Nottinghamshire Healthcare NHS Foundation Trust

Inspection report

Duncan Macmillan House
Porchester Road
Nottingham
Nottinghamshire
NG3 6AA

Tel: 01159691300
www.nottinghamshirehealthcare.nhs.uk

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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.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Good
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Summary of findings

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.

Background to the trust

Nottinghamshire Healthcare NHS Foundation Trust is an integrated healthcare provider and provides community health care and mental health care including high secure services. The trust operates within a budget of £400 million. It became a foundation trust in 2015.

The population served by the trust is 1,090,495 within Nottingham City and Nottinghamshire, with some of the services offered nationally (England and Wales) or regionally (East Midlands and South Yorkshire). They see about 190,000 people every year. The trust employs approximately 9000 staff.

The trust provides the following mental health core services:

- Acute wards for adults of working age and psychiatric intensive care units.
- Wards for older people with mental health problems.
- Wards for people with learning disability or autism.
- Forensic low and medium secure wards
- Forensic High secure hospital
- Child and adolescent mental health inpatient wards.
- Long stay/rehabilitation mental health wards for working age adults.
- Community mental health services for people with learning disabilities or autism.
- Community based mental health services for older people.
- Community mental 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 adolescents.

Other services include;

- Specialist perinatal inpatient and community services (mother and baby).
- Specialist eating disorder services.
- Inpatient substance misuse services.
- Rapid response liaison psychiatry.
- The trust provides healthcare into five prisons and one immigration removal centre across the East Midlands and South Yorkshire and one immigration removal centre.

The trust provides the following community health core services:

- Community Health inpatient services.
- Community health services for adults.

Summary of findings

- Community health services for children, young people and families.
- End of life care.

Other services include;

- Community dental services.

Nottinghamshire Healthcare NHS Foundation Trust is part of the Nottingham and Nottinghamshire and the South Yorkshire and Bassetlaw Sustainability and Transformation Partnerships. Services are commissioned by the following Clinical Commissioning Groups (CCG):

- NHS Mansfield and Ashfield CCG
- NHS Newark and Sherwood CCG
- NHS Nottingham City CCG
- NHS Nottingham North and East Clinical CCG
- NHS Nottingham West CCG
- NHS Rushcliffe CCG
- NHS England – Forensic Services, Offender Health and Dental Services
- Nottingham City Council
- Nottinghamshire County Council

Nottinghamshire Healthcare NHS Foundation Trust was first registered with CQC on 1 April 2010.

The last comprehensive inspection of this trust was in May 2014 and we rated the provider as 'good' overall. At the time of our last comprehensive inspection, we issued the trust with 55 areas of improvement. There were eight breaches across the following seven core services:

- Community healthcare inpatient services.
- Children and young people.
- Acute wards for adults of working age and psychiatric intensive care units.
- Forensic inpatients wards.
- Long stay/rehabilitation mental health wards for working age adults.
- Wards for people with learning disabilities.
- Child and adolescent mental health wards.

We told the trust that they must make improvements to:

- The complaints procedure within the Health Partnerships division.
- The medicines management policy at the Children's Development Centre.
- The monitoring of single gender facilities on B2 ward at Bassetlaw Hospital.
- The support plans in the learning disability service.
- The monitoring and recording of people's physical health needs on the Orion unit.

Summary of findings

- The seclusion reviews at Arnold Lodge.
- Female only communal areas within Thorneywood inpatient unit.
- Care plans and risk assessments on Orion unit.
- Section 17 leave forms to include information specific to individuals and the specified period of leave.
- Making sure all areas followed the trusts policy regarding annual ligature risk assessments.
- The Lucy wade ward environment because two doors were missing from the ensuite in two rooms.

These breaches related to the following regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010:

Regulation 9 – care and welfare.

Regulation 10 – assessing and monitoring the quality of service provision.

Regulation 11 – safeguarding.

Regulation 15 – safety and suitability of premises.

Regulation 17 – respecting and involving.

Regulation 19 – complaints.

Regulation 20 – records.

Following the inspection in 2014, we monitored the action plans addressing the regulatory breaches, carried out focused inspections of some services and looked at documentary evidence to support that the breaches were met.

We carried out focused inspections on wards for people with learning difficulties, Child and adolescent wards and community child and adolescent services the reports were published on 23rd December 2015. Focused inspections were carried out on acute psychiatric wards and PICU and the report published on 14th February 2017. Focused inspection reports for Rampton high secure hospitals were published on the 19 July 2016 and 26 October 2016, a comprehensive inspection of Rampton high secure hospital was published on the 15 June 2017. Community health services for adults and community health services for children, young people and families were published on 30 October 2015.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Good

What this trust does

Nottinghamshire Healthcare NHS Foundation Trust provides mental health, learning disability, substance misuse and community physical health services across Nottinghamshire.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Summary of findings

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against registered service providers and registered managers who fail to comply with legal requirements, and help them to improve their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected five complete core services in total. These were selected due to their previous inspection ratings or our ongoing monitoring identified that an inspection at this time was appropriate to understand the quality of the service provided.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed is this organisation well-led?

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as good because:

- We rated effective, caring, responsive, and well led as good for the trust and safe as requires improvement. We rated 15 of the 19 core services provided by the trust as good. Our rating for the trust took into account the previous ratings of services not inspected this time.
- We rated well led for the trust overall as good.
- There was good leadership at corporate level. The board understood the challenges the trust faced and made sure that plans were in place to manage these, while planning for the future. The board members challenged each other to make sure the right implementation of decisions occurred. Leaders at service level were visible.
- Good partnership working continued with other organisations to help plan and meet the needs of the local people. Stakeholders were positive about the trusts contribution to the local health economy planning.
- There was good multidisciplinary working within clinical teams and with external partners.
- Patients and carers could still contribute to service planning and delivery through the involvement centres. Patients were positive about the care and treatment provided by staff.
- Patients were still at the centre of the trust culture, which involved them through a range of initiatives. Patient needs were assessed, and care and treatment were planned;- with outcomes to measure progress monitored. There was an established recovery college for patients to learn skills in in managing their physical and mental health.
- Staff continued to have good access to training and development. Staff knew how to raise safeguarding concerns to protect patients. They knew how to report incidents and were open and transparent when things went wrong.
- There were effective complaint management systems, and the trust had set up good processes to investigate and learn from deaths.
- Learning from incidents, audits, complaints, deaths, was publicised through a variety of methods to improve practice. The trust carried out and shared the research it had undertaken.

Summary of findings

However:

- Medicines management practice in storage and recording and effective monitoring of action plans was not consistent.
- Staff recruitment and retention was a challenge and nursing fill rates of shifts did not consistently meet the trust target of 90%.
- Staff did not consistently assess record and monitor patients' physical health needs.
- The physical environment on some ward were not conducive to good quality care. On some wards patients had to share bedrooms and other wards did not have disabled access. On some wards staff found it difficult to observe all areas because there were no mirrors to help them see round blind corners.
- The Mental Health Act Code of Practice was not followed in relation seclusion facilities, giving patient rights and copies of leave forms.
- Representatives of Black and minority ethnic staff groups interviewed said they did not feel engaged. They reported a lack of career development and opportunities and they did not feel able to speak up.
- Not all staff knew about the Freedom to Speak up Guardian role in the trust.

Are services safe?

