

Good 

Nottinghamshire Healthcare NHS Trust

Adult community-based services

Quality Report

Tel: 01159691300

Website:

www.nottinghamshirehealthcare.nhs.uk

Date of inspection visit: 29 - 30 April 2014

Date of publication: 25/07/2014

Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
Duncan Macmillan House (Trust Headquarters)	RHAPA	Newark and Sherwood FACT Team	NG24 1HD
Duncan Macmillan House (Trust Headquarters)	RHAPA	City Recovery Team	NG3 2FH
Duncan Macmillan House (Trust Headquarters)	RHAPA	Early Intervention Psychosis Team	NG6 9DR
Duncan Macmillan House (Trust Headquarters)	RHAPA	Gelding Community Mental Health Team	NG4 3AY
Duncan Macmillan House (Trust Headquarters)	RHAPA	Rushcliffe Community Mental Health Team	NG2 7PG

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

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

Summary of findings

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

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for Adult community-based services (Mental Health)

Good 

Are Adult community-based services (Mental Health) safe?

Requires Improvement 

Are Adult community-based services (Mental Health) caring?

Good 

Are Adult community-based services (Mental Health) effective?

Good 

Are Adult community-based services (Mental Health) responsive?

Good 

Are Adult community-based services (Mental Health) well-led?

Good 

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

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

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

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	5
The five questions we ask about the service and what we found	6
Background to the service	8
Our inspection team	8
Why we carried out this inspection	8
How we carried out this inspection	8
What people who use the provider's services say	9
Good practice	9
Areas for improvement	9

Detailed findings from this inspection

Locations inspected	10
Mental Health Act responsibilities	10
Mental Capacity Act and Deprivation of Liberty Safeguards	10
Findings by our five questions	11

Summary of findings

Overall summary

Nottinghamshire Healthcare NHS Trust has several teams that together provide an adult community-based service:

- Newark and Sherwood Flexible Assertive Community Treatment (FACT) Team is a recovery-orientated service that provides mental health services for people in Newark and Sherwood aged 18 to 64 years.
- Rushcliffe Mental Health Team helps people aged 18 to 64 in Rushcliffe to cope with periods of mental illness and severe distress.
- Gedling Mental Health Team works with people in Gedling with a wide range of mental health difficulties, who require short-and long-term intervention.
- City Recovery Team helps people aged 18 to 64 years, who have a GP within the boundary Nottingham City Council, to cope with periods of severe mental illness and to develop recovery pathways.
- The Early Intervention Psychosis Team provides early detection, assessment and treatment of psychosis for people who show symptoms of a first episode psychosis.

We found that the adult community-based mental health services provided by Nottinghamshire Healthcare NHS Trust were delivered effectively. People told us that staff were kind and skilful in the way they dealt with them.

Staff understood the risks to the health and welfare of the people they cared for. However, we found that records were not up-to-date or regularly reviewed for risk. This meant that staff unaware of a person's history may not have access to their current needs or risks.

Staff understood how to follow the local multi-agency policies and procedures for safeguarding adults and children. The teams we visited worked well with other teams and agencies, both in the trust and externally, such as primary and secondary healthcare.

We saw that staff were compassionate and respectful towards people who used the services. Outcomes and aims were discussed with people during their meetings, and people told us that they felt involved in making decisions about their care.

We were told that there were issues with out-of-hours care, which meant that people's preferences for receiving care close to home were not always met. However, assessments could be made by phone, or people could have a face-to-face consultation at the Queen's Medical Centre if needed.

People knew how to give feedback about the service.

Staff told us that they enjoyed their work and felt supported by their managers. However, some staff said that they felt detached from the wider trust issues and were not involved in meetings about its vision and values.

Summary of findings

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

Are services safe?

