs did not send them complaints data on a periodic basis.

There did not appear to be a clear process in place for managers to review complaints at ward level and identify themes and trends at ward level. Although one member of staff provided an example of how learning had been fed back following a complaint, we were concerned that this impacted managers ability to share feedback from complaints with staff and use learning to improve the service.

Is the service well-led?

Requires Improvement

Wards for older people with mental health problems

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed but were not always visible in the service or approachable for patients and staff.

Staff were mostly complimentary about their immediate managers and team leaders. They were approachable, visible and supportive. Managers were knowledgeable and experienced.

Managers above team leader level were generally less visible. Some staff said those managers rarely visited the wards or spoke with staff.

Managers could access leadership training and had the support to do their job. The managers we spoke with described a comprehensive course they had attended which covered different aspects of leadership.

There were acting ward managers in post at two of the five wards we inspected. The service was in the process of recruiting permanent staff for those positions.

Vision and strategy

Staff did not know and understood the provider's vision and values and how they applied to the work of their team.

Most staff were unaware of the trusts vision and values, although they were aware that they had access to this information through the trust intranet. However, staff were able to provide examples of how they promoted care and compassion on the ward.

Some staff did not believe that others within the teams promoted the trust values in their own actions and behaviours. Some staff described a lack of respect from management or said there were "frictions" within teams.

Culture

Staff did not always feel respected, supported and valued. They said the trust promoted equality and diversity in daily work and but that opportunities for development and career progression were limited due to ongoing staffing issues and the impact of Covid-19. They could raise any concerns without fear.

Staff expressed concerns about the skill mix and numbers and number of staff on shift. Some staff said they didn't feel supported and described the challenges of regularly working extra hours or additional shifts on the wards.

Some staff said that they felt that the older adults' wards were of a low priority to management and that there was not enough focus on recruiting staff into the service

Staff morale varied and some staff did not feel listened to by senior managers. They cited a lack of contact and communication as examples of this. Some staff felt that they were not valued and said that support and recognition was mainly from their peers or line manager.

Despite the staffing issues across the service, staff spoke very positively about how they worked as a team and described good teamwork with patient care being the priority. Staff enjoyed working with the patient group and many staff told us they worked longer hours or additional shifts to ensure that patients' needs were met.

Staff said they felt able to raise concerns to managers or senior managers and could do so without fear. The staff we spoke with knew who their freedom to speak up guardian was.

Governance

Our findings from the other key questions demonstrated that there were clear governance processes in place, but these did not always operate effectively at team level.

Managers had a process in place for staff to have access to e supervision and appraisals. The process was not robust and they services was not meeting the trust target for compliance. Managers we spoke with reported that the compliance rates were low to due staffing issues across the service.

There were monthly inpatient business meetings. and these were well-attended by ward managers and other staff in management roles. These meetings enabled staff to review key performance indicators across the service and identify concerns at ward level.

Managers had not assured that staff would have access to personal call alarms to summon help if they needed to Amber ward. During the inspection there were no additional alarms other than those that were being used by the staff currently on shift. It was unclear whether additional staff would have access to an alarm if staffing numbers needed to be increased

Managers had closed the female lounges at both Amber ward and Cherry ward in order to create a staff changing room for personal protective equipment and a COVID isolation ward. However, the impact of this for the females had not been considered and alternative arrangements had not been made. At the time of the inspection we were not clear if there were plans in place to address this issue.

Although we saw that team meetings were taken place across the service managers had not ensured that standardised templates were in use. We were not assured when we reviewed them that staff were discussing and reviewing issues that needed to be or that sharing of learning and bench marking against other wards outcomes was taking place.

Managers monitored key performance indicators, mandatory training, staff supervision and appraisals. There was evidence of oversight by senior management which included a review of the service during monthly quality and risk meetings. There was a risk register in place which was subject to regular review and monitoring.

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

There was evidence that good handovers took place. We saw that handovers set out what the priorities were for patients, specific risks, observation levels, physical health needs, and updates regarding patients' 'Do not attempt cardiopulmonary resuscitation' status. Handovers also specified where cross ward support could be obtained if necessary.

There was a bi- monthly meeting across the directorate for managers to review their services and identify themes and trends. Managers told us how this led to shared learning and the development of a violence reduction programme.

Information management

Staff engaged actively in local and national quality improvement activities.

Wards for older people with mental health problems

Managers and staff monitored the effectiveness of their service to enable quality improvement. Staff audited targets for care programme approach reviews, crisis gatekeeping assessments, delayed discharges and 72- hour follow up for patients discharged from the wards.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

There was evidence that managers liaised with primary care services and had effective communication with GP practices. Staff obtained background or historical information in relation to patients to help inform care and treatment.

Managers liaised with other providers to plan patients transfer or discharge. This included working closely with staff at residential placements and care homes. We saw evidence of joint working with social services and district nurses. Staff from other health and social care providers were invited to discharge meetings, and section 117 after care meetings where appropriate.

Managers discussed delayed discharges with social services during a weekly meeting and reviewed actions.

There was evidence that staff and management were closely involved in the relocation of the older adults' services to the Millbrook hospital site. Staff told us they attended meetings and could provide input into how the layout and environment of the wards could improve quality of care.

Learning, continuous improvement and innovation

Managers used quality improvement methodologies to implement changes and make improvements. The managers we spoke with provided recent examples of quality improvement initiatives. This included a twelve month falls reduction program across the service.

Staff audited patient notes to ensure that staff made regular contact with family and carers and this was monitored and reviewed on a quality improvement plan. Managers described a quality improvement initiative for the complaints process which aimed to ensure that detailed feedback was provided following at the end of each complaint.

Staff provided examples of audits that they had devised as a result of quality improvement initiatives. There was a designated quality improvement meeting which was attended by ward managers and other staff from across the service.