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

- We rated eight of the 19 core services provided by the trust as requires improvement for safe, and one service as inadequate.
- Medicines management practice was not consistently good. There were issues of; a lack of recording medicine fridge temperatures or not taking action when fridge temperatures exceeded ranges, lack of signing for medicines administered, medicines not always being securely stored and medical teams not consistently reviewing and acting on advice provided by the pharmacists. There was a lack of monitoring of action plans to make sure consistent improvements occurred in medicines management.
- Staffing levels were a consistent challenge to the trust, despite proactive recruitment and retention plans for all types of staff, in particular nurses and psychiatrists. Nursing fill rates of shifts did not consistently meet the trust target of 90%.
- Staff did not consistently assess, record and monitor patients' physical health needs. Although trust policy was to treat patients identified with sepsis promptly, this did not happen. Staff did not consistently complete and record patient National Early Warning Scores.
- The physical environment on some ward were not conducive to good quality care. On some wards patients had to share bedrooms and other wards did not have disabled access. On some wards staff found it difficult to observe all areas because there were no mirrors to help them see round blind corners. Two locations had not completed environmental risk assessments and ligature audits since July 2015. There was lack of disabled access for people in community child and adolescent services, and lack of soundproofing in consultation rooms in the community.
- The Mental Health Act Code of Practice requirements were not met in relation to the seclusion facility at the Willows and Lucy Wade.

However:

- Safeguarding practices were good. Staff had training in safeguarding and knew how to make a safeguarding alert appropriately. Staff accessed safeguard leads for advice. Policies and ward offices displayed adult and children referral processes to assist staff.

Summary of findings

- Staff knew what incidents to report and how to report them. Staff received debriefing following incidents. Staff were open and transparent and explained to patients when things went wrong. There was evidence of changes made following learning.

Are services effective?

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

- We rated 16 of the 19 core services as good and three as requires improvement.
- Patients received a range of treatment options that followed national guidance. Use of recognised outcome measures enabled monitoring of individual recovery journeys.
- The trust participated in a range of national and local audits to monitor and improve practice. Monitoring of action plans occurred and the trust shared learning shared in a variety of ways.
- There were good multidisciplinary team meetings to discuss patient needs which involved discussion of physical and mental healthcare.
- Staff received regular supervision and appraisals. Supervision was available individually or in groups.

However:

- The Mental Health Act Code of Practice requirements were consistently not met for example Patients were not provided with information in accordance with Section 132 of the Act about their rights, particularly those on community treatment orders. Leave forms were not complete with all details and staff did not give copies to the patient or their families.
- Not all staff had a good understanding of the Mental Capacity Act 2005. For patients who might have impaired capacity, staff did not consistently assess and record capacity to consent on a decision specific basis.
- Information needed to deliver care was not easily available to staff when they needed it, because there was a lack of coordination between different electronic and paper based systems.

Are services caring?

Our rating of caring went down. We rated it as good because:

- We rated 16 of the 19 core services provided by the trust as good for caring. Two core services as outstanding (not inspected this time) and the rating fell due to one requires improvement.
- Staff attitudes and behaviours when interacting with patients were responsive, discreet, and provided appropriate practical and emotional support. Patients reported staff treated them with respect and dignity. Staff showed good understanding of individual needs of patients.
- People were able to give feedback on the service they received through surveys or community meetings, and the patient involvement centres let people get involved in decisions about their service. This was evident for example in the new build for the child and adolescent mental health and perinatal service.
- There was good carer involvement and feedback. Carers were given information on how to access carer assessments.

However:

- Care plan records did not consistently demonstrate recording of patients' active involvement and participation in care planning and risk assessment, nor whether they had access to a copy of their care plan.

Summary of findings

Are services responsive?

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

- We rated 16 of the 19 core services good for responsive and three as requires improvement.
- Patients knew how to complain or raise concerns and the trust provided a policy and procedure to support this. Staff knew how to respond to complaints or concerns raised with them. Staff shared feedback and learning from complaints through handovers, emails or during team meetings.
- The trust provided information in a range of formats for patients with communication difficulties and those whose first language was not English.

However:

- Wards did not always have beds available in their catchment areas and out of area, placements were used.
- The trust had dormitories in some ward areas. Staff were not aware of any plans to eliminate dormitory accommodation.

Are services well-led?

Our rating of well-led stayed the same. See the section headed 'Is this organisation well led' for more information. We rated it as good because:

- Local leaders were visible, staff delivered care that demonstrated behaviour in line with the trust values.
- There was excellent service user engagement and carer involvement.
- There was good partnership working with other agencies to meet the needs of the population.
- There was a strong culture of learning and recognition of staff for innovative practice occurred.

However:

- Not all staff were aware of the Speak up Guardian and not all staff felt able to raise concerns.
- The trust recognised leadership investment in middle managers was crucial to managing significant change.

Acute wards for adults of a working age and psychiatric intensive care units

Our overall rating of this service went down. We rated it as requires improvement because:

- We rated safe, effective, caring, responsive, and well led as requires improvement.
- Medicines management across wards was poor. All wards had prescription charts showing times where staff had failed to sign for medicines administered to patients. Not all staff followed the trusts policy when making checks of controlled drugs. Records did not demonstrate staff regularly reviewed the effects of medication on patients' physical health.
- We found risks in the ward environments visited. This included blind spots and an absence of fixed-point call systems in some areas. We identified anti-barricade doors on wards as unfit for purpose and seclusion facilities did not meet Mental Health Act Code of Practice requirements.
- Patients and staff had concerns about ward staffing levels. Patients described nurses as busy and not very visible in communal areas. Staff reported that one to one time with patients was decreased when wards were very busy or patient observation levels were high. It was also reported that patients' escorted leave and access to outside areas could be cancelled or delayed at times because of staff shortages.

Summary of findings

- Patients had little access to psychological therapies on inpatient wards. Psychological therapies are recommended in National Institute for Health and Care Excellence guidance on the treatment of personality disorders.
- Staff did not always provide patients with information about their rights or details of their Section 17 leave whilst detained under the Mental Health Act. Records failed to demonstrate thorough discussions and evidence how staff had arrived at decisions about patients' mental capacity.
- Staff did not always protect the privacy of patients admitted to wards. Patients reported that staff failed to knock before entering rooms and did not shield observation windows following observations.
- Entries in patients' electronic records failed to demonstrate if staff offered patients copies of care plans. Most patients we spoke with reported that they were not familiar with their care plan and staff had not offered them a copy.
- Beds were not always available when needed for patients living in a ward's catchment area and staff reported that pressure for beds was high. Beds were not always available for patients upon return from leave of absence.
- The trusts monitoring of action plans demonstrated that, while staff made progress to address concerns, these were not consistent across wards, and issues persisted in areas of the Mental Health Act and medicines management.

However:

- The trust did regular risk assessments of the ward environments, including; ligature risk assessments, environmental violence reduction audits, and infection control audits.
- Safeguarding practices were good. The trust provided staff with safeguarding training for adults and children. Staff knew what to report and how to report it. Staff accessed safeguard leads for advice. Policies and ward offices displayed adult and children referral processes to assist staff.
- Practices around reporting incidents and learning from incidents were good. All staff we spoke with knew what events to report as an incident and records showed reported incidents included physical assaults, damage to trust property, and use of ligatures. Staff received feedback from the investigation of incidents and we saw examples of changes made because of feedback.
- The trust provided patients with initiatives to support a healthier lifestyle. Interventions included wellbeing clinics and stop smoking interventions.
- Staff clinical supervision practices were good. The trust provided a clinical supervision policy to guide and support staff in the delivery of supervision. Records showed supervision sessions followed an agenda, were recorded, signed, and happened regularly. Group supervision and reflective practice sessions were also available to staff in some areas.
- The trust involved families and carers in patient care. Wards often had staff identified as carer leads and staff trained in behavioural family therapy. The Trust provided access to information packs, handbooks, carer events and meetings.
- Patients knew how to complain or raise concerns and the trust provided a policy and procedure to support this. Staff knew how to respond to complaints or concerns raised with them. Staff shared feedback and learning from complaints through handovers, emails or during team meetings.
- The trust has acted on recommendations and outcomes from external inspections, deaths, incidents, and safeguarding reviews. Including; taking the decision to close the psychiatric intensive care facility on the Lucy Wade Unit and the purchase of additional acute hospital beds.