Adult community-based staff had a good understanding and knowledge of safeguarding procedures. There was a strong system in place for reporting safeguarding issues and other incidents, and we saw that staff learned from past incidents. In addition, risks to people who used the service and others were identified at their initial assessment. However, the records showed that these were not regularly reviewed and updated. This meant that information may not be up-to-date for staff delivering care to people, and staff unaware of a person's history may not have access to their current needs or risks.

Requires Improvement



Are services effective?

People had a comprehensive assessment of their needs when first in touch with the service, and staff monitored and documented the progress of their recovery after every consultation. The community teams we visited offered a range of psychological therapies and outcomes from the interventions were evaluated. The people we spoke with were complimentary about the therapy they received.

Staff worked well together and also worked closely with primary and secondary care health providers. There was a wealth of knowledge and skills within the teams, which was shared through best practice forums and national conferences. All staff were given regular supervision and an annual appraisal.

Good



Are services caring?

People told us that they were treated with dignity and respect, and we saw that they had access to appropriate literature and information. Staff were skilled and knowledgeable, and spoke to people in a way that was empathetic, clear and simple, without the use of jargon. They were also flexible in their approach to people's needs, often providing support on social and domestic issues. We also saw that each team used a different approach to identifying carer support needs. Staff in the Early Intervention Psychosis Team had adopted innovative and engaging ways to promote the service to young people and engage carers.

Good



Are services responsive to people's needs?

We found that people's preferences for receiving care close to home were not always met out of hours, and they often had to travel some distance for assessment or treatment. However, waiting lists, which overall were small, were managed effectively. Information about

Good



Summary of findings

how to access help was also provided for people waiting for a service, and the teams had good links with voluntary agencies to access services for people. In addition, local people were encouraged to have their say in how services were developed.

Are services well-led?

Overall, community teams were well-led at a local level. Staff told us that they were proud of the service they delivered, and that they felt well-supported by their immediate managers. We also observed that the team members were supportive of each other. There were systems in place to ensure that staff received information from the trust, and most staff were aware of board level leadership and the overall vision of the trust. However, some staff told us that had little or no involvement in local meetings, for example about governance, and said that they felt somewhat detached from the issues. The trust recognised staff through an annual awards scheme, which highlighted staff innovation and excellence in the delivery of care.

Good



Summary of findings

Background to the service

Newark and Sherwood Flexible Assertive Community Treatment (FACT) Team

Based in Newark, the FACT team provides mental health services for people in Newark and Sherwood aged 18 to 64 years. The team is recovery-oriented and offers tailored packages of care, as well as a variety of care pathways for people experiencing serious and/or enduring mental health problems.

Rushcliffe Mental Health Team

This team helps people aged 18 to 64 to cope with periods of mental illness and severe distress. The service is open to people who have a GP in the Rushcliffe area.

Gedling Mental Health Team

The Gedling Mental Health Team works with people with a wide range of mental health difficulties. They offer support to people with a GP in the Gedling area who require short term intervention, as well as those requiring longer term care plans.

City Recovery Team

The City Recovery Team provides mental health services for people aged 18 to 64 years, who have a GP within the boundary Nottingham City Council. They help people to cope with periods of severe mental illness and to develop recovery pathways.

Early Intervention Psychosis Team

This service provides early detection, assessment and treatment of psychosis for people who show symptoms of a first episode psychosis. The service was available to people aged 18 to 65 years old. The team we visited were based at Highbury Hospital.

These services have not previously been inspected by CQC.

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Lelliott, Care Quality Commission

Team Leader: Jenny Wilkes, Care Quality Commission

The team included CQC inspectors and a variety of specialists: consultant psychiatrist, consultant nurse, social worker and nurses.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?

- Is it well-led?

We visited the adult community-based services of Nottinghamshire Healthcare NHS Trust, including visits to the teams' bases, on 29 and 30 April. Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. During the visit, we held focus groups and

Summary of findings

individual interviews with a range of staff, including nurses, doctors and therapists. We also spoke with

people who use the services and their carers, who shared their views and experiences. We observed how people were being cared and reviewed their care or treatment records.