Wards for people with a learning disability or autism

Our overall rating of this service improved. We rated it as good because:

Summary of findings

- Since the last inspection, the units had acted upon our feedback and there had been improvements in the quality of patient care. The units now forward planned staffing levels required for the safe delivery of patient care. Activities were available for patients on the units every day, including weekends. Patients on Orion unit in long-term segregation and seclusion had their privacy and dignity protected. All staff had completed their mandatory training, complaints were acted upon, and patients received feedback.
- Safety was a priority for the units, measures were in place to ensure the safety and quality of the units were monitored, and any changes required were responded to in a timely manner. Patients had comprehensive risk assessments in place and staff updated and reviewed management plans regularly. Staff reported incidents and raised safeguarding concerns.
- Staff treated the patients with dignity and respect and patients were involved in all aspects of their care and treatment. Care plans were personalised contained the voice of the patient, holistic and included their needs and wishes. All patients had discharge plans in place.
- Staff were kind, caring and compassionate when interacting with patients. Staff communicated effectively with patients using a range of tools to meet the patients' individual needs. Information displayed on the ward was available in a range of formats.
- Staff respected the senior leaders on the wards. They said they felt supported, listened to and could raise concerns without fear of victimisation.

However:

- Staff on Orion unit told us they felt fearful working on the unit due to the increase of patient assaults on staff.

Community-based mental health services for adults of working age

Our overall rating of this service went down. We rated it as requires improvement because:

- Not all staff followed the trusts controlled drugs protocol. We witnessed a staff member not following the controlled drugs protocol and saw a controlled drugs book had errors and omissions on nine separate pages. A Warning Notice was issued to the provider, instructing them to address this matter.
- Staff at two locations said they did not have access to personal alarms during community visits and whilst based in team offices. At two locations, patient interview rooms were not fitted with alarms and soundproofed.
- Staff did not have rapid access to psychiatrists. Social care staff said Mental Health Act assessments were delayed due to the availability of psychiatrists to attend assessments. Staff said locum psychiatrists were used by the service; this was due to the trust experiencing difficulties recruiting and retaining psychiatrists.
- Not all patient care plans we saw were holistic and did not reflect language used by patients. Not all risk assessments and care plans were updated in line with patient needs. Patient's records were stored in three separate areas, which not all staff could access. In one location, medication records were stored in a different area to where the patient received a service. We found similar issues in records management at the July 2014 inspection and found evidence in the October 2017 inspection where records management was not consistently reviewed and updated promptly.
- Local mental health teams did not audit their use of the Mental Capacity Act. We found two locations had not completed environmental risk assessments and ligature audits since July 2015.
- Patients and carers were not aware of the restructure of adult community mental health services. We saw at some locations, leaflets informing patients of the service, but were told by staff that patients and carers were not informed of the restructure due to staff making a clinical decision. Social care staff said they were not informed of the restructure and working relationships with local mental health teams had weakened.

Summary of findings

- In some locations, not all staff had completed training on the Mental Health Act and Mental Capacity Act. In one team, staff did not document they had reminded patients from time to time of their rights subject to a Community Treatment Order. Some staff were unsure where to get advice on the Mental Capacity Act.

However:

- Patients and carers had access to a duty service. Patients said staff responded quickly to concerns and crises. External professionals had quick access to a team of professionals including psychiatry via an urgent mental health line to access professionals. Patients received an initial assessment, which covered their physical health and cultural needs. We found in the July 2014 inspection this was an issue that had been addressed by the trust.
- All patients and carers said staff were caring, efficient and responded well to crises. Carers said they valued the service they received from the Carer Support Service. Patients and carers had the opportunity to provide feedback on services provided by the trust in different formats.
- Staff used various therapeutic interventions, which were in accordance with National Institute for Health and Care Excellence guidance.
- Staff had an understanding of safeguarding procedures, incident reporting and handling complaints.
- All staff received monthly supervision and annual appraisals, which they found to be meaningful. Performance management was addressed within supervision. Staff said they had access to specialised training.
- Staff helped people who were difficult to engage with services to engage with the service. We saw staff follow the trust's Did Not Engage policy; and offered appointments that were flexible. Patients said staff rarely cancelled appointments.
- The service had a risk register, which mainly reflected staffs' concerns about the service. Team managers and clinical leads completed audits, which were passed to the trust's clinical governance team.

Specialist community mental health services for children and young people

Our overall rating of this service stayed the same. We rated it as good because:

- There were no long waiting lists and all children and young people open to the service could be tracked and monitored at any stage during their pathway.
- Managers monitored clinicians' caseloads using a caseload management tool and there was effective tracking of patients during their time within the service.
- We saw comprehensive, holistic mental health assessments were completed and care plans were person centred and recovery orientated.
- There was a good range of evidence based psychological therapies offered by a range of staff disciplines and routine outcome measures were used to monitor the effectiveness of treatment.
- The service had good working relationships with other teams within and outside of the organisation. Staff used these working relationships to reduce challenges, such as transitions between services.
- All communal areas were clean, spacious and had furnishings of good quality. The main base's waiting rooms were age appropriate and had toys, books and magazines.
- There was good participation of young people in service delivery and development and young people were involved in recruitment.

Summary of findings

- Staff were respectful, kind and supportive towards young people and their families/carers using the service. Staff involved young people and their families/carers in decisions about their care and treatment and gave regular opportunities for them to provide feedback on the service they received.
- Staff worked hard to engage with young people who found it difficult to or were reluctant to engage with mental health services. The service used innovative ways to make follow up contact with people who did not attend appointments and were flexible in their approach to support the needs of the young people and their families.
- There was a good governance framework and all staff knew how to raise incidents and how they would be fed back and lessons learnt and shared.
- There was good leadership throughout the service. Staff felt well supported in their roles and were given opportunities for leadership development.
- The service recognised the successes of the teams and dealt with poor staff performance promptly and effectively. We saw examples of effective management of staff performance, including evidence of close working with the staff members and clear action plans to support these staff.

However:

- Interview rooms at the main community CAMHS bases were not fitted with alarms and not all staff were aware of the protocols for using personal alarms.
- Clinic rooms were unclean and untidy at two of the community CAMHS bases we visited and we did not see evidence of cleaning records. We also found equipment that was out of date at one of the bases we visited.
- Several members of staff raised concerns across the service about access to and availability of psychiatrists. Staff told us that psychiatrists were stretched and this presented a risk to patients. Psychiatrists told us routine cases/clinics were cancelled frequently in order to respond to urgent cases.
- Staff did not record young people's physical health needs consistently across all teams. However, when speaking with staff it was clear that staff were aware of the physical health needs of their patients.
- Staff did not consistently record whether the young person and/or parent had consented to the initial assessment and/or subsequent intervention.
- The North and South bases were not adequately soundproofed and were not fully accessible for people requiring disabled access. The provider informed us both of these teams were moving bases at the end of the 2017 and these issues would be resolved.
- We noted there was not a diverse range of staff within the teams and this did not reflect the local population.

Community health inpatient services

Our overall rating of this service went down. We rated it as requires improvement because:

- We rated safe, effective, and well led as requires improvement and caring and responsive as good.
- The service did not always control infection risk well. We were not assured patient equipment had been cleaned or correct processes were followed when dealing with 'high risk' clinical samples.
- Medicines were not always stored securely and where medicine incidents had occurred we were not assured staff reported them appropriately.
- The service did not ensure patients identified with sepsis were treated promptly in line with trust policy.

Summary of findings

- The service did not ensure they had staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. We did not see a formal induction/ orientation process for those bank or agency staff new to the ward area(s).
- Staff did not always understand their roles and responsibilities under the Mental Capacity Act 2005. Deprivations of Liberty Safeguards (DoLS) were not always applied appropriately.
- The service did not always ensure staff were competent for their roles. We did not see evidence of medical device training.
- The service did not have effective systems in place for identifying risks. Ward managers appeared to have little oversight of the issues we had identified throughout our inspection. These included; concerns around staffing, mental capacity and deprivation of liberty safeguards, arrangements for the induction of agency staff, staff training in the use of medical devices and the security of medicines.

However:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment. Staff provided emotional support to patients to minimise their distress.
- The trust planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs. The service received no complaints between 1 July 2016 and 30 June 2017.

Ratings tables

The ratings tables in our full report show the ratings overall and for each key question, for each service, and for the whole trust. They also show the previous ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account, for example, the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in specialist community mental health services for children and young people and community health inpatient services. For more information see the outstanding practice section of this report.

Areas for improvement

We found areas for improvement including 25 breaches of legal requirements that the trust must put right. We found 48 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

Action we have taken

We issued eight requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

Our action related to breaches of 25 breaches of legal requirement in four core services. For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

Summary of findings

What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

We found the following outstanding practice:

Specialist community mental health services for children and young people

•The psychiatric liaison team based at Kings Mill hospital had presented their service evaluation following the six-month pilot to NHS England. The service evaluation showed the positive contribution the service had made in reducing hospital admissions and length of stay for young people during the six-month period. Out of the 76 patients, the service had seen since the pilot began, 21 hospital admissions had been avoided.

•In the eating disorders team, a transitional worker role had been developed to support young people in managing the transition to adult services. This staff member worked across both the adult and child eating disorders teams. Staff also put relapse prevention and wellness plans in place with patients who were transitioning or exiting treatment. Staff remained heavily involved in the care of patients who were admitted to inpatient services. For example, care co-ordinator responsibilities did not lapse when a patient was admitted to inpatient services.

•In the West Community CAMHS team, staff used a clinical audit tool to produce a weekly report of staff feedback. Staff completed this in 'survey monkey' weekly and the manager sent an email to staff outlining the actions. Staff used the survey monkey results to send a monthly report to the clinical lead, allowing them to make changes and improvements to the service based on staff feedback.

Community health inpatient services

•The hospital had worked previously with a regional charity to raise staffs awareness of the impact loneliness has on older people looking also at this in respect of discharge planning. As a result, staff were committed to assessing for and where possible, sign posting or supporting more social engagement.

Areas for improvement

Action a trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breech that did not justify regulatory action, 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 it must take action to bring services into line with 25 legal requirements and this related to four core services.

In acute wards for adults of working age and psychiatric intensive care units:

- The trust must ensure that seclusion facilities at the Willows and Lucy Wade Unit meet Mental Health Act Code of Practice requirements.
- The trust must ensure that staff record clinic room and medicines fridge temperature checks.

Summary of findings

- The trust must ensure that staff take the necessary action to ensure that medicines remain safe to use when fridge temperatures exceed maximum temperature ranges.
- The trust must ensure that staff check resuscitation equipment regularly.
- The trust must ensure that staff sign for medicines administered to patients.
- The trust must ensure that staff make checks of controlled drugs in accordance with trust policy and guidance.
- The trust must ensure that staff protect the privacy and confidentiality of patients at all times.
- The trust must ensure that staff share copies of care plans with patients and that this is demonstrated in patients' records.
- The trust must ensure that patients admitted to wards have access to psychological therapies.
- The trust must ensure that Section17 leave forms are complete and staff make copies available to patients, family members and carers.
- The trust must ensure that staff provide patients with information in accordance with Section 132 of the Mental Health Act.
- The trust must ensure that staff make capacity assessments that are decision specific and evidence thorough discussions and outcomes in patient records.

In specialist community mental health services for children and young people

- The trust must ensure that clinic rooms are clean, secure and contain equipment that is in date and suitable for the purpose for which they are being used.
- The trust must ensure that it provides cleaning records for all of the rooms within the community CAMHS locations.

In community-based mental health services for adults of working age

- The trust must ensure that all staff follow their controlled drugs protocol.
- The trust must ensure that all patients' files and medication records are easily accessible to staff when needed.
- The trust must ensure that all patients have care plans in place that contain patients' views, strengths and goals, be recovery orientated and holistic.
- The trust must ensure that care plans and risk assessments are updated in line with patient needs.
- The trust must ensure that all staff access training in the Mental Health Act and Mental Capacity Act.
- The trust must ensure that local mental health teams demonstrate and apply good practice in using the Mental Capacity Act.

In community health inpatient services

- The trust must ensure that there are appropriate arrangements in place for using bank and agency staff.
- The trust must ensure that medicines are always stored securely.
- The trust must ensure that staff understand and work within the requirements of the Mental Capacity Act 2005.
- The trust must ensure that Deprivation of Liberty Safeguards (DoLS) are always applied appropriately.
- The trust must ensure that patients identified with sepsis are treated promptly in line with trust policy.

Action the trust SHOULD take to improve

Summary of findings

We told the trust that is should take action either to comply with a minor breach that did not justify regulatory action, to avoid breaching a legal requirement in future or to improve services. This 48 actions related to the whole of the trust and four services.

Trust wide

- The trust should consider promotion of the role of the Freedom to Speak up Guardian more widely.
- The trust should consider obtaining and act on the feedback of black minority ethnic staff.
- The trust should consider making sure more middle managers undertake leadership development.

In acute wards for adults of a working age and psychiatric intensive care units

- The trust should ensure that the continued review and improvement of systems to ensure that ward anti-barricade doors are fit for purpose and staff are trained in their use.
- The trust should ensure that ward 'flex areas' have mirrors to reduce blind spots and assist observations.
- The trust should ensure that ward staffing levels allow for patients to have regular one-to-one time with their named nurses, patients do not experience delays and cancellations in accessing escorted leave or outside spaces, and nurses are visible to patients in communal areas of wards.
- The trust should ensure that medical teams review and where appropriate act on the advice provided by pharmacists.
- The trust should ensure that staff complete and record patient National Early Warning Scores.
- The trust should ensure that continued monitoring of bed usage and review the impact of initiatives introduced to reduce bed pressures and ensure that patients can return to the same ward they went on leave from.
- The trust should consider reviewing medical staffing and on-call medical cover to wards to ensure medical provision is adequate to ward demands, response times are not delayed and necessary patient reviews are not missed.
- The trust should consider that a system of fixed point call assistance is present on B2 ward.
- The trust should consider that advice for informal patients admitted to wards is consistent and presented in an accessible way for all patients to understand.
- The trust should consider that newly qualified staff have access to support from other suitably trained and experienced qualified staff.
- The trust should consider plans to eliminate dormitory accommodation from wards.
- The trust should consider that patients are not moved between wards after 10 pm.
- The trust should consider that that old or unused equipment is removed from ward areas.
- The trust should consider that initiatives to promote staff engagement are continued and monitored.
- The trust should consider that actions plans are monitored to deliver consistent improvements across the trust in areas of medicines management and the Mental Health Act.
- The trust should consider that the number of consultants allocated to each ward does not negatively impact ward staff and reduce direct patient care.