What people who use the provider's services say

Before the inspection, we used focus groups to speak with people who used the service and during the

inspection we spoke with people who were receiving services and their carers. We found that people were very positive about their experiences of care and saw people being dealt with in a kind and compassionate manner.

Good practice

- People received care that was empathetic and compassionate.
- The community teams provided a range of evidence-based, psychological therapies to individuals and in groups.
- The ongoing development of community clinics, for example access to rapid assessment and treatment by non-medical prescribing staff, such as nurses.
- Support for staff to undertake specialist therapeutic training, which in turn would improve outcomes and choices.

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

Action the provider **SHOULD** take to improve:

- The trust should ensure that in the community MH teams, records on risk management are consistently reviewed and updated promptly.
- The trust should ensure that in the community MH teams, people's physical health and cultural needs are fully considered at the initial stages of care, and regularly reviewed to assess any impact on their mental health and wellbeing.

Nottinghamshire Healthcare NHS Trust

Adult community-based services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Newark and Sherwood FACT Team	Duncan Macmillan House
City Recovery Team	Duncan Macmillan House
Early Intervention Psychosis	Duncan Macmillan House
Gelding Community Mental Health Team	Duncan Macmillan House
Rushcliffe Community Mental Health Team	Duncan Macmillan House

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

We found that staff in the community had received training specifically related to the Mental Health Act (1983). Information we reviewed in records indicated that there

was an understanding of the responsibilities of community staff in relation to people who were subject to Community Treatment Orders (CTO) and Section 117 aftercare. We found that there was information displayed in reception and waiting areas regarding access to advocacy services for people.

Mental Capacity Act and Deprivation of Liberty Safeguards

We found that nursing staff and managers had a broad understanding of the Mental Capacity Act in Adult

community based services. Staff attended training to ensure that they had the required knowledge. This training was completed online and was a part of mandatory trust training.

Are services safe?

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

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

Summary of findings

Adult community-based staff had a good understanding and knowledge of safeguarding procedures. There was a strong system in place for reporting safeguarding issues and other incidents, and we saw that staff learned from past incidents. In addition, risks to people who used the service and others were identified at their initial assessment. However, the records showed that these were not regularly reviewed and updated. This meant that information may not be up-to-date for staff delivering care to people, and staff unaware of a person's history may not have access to their current needs or risks.

Our findings

Newark and Sherwood Flexible Assertive Community Treatment (FACT) Team

Gedling Mental Health Team

Rushcliffe Mental Health Team

Track record on safety

Staff were trained in safeguarding vulnerable adults and children. Staff we spoke with were knowledgeable about their responsibilities in regard to safeguarding. Some staff gave examples of safeguarding concerns they had reported and described the process for completing this. They told us concerns were discussed with line managers, where appropriate, in the first instance. A single point of access for referrals was the Multi Agency Safeguarding Hub (MASH), a service provided by Nottingham City Council. Safeguarding leads monitored and updated any action plans and ensured their implementation. One staff member described the service as a, "Central strong link".

Learning from incidents and improving safety standards

Staff told us they used the trust's electronic incident reporting system, 'Ulysses', for reporting any incidents, concerns or near misses. Feedback from serious untoward incidents was fed back to the individuals involved and

wider trust incidents distributed by email globally. Staff were able to give us examples of learning which had informed service development. Lessons learnt from incidents relating to the team, and the wider trust, were included in the agenda for monthly team meetings. In a focus group we held, during our visit, staff reported they had poor feedback from more minor clinical incidents reported. However they told us serious untoward incidents were routinely on the agenda for these meetings which ensured that learning was cascaded effectively.

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

Safeguarding concerns were referred to the social work team who led in organising investigations and processes. Staff felt that this made the process less confusing and provided clarity for them. Staff undertook safeguarding training. We were told that the trust safeguarding team were responsive when concerns were raised and assisted with advice.