Community-based mental health services for adults of working age

- The trust should ensure that staff document they had reminded patients from time to time of their rights subject to a Community Treatment Order.

Summary of findings

- The trust should ensure that all staff was aware of the role of the Freedom to Speak up Guardian within the Trust.
- The trust should ensure that all rooms used to provide care and treatments at local mental health team bases are adequately soundproof.
- The trust should ensure that is sufficient psychiatric provision to support the safe care and treatment of patients within all of the local mental health teams.
- The trust should ensure that patients, carers and external organisation are informed and consulted of changes in service provision. The trust should ensure all staff have access to personal alarms. The trust should consider appropriate actions in response to audits to reduce the risk of ligature and environmental risk.

In specialist community mental health services for children and young people

- The trust should ensure that staff are aware of the procedure for responding to alarms.
- The trust should ensure that there is sufficient psychiatry provision to support the safe care and treatment of patients within all of the Community CAMHS services.
- The trust should ensure that staff assess, record and monitor patients' physical health needs.
- The trust should ensure that all staff receive regular clinical supervision.
- The trust should ensure that patients' capacity/competence and consent to treatment and/or information sharing is accurately recorded.
- The trust should ensure that all staff are aware of the role of external advocates in order to signpost patients and their families where appropriate.
- The trust should ensure that all information is available to patients and their families about the service they are accessing in an accessible format, including other languages.
- The trust should ensure that all staff are aware of the role of the Freedom to Speak up Guardian within the Trust.
- The trust should ensure that all information technology systems are effective in supporting staff to provide care and treatment to patients.
- The trust should ensure that all community CAMHS locations are accessible for people requiring disabled access.
- The trust should ensure that all rooms used to provide care and treatment at community bases are adequately soundproof.
- The trust should consider appropriate actions to reduce the risk of ligature in the public disabled toilets at all three community CAMHS bases.

In community health inpatient services

- The trust should ensure that there are consistent processes in place to identify when patient equipment has been cleaned.
- The trust should ensure that all untoward incidents are reported appropriately.
- The trust should ensure that patient identifiable information is protected in line with the requirements of the Data Protection Act 1998.
- The trust should ensure that 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms are reviewed appropriately in accordance with national guidance, best practice and in line with trust policy.

Summary of findings

- The trust should ensure that staffing requirements on Castle ward are reviewed to allow for the cohort nursing of 'discharge to assess' patients and avoid unnecessary delays in the patients admission.
- The trust should ensure that ward managers are given sufficient 'non-clinical' time to maintain a robust oversight of the quality and sustainability of services delivered on the wards.
- The provider should ensure that the 'local' risk register for this hospital is reviewed to reflect current risks in the service.
- The trust should consider implementing a patient activities programme on the wards.
- The trust should consider a consistent approach for managing 'high risk' samples.
- The trust should consider alternative methods of obtaining feedback from staff leaving the service.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated the organisation as good for well led because;

- The trust operates as a unitary board, which means executive and non-executive directors acted corporately and shared responsibility and liability for decision-making. The trust operated a devolved leadership and management model across two divisions, which was effective.
- The trust had an experienced leadership with the right skills and abilities to provide high quality care services. Board development took place.
- The trust had a strategy, which set out the vision and values. Staff had an understanding of the vision and values in relation to the local service.
- Governance systems from ward to board provided good performance management information to make decisions.
- The board reviewed performance reports that included data about the divisional services. Performance reports were available from ward to board to support monitoring and decision making.
- The senior management team were visible and engaged with staff by visiting service areas. Local leaders were visible, staff delivered care that demonstrated behaviour in line with the trust values.
- Communication occurred through a variety of media. The trust "POSITIVE" newsletter was prominent in all public places.
- There was excellent patient engagement and carer involvement.
- There was good partnership working with other agencies to meet the needs of the population.
- Recruitment and retention of staff was a challenge; the trust was proactive in its recruitment and retention plans for staff.
- There was a strong culture of research and learning and recognition of staff for innovative practice occurred.

However:

Summary of findings

- Not all staff were aware of the Speak up Guardian and not all staff felt able to raise concerns.
- Staff in black and ethnic minority focus groups told us they did not feel there was equity of opportunity.
- Action plans on local risk registers lacked detail.
- The trust recognised leadership investment in middle managers was crucial to managing significant change; numbers going through leadership programmes were low.
- The trust leadership recognised further staff engagement was required to support cultural and service level change.

Ratings tables

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 →← Jan 2018	Good →← Jan 2018	Good ↓ Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018

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
Community	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018
Mental health	Requires improvement →← Jan 2018	Good →← Jan 2018	Good ↓ Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018
Overall trust	Requires improvement →← Jan 2018	Good →← Jan 2018	Good ↓ Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018

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.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Jul 2014	Good Jul 2014	Good Jul 2014	Requires improvement Jul 2014	Good Jul 2014	Good Jul 2014
Community health services for children and young people	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Community health inpatient services	Requires improvement ↓ Jan 2018	Requires improvement ↓ Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Requires improvement ↓ Jan 2018	Requires improvement ↓ Jan 2018
Community end of life care	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Community dental services	N/A	N/A	N/A	N/A	N/A	N/A
Overall*	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018

*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.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018
Long-stay or rehabilitation mental health wards for working age adults	Requires improvement Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Forensic inpatient or secure wards	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Child and adolescent mental health wards	Requires improvement Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Wards for older people with mental health problems	Good Jul 2014	Good Jul 2014	Outstanding Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Wards for people with a learning disability or autism	Good ➔➔ Jan 2018	Good ➔➔ Jan 2018	Good ➔➔ Jan 2018	Good ➔➔ Jan 2018	Good ➔➔ Jan 2018	Good ➔➔ Jan 2018
Community-based mental health services for adults of working age	Inadequate ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Good ➔➔ Jan 2018	Good ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018
Mental health crisis services and health-based places of safety	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Specialist community mental health services for children and young people	Requires improvement ➔➔ Jan 2018	Good ➔➔ Jan 2018	Good ➔➔ Jan 2018	Good ➔➔ Jan 2018	Good ➔➔ Jan 2018	Good ➔➔ Jan 2018
Community-based mental health services for older people	Good Jul 2014	Good Jul 2014	Outstanding Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Community mental health services for people with a learning disability or autism	Requires improvement Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
High secure hospital	Requires improvement Jun 2017	Requires improvement Jun 2017	Good Jun 2017	Requires improvement Jun 2017	Inadequate Jun 2017	Requires improvement Jun 2017
Perinatal service	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Specialist eating disorders	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Rapid response psychiatric	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014

Overall	Requires improvement ➔➔ Jan 2018	Good ➔➔ Jan 2018	Good ➔ Jan 2018	Good ➔➔ Jan 2018	Good ➔➔ Jan 2018	Good ➔➔ Jan 2018

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.

Wards for people with a learning disability or autism

Good ↑

Key facts and figures

Nottinghamshire Healthcare Foundation Trust provides two units for people with learning disabilities or autism, focusing on those whose needs cannot provided by mainstream provision.

Alexander house is an eight-bed unit for males only and is a step down from low secure provision. The unit works with patients who have a history of offending behaviour who require rehabilitation and reintegration into community settings. At the time of the inspection, six patients were admitted.

The Orion unit is an 15 bed mixed gender inpatient unit providing assessment and treatment for patients with a learning disabilities and other challenging behaviours and mental health issues, who at the time of their admission cannot be managed safely in the community. At the time of the inspection, nine patients were admitted and the ward had been closed to new admissions since the beginning of October 2017.

The units admitted patients who were detained for treatment under the Mental Health Act (1983). The Orion unit admitted patients who had capacity to stay on the unit informally and patients with deprivation of liberty safeguards in place.

At the last inspection, the wards had two key questions (caring, responsive) rated as good and the other key questions (safe, effective, and well led) rated as requires improvement. We re-inspected all of the key questions to see if they had made improvements.

Our inspection between 7 and 8 November 2017 was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before the inspection visit, we reviewed information we held about the service and requested information from the trust.

During the inspection visit, the inspection team:

- visited both units and looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with four patients who were using the service
- spoke with the ward managers, modern matron and responsible clinician
- spoke with 12 other staff members including qualified and unqualified nurses (health care assistants), speech and language therapists and activity co-ordinators
- looked at the care and treatment records of five patients
- reviewed medication management including the medication administration records for all 15 patients
- attended and observed three meetings including a ward round, a ward handover and a patient meeting
- we attended and observed a further education group
- Observed two patients care
- Looked at a range of policies, procedures and other documents relating to the running of the units.

Wards for people with a learning disability or autism

Summary of this service

Our rating of this service improved. We rated it it as good:

A summary of our findings about this service appears in the Overall summary.

Is the service safe?

Good ↑

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

- The units were visibly clean and maintained to a high standard. Staff undertook environmental checks and audits to ensure the standards were met.
- Managers were aware of the risks to patients and staff and took action to reduce the risks. All patients had up to date risk assessments and management plans that were regularly updated and reviewed.
- Clinic rooms were organised and free from clutter. Medication was checked and in date, medication charts were in order, fridge and room temperature checks were carried out daily.
- A range of professionals now delivered safe care and treatment. The staff were up to date with their mandatory training. Staff had been trained in de-escalation techniques to reduce the need to use restraint on a patient.
- Patients told us they felt safe on the units, they were issued fobs to access their bedrooms, which had lockable units to store personal items.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- Patients still received effective personal centred care. They all had up to date individualised care plans, which now took into account physical health, psychological and wellbeing needs and wishes of the patient. Copies of the care plan were provided to patients in an easy read format.
- The multidisciplinary team had the skills and specialist training to support patients with learning disabilities and autistic spectrum disorder. The team took part in the shift handovers and met weekly to review each patients care.
- The care of the patients still followed national guidance and best practice and outcomes were monitored using recognised rating scales.
- All staff had completed Mental Health Act and Mental Capacity Act training and applied the training in their practice. The Mental Health Act paperwork was in good order and patients had their rights explained on admittance and every eight weeks following detention.

Is the service caring?

Good →←

Wards for people with a learning disability or autism

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

- Patient we spoke with said staff treated them with respect, dignity, were kind, caring and were positive about the care they received.
- Family and carers were involved in the care of the patient and we saw letters and cards to staff thanking them for the care the patient had received.
- Patients had access to a wide range of group and individual activities on the ward and in the community, which could be accessed seven days a week.
- Both units held weekly community meetings that enabled patients the opportunity to suggest improvements.

Is the service responsive?

Good

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

- The units had clear admission criteria. Alexander house would work with other professionals pre-admission to ensure the unit could meet the patient needs. Orion unit would work with the community teams to ensure the information required was available at the point of admission.
- Each patient was treated as an individual and the care and treatment package was developed to meet the needs of the patient, which took into account their wishes and choices.
- Plans for discharge were completed at the point of patient admission. Staff regularly reviewed progress with the patient and during care and treatment review meetings. This meant that all agencies and commissioners, involved in the patient's care, were working towards discharge and reduced the numbers of delayed discharges.
- The units now practiced positive risk taking to allow the least restrictive practice to be applied; this meant patients with highly complex needs had the opportunity to access activities and have leave away from the unit.

Is the service well-led?

Good

Our rating of well-led improved. We rated it as good because:

- The trust senior leadership team visited the units. Staff on Orion unit said the leadership team had listened to their concerns about staff and patient safety on the ward and had temporarily closed the unit to future admissions.
- The local leadership team were well known to staff and patients and now had a visible presence on the units. Staff felt supported and valued by the local leadership team and spoke highly of them.
- The units had good governance systems in place. Risks and incidents were routinely monitored and discussed shift handover, team meetings and at the weekly multidisciplinary team meeting.
- Staff at all levels were offered the opportunity to undertake additional training to progress their skills and opportunities.
- The units had developed a caring and compassionate culture that encouraged staff and patients to contribute to the development and improvement of the services.

Wards for people with a learning disability or autism

However':

- Staff at Alexander house felt uncertain about the unit future, as the trust reviewed the viability of the unit on a yearly basis.Staff on Orion unit felt fearful whilst on duty due to the increased number of patient on staff assaults.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Key facts and figures

At the last comprehensive inspection in July 2014, acute admission wards (mental health) were rated as 'GOOD' overall. The inspection did identify concerns about gender separation on both B2 and Orchid wards, and the medicines administration practices of some ward staff.

Psychiatric intensive care units (PICU) and health-based places of safety were rated as 'GOOD' overall. The inspection did identify concerns about the environment of the Lucy Wade female PICU.

The acute wards and psychiatric intensive care units (PICU) for adults of working age provided by Nottinghamshire Healthcare NHS Foundation Trust are based at three sites across Nottinghamshire. The trust has a total of seven acute wards and two PICUs.

There are five wards at Highbury Hospital. Four of these are acute wards and one is a PICU.

Rowan 1-14 bedded male acute ward

Rowan 2- 14 bedded female acute ward

Redwood 1- 14 bedded male acute ward

Redwood 2-14 bedded female acute ward

Willows- 10 bedded PICU

Millbrook Mental Health Unit has three wards. Two of these are acute wards and one is a PICU.

Lucy Wade Unit- 11 bedded mixed sex acute ward

Lucy Wade Unit- 5 bedded female PICU

Orchid Ward- 25 bedded mixed sex acute ward

Bassetlaw Hospital has one ward.

B2- 24 bedded mixed sex acute ward

We completed a full inspection of B2, the Lucy Wade Unit, Orchid Ward, Rowan 1, Redwood 2 and the Willows. We made additional night time visits to Redwood 1 and Rowan 2 to observe staff handover meetings, to speak with night staff, and to speak with patients.

During the inspection, we visited nine wards.

At the last inspection, the acute wards had one key question (safe) rated as requires improvement and the other key questions (effective, responsive and well led) rated as good and caring as outstanding . At the last inspection the PICU had one key question (safe) rated requires improvement and the other key questions (effective, caring, responsive and well led) rated as good. We re-inspected all of the key questions to see if they had made improvements.

Our inspection between 10 and 12 October 2017 was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Acute wards for adults of working age and psychiatric intensive care units

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

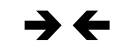
- spoke with 38 members of staff from different wards including ward mangers, nurses, doctors, pharmacists, occupational therapists and healthcare support workers
- spoke with 25 patients currently using the service
- reviewed the care and treatment records of 33 patients and 101 prescription charts.
- completed tours of all the wards subject to a full inspection
- observed three multi-disciplinary review meetings, two ward handovers, and one bed management and daily demand meeting
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

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

A summary of our findings about this service appears in the Overall summary.

Is the service safe?

Requires improvement 

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

- Patients and staff reported a number of concerns relating to ward staffing levels. Including staffing levels not always allowing patients to have regular one-to-one time with their named nurse, patients experienced delays and cancellations in accessing escorted leave or outside spaces, and nurses were not always visible in communal areas of wards.
- Anti-barricade doors present on wards were identified as unfit for purpose on the trust's risk register. Anti-barricade mechanisms varied across wards and staff were not trained in their use.
- Seclusion facilities at the Willows and Lucy Wade Unit did not meet Mental Health Act Code of Practice requirements. Willows had no toilet facilities and did not allow staff to make clear observation of the patient. Lucy Wade Unit used bedrooms to seclude patients; rooms had blind spots; poor observation arrangements and doors opened inwards.
- Staff did not always record resuscitation equipment checks, and temperature checks of clinic rooms and medicine fridges. When staff identified fridge temperatures temperature as high there was no record of any resulting action.
- Medicine management practices were poor across the wards we visited. We saw examples of staff failing to sign for medicines administered to patients, staff checks of controlled drugs were not completed in accordance to policy, and medical staff did not always act on recommendations of pharmacy staff. Records did not demonstrate that staff regularly reviewed the effects of medication on patients' physical health.

However':

Acute wards for adults of working age and psychiatric intensive care units

- Wards were clean and had up-to-date environmental risk assessments in place. These included ligature risk assessments, environmental violence reduction audits and infection control audits.
- Ligature risk assessments were up-to-date and identified the location of ligature points, level of risk posed and actions to reduce the risk. Staff escalated risk to the trust's risk register and action plans were in place to address the highest areas of risk.
- Staff received mandatory training. The trust monitored completion rates monthly and reported them as part of key performance indicators. The trust was taking action to improve staff access to mandatory training opportunities.
- Staff assessed and updated patient risk assessment. Staff worked together to identify and manage patient risks. Staff were trained in the management of violence and aggression and participated in a No Force First Project to reduce the risk of restraint and restrictive practices.
- The trust provided staff with safeguarding training and staff knew when and how to report concerns. Staff described how they would protect patients from harassment and discrimination.
- Staff knew what constituted an incident and how to report it. The trust investigated incidents and staff met to discuss feedback. The trust produced a regular bulletin of lessons learnt that staff could access.

Is the service effective?

Requires improvement

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

- The trust provided patients with little or no access to psychological therapies. Staff reported that psychological therapies were missing from inpatient admission wards.
- Staff did not always fully complete and share information with patients detained under the Mental Health Act. Staff had not consistently provided patients with information in accordance with Section 132 and staff did not make copies of completed Section 17 forms available to patients, family members or carers.
- Records did not demonstrate thorough discussions and evidence how staff had arrived at decisions about capacity. Staff in some areas made capacity assessments that were not decision specific.

However':

- Records showed staff completed care plans. We found most care plans to be detailed and contained identified recovery goals.
- The trust provided patients with physical healthcare and initiatives to support healthier lifestyles. Interventions included physical examinations, monitoring of ongoing physical health conditions well-being clinics and stop smoking interventions.
- The trust provided staff with supervision and appraisals. Records showed supervision sessions followed an agenda, were recorded, signed and happened regularly. The trust provided a clinical supervision policy to guide and support staff.
- Staff met throughout the day to effectively share and discuss information about patients. This happened at multidisciplinary team meetings and handovers between staff.

Acute wards for adults of working age and psychiatric intensive care units

Is the service caring?

Requires improvement

Our rating of caring went down. We rated it as requires improvement because:

- Staff did not always offer patients help and support. Patients reported that staff spent significant periods in offices or at computers. We saw engagement was often needs led and initiated by patients.
- Staff did not always protect the privacy of patients admitted to wards. Patients reported staff failed to knock before entering rooms and did not shield observation windows following observations. Staff did not always ensure discussions about patient care took place where they could not be overheard.
- Staff did not share copies of care plans with patients. Patients we spoke with reported they were not familiar with their care plan. Electronic records failed to demonstrate if staff offered patients copies of care plans.

However':

- Staff enabled patients to give feedback on the service they received and patients told us they knew how to provide feedback. The Trust's website included links to feedback surveys, reports and articles detailing improvements made as a result of feedback received.
- Staff ensured patients could access advocacy. We saw advocacy posters displayed in ward areas and patients that we spoke with were aware of advocacy services.
- The trust involved families and carers in patient care. Wards often had staff identified as carer leads and staff trained in behavioural family therapy. The Trust provided access to information packs, handbooks, carer events and meetings.

Is the service responsive?

Requires improvement

Our rating of responsive went down. We rated it as requires improvement because:

- Wards did not always have beds available for patients in their catchment areas and used out-of-area placements to admit patients to. Bed occupancy was high across wards and the trust sometimes used health-based places of safety to admit patients to. Patients did not always return to the same wards following leave or absence.
- Patients were expected to sleep in dormitories at two of the wards we visited. Staff were not aware of any plans by the trust to eliminate dormitory accommodation from wards.

However':

- The trust had introduced initiatives to reduce bed pressure across wards. This included purchasing additional inpatient beds, holding regular meeting to discuss bed occupancy, and planned to introduce an electronic bed management system to wards.
- Patients knew how to make complaints and staff provided complaints feedback to patients during community meetings. Staff knew how to deal with complaints and received feedback from investigations made.

Acute wards for adults of working age and psychiatric intensive care units

- The trust provided a range of information to patients using wards. Staff could access material in a range of formats for patients with communication difficulties, including easy-read and other languages. Staff had access to interpreting and signing services.

Is the service well-led?

Requires improvement

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

- Staff did not always feel that they were listened to and recognised for the work they did above ward level. Despite trust initiatives to engage staff in strategy discussions, staff did not feel heard or able to influence decisions above ward level.
- Staff reported busy wards, low staff numbers and conflicts within teams all contributed to unhappy ward teams.
- The trusts monitoring of action plans did not always demonstrate that identified standards and actions were practiced consistently and maintained across wards.
- However':
- The trust acted on recommendations and outcomes from external inspections, deaths, incidents and safeguarding.
- The trust engaged patients, carers and external stakeholders to gain feedback and improve services.
- Staff knew and understood the trust's vision and values. The trusts vision, values and five year strategy were available to staff and patients online. Trust staff were aware forums aimed at gaining feedback and engagement from frontline staff.

Areas for improvement

For more information, see the Areas for Improvement section above.

Community-based mental health services of adults of working age

Requires improvement

Key facts and figures

At the last inspection in July 2014, Adult Community Mental Health Services was arranged into specialist teams, which covered Nottingham City and Nottinghamshire county areas. These specialist teams included Assertive Outreach, Early Intervention in Psychosis, City Recovery Services, Community Mental Health and Community Assessment Treatment teams.

During the comprehensive inspection of this service in 2014, we found the following concerns:

- We raised concerns that community mental health teams' records management were not consistently reviewed and updated promptly.
- We raised concerns that in community mental health teams, patients' physical health and cultural needs were not fully considered at the initial stages of care, or regularly reviewed to assess any impact on their mental health and wellbeing.

In June 2017, following consultation, Adult Community Mental Health Services were restructured to form 11 geographical Local Mental Health Teams covering Nottingham City and Nottinghamshire county areas. The local mental health teams consisted of the merged specialist teams covering: Ashfield, Bassetlaw, Broxtowe and Hucknall, City Central, North, East and South, Gedling, Newark and Sherwood, Mansfield and Rushcliffe areas.

During the inspection, we visited all teams, which are spread over 11 sites

At the last inspection, CMHTs had one key question (safe) rated as requires improvement and the other key questions (effective, caring, responsive and well led) rated as good. We re-inspected all of the key questions to see if they had made improvements.

Our inspection between 9 and 11 October 2017 was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection, the inspection team:

- spoke with 50 members of staff from
- spoke with 17 social care staff
- spoke with 17 patients and carers that were using the service
- reviewed 37 patients' records
- completed tour of the premises of each location
- observed four red amber green meetings, two single point of access meetings, two duty systems and one multidisciplinary team meeting.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

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A summary of our findings about this service appears in the Overall summary.

Is the service safe?

Inadequate

Our rating of safe went down. We rated it as inadequate because:

- At Rushcliffe local mental health team, we witnessed staff did not follow the trust's controlled drugs protocol. We found five boxes of a controlled drug in the controlled drugs cabinet not recorded in the controlled drugs book, the patient index page was not filled in and staff did not follow guidance on how to sign in controlled drugs received from pharmacy and given to patients. We issued a Warning Notice to instruct the trust to address this issue.
- In the year before this inspection, staff at Gedling and Rushcliffe teams had not completed an environmental ligature risk assessment. Rushcliffe local mental health team had not completed an infection control audit since July 2015.
- Interview rooms at some locations we inspected were not fitted with alarms. Not all staff had access to personal pin point alarms and lone worker devices although staff had requested them.
- Staff did not have rapid access to a psychiatrist when required. Staff said the service had experienced difficulties recruiting and retaining psychiatrists. Social care staff said mental health act assessments were delayed due to the availability of psychiatrists.
- Patient information was stored in three separate areas, computerised patient record system, paper files and computerised shared drive. Mental Health Act paperwork was stored in patient paper files, which affected staff working in different office locations or out of office hours having immediate access to Mental Health Act paperwork.
- Staff completed risk management plans with patients using a recognised risk assessment tool; but in 13 patient care records, we found staff had not updated risk management plans.

However':

- Clinic rooms were well equipped with the necessary equipment, were clean, tidy and organised. Staff adhered to infection control principles.
- The Trust provided staff with safeguarding training and staff knew when and how to report concerns. Staff described how they would protect patients from harassment and discrimination.
- Staff knew what constituted an incident and how to report it. The Trust investigated incidents and staff received feedback during team meetings. The trust produced a regular bulletin of lessons learnt that was available to staff.

Is the service effective?

Requires improvement

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

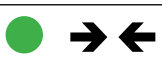
- We looked at 37 care plans and saw 27 were not personalised, holistic and recovery orientated and 14 patient care plans were not updated in line with patient need or change of circumstances.

- Staff said they did not have the skills and knowledge to meet the needs of the patient group as due to the restructure, they were completing duties they had not done previously. Although, we saw evidence of the trust offering staff specialist training relating to their role.
- Training on the Mental Health Act and Mental Capacity Act at some local mental health team locations were below the trust's key performance indicators.
- At Rushcliffe, staff did not document whether they had reminded patients from time to time, of their rights subject to a Community Treatment Order according to section 132 Mental Health Act.
- The trust had policies linked to the Mental Capacity Act; however, the review date for the Advanced Statements (Mental Capacity Act) was September 2017. We could not find this updated policy on the Trust's intranet website.
- Staff were unsure where to obtain advice about applying the Mental Capacity Act to their practice. We saw no evidence of managers auditing the use of the Mental Capacity Act within teams and staff receiving learning from the outcomes of audits.

However':

- Local mental health teams spoke with GPs about patients' physical health care. Teams offered patients the choice to have annual reviews at their GP practices or at a team base. Staff supported patients to attend physical health care appointments.
- Staff offered patient care and treatment interventions linked to National Institute for Health and Care Excellence guidelines. Local mental health teams used recognised rating scales such as Therapy Outcome Measures.
- The trust provided staff with supervision and appraisals. Records showed supervision sessions followed an agenda, were recorded, signed and happened regularly. Each team had a supervision structure staff followed and the trust provided a clinical supervision policy to guide and support staff.
- We reviewed 25 paper patient files for patients subject to a Community Treatment Order, saw they were all in order, up to date, and stored correctly.
- Staff at all teams met every morning day to effectively share and discuss information about patient concerns. This happened during the Red Amber Meeting, actions of this meeting were distributed between staff and minutes taken.

Is the service caring?

Good 

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

- All patients and carers described staff as respectful, efficient, punctual, caring and responsive to crises. Staff behaved appropriately towards patients and had an understanding of their individual needs.
- Staff supported patients to access community services. Patients had access to peer and employment support workers who enabled them to gain meaningful employment and access community activities.
- Patients were involved in care planning and risk assessments, stating they felt consulted, listened to and involved in their care. All patients we spoke with said they were offered copies of their care plans.
- Carers were provided with information about how to access a carers assessment and received support from Adult Community Mental Health Carer Support Teams.

- Staff enabled patients and carers to give feedback on the service they received. Patients and carers had various ways they could provide feedback about the service.

However':

- Patients and carers we spoke with they were not aware of the restructure of adult community mental health services. Staff said they did not tell some patients of the restructure due to a clinical decision.

Is the service responsive?

Good

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

- All teams had clear criteria to which patients would be offered a service. All staff we spoke with was aware of the criteria.
- Local mental health teams were able to assess urgent patient referrals within 72 hours and up to eight weeks for non-urgent patient referrals.
- Patient appointments usually ran on time and staff kept patients informed when they did not. Staff cancelled appointments only when necessary and when appointments were cancelled, staff explained why.
- Local mental health teams attempted to engage with people who found it difficult to engage with mental health services. Staff followed the trust's Did Not Attend Policy, contacting patients to explore the reasons why they did not attend their appointments.
- Patients knew how to make complaints and staff provided complaints feedback to patients during community meetings. Staff knew how to deal with complaints feedback to patients from investigations made.
- The Trust provided a range of information to patients using adult community mental health services material in a range of formats for patients with communication difficulties, including easy-read and other languages. Staff had access to interpreting and signing services.

However':

- Interview rooms at Gedling, Rushcliffe and City South and East local mental health teams did not have soundproofing. However, interview rooms at City South and East local mental health teams at the time of inspection were awaiting soundproofing.

Is the service well-led?

Requires improvement

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

- Not all staff felt respected supported and valued. Staff did not feel positive and proud about working for the trust. Staff spoke about low morale which they contributed to the restructure of adult mental health services and collecting data to assess staff productivity.

Community-based mental health services of adults of working age

- Staff did not know the trust's vision and values and how they applied following the restructure of adult mental health services.
- Patients and carers were not involved in the decision making process about the restructure of services and unaware they could meet members of the trust's senior leadership team and governors to give feedback. Social care staff said they were not consulted in the decision making process regarding the restructure of adult mental health services.
- Senior leaders were not visible; although patient and staff said service directors, team leaders and clinical leads were visible and approachable.

However':

- Staff were able to raise concerns without fear of retribution and positive and proud about working with their team.
- The trust implemented recommendations from reviews of deaths, incidents and complaints at service and team levels by using action plans.
- Concerns raised by staff reflected those on the risk register for adult community mental health services. The risk register assessed the severity and likelihood of risk.

Areas for improvement

For more information, see the Areas for Improvement section above.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Our inspection team

James Mullins, Head of Hospitals Inspection, led this inspection. We had one executive reviewer - Melanie Johnson, an Executive Director of Nursing and Patient Experience - on this inspection. Six specialist advisers supported the well-led review in the areas of equality and diversity, safeguarding and incidents, information governance, complaints and patient experience, and human resources.

The inspection team across five core services and well led included two inspection managers, nine inspectors, a Mental Health Act reviewer, a pharmacist, 14 specialist advisers, and three experts by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.