We saw that medication was appropriately administered, securely stored and the keys stored safely. Medicines management was seen to be effective with yearly audits undertaken by pharmacy.

Records management, in the main, used a paperwork system although an electronic system did have limited data that staff could access from other departments. The Newark and Sherwood team staff told us that they experienced issues accessing information due to distance from other bases. This meant that a full picture and background, particularly in terms of risks, may not be readily available to staff.

There was a lone working policy and procedure in place. Within both the electronic and paper system, there was a facility to highlight where people presented identified risk to staff safety. We saw "whereabouts" sheets were completed when out of office and the duty worker was responsible for ensuring those out had returned safely.

Assessing and monitoring safety and risk

We observed a handover at the Newark and Sherwood service. This appeared well planned and organised with the sharing of information to ensure continuity and safety of care. Each person currently receiving care was discussed,

Are services safe?

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

including any new referrals for follow up. On receipt of a referral the duty worker would establish the person's care and support needs through utilising information available from the referrer, their own systems, both paper and electronic and contacted the person by phone. A plan of action was agreed and documented on a triage form and shared with the person and wider team.

We reviewed seven paper based records within each team. Potential safeguarding and abuse issues were considered within the assessment document and considered children who are being cared for. If concerns were identified then a referral to the local authority children and families teams was made. This meant that staff responded appropriately to any signs or allegations of abuse.

The risk assessments we reviewed lacked any person centred content and in the main were a "tick box" document with little space for free text. Four out of the seven records we looked at had not been reviewed or updated. Staff were unable to clearly identify any regime or timeframe for review. We were told by team managers that risk was reviewed at each meeting with people or as required. Progress notes we reviewed in these records documented changes in the person's risk but the risk assessment did not reflect this. In one file we reviewed no risk assessment had been completed. Team managers informed us that checks on reviews of risk assessment were not part of their routine audits. This meant that emerging risks may not be fully explored or be accessible for other teams to view or access in a timely manner.

We saw that staff worked jointly with other agencies and across services to promote safety. We observed the communication of risk management in regard to a person being seen in community between a nurse and two other health professionals. Caseloads and capacity were monitored by the team manager through monthly supervision. These sessions included discussion around discharges which established capacity for new referrals. Levels of caseloads had agreed limits. This meant that capacity for staff to provide continuity of care to keep people safe, and meet their needs, was effective.

Understanding and management of foreseeable risks

Service development was monitored for its impact on people, for example the newly amalgamated FACT Team (Newark and Sherwood) was evaluated in its first quarter from October 2013 to January 2014. This looked at quality

outcome measures in regard to referrals and activity levels, with plans for a more detailed second quarter report to monitor the facilitation of patient movement between pathways. Staff and service user opinion was also sought in the report.

Managers told us risks to the service that were identified due to capacity or staffing levels, were mitigated through formulating a business case. Senior managers were described as receptive to concerns raised. Any disruption to staffing levels incurred due to staff sickness were dealt with through cross cover amongst teams to fill any gaps and limiting any impact upon people using services.

City Recovery team – Stonebridge Centre Track record on safety

Staff were trained in safeguarding vulnerable adults and children. Staff we spoke with knew their responsibilities in regard to safeguarding. A flowchart was displayed in the base relating to the process for reporting safeguarding concerns which staff referred to. Staff told us they used the trusts electronic incident reporting system for reporting any safety incidents, concerns or near misses. Staff told us that received regular updates by email and bulletins containing feedback.

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

Records management was in the main using a paperwork system although an electronic system did have limited data that staff could access from other departments, via the shared drive. Staff said the use of two systems was inadequate with increased risk around access to paper records in locations. This meant that a full picture and background, particularly in terms of risks, may not be readily available to staff.

Staff were aware of the lone working policy and we saw this was implemented within the service. Systems were in place to ensure all staff returned from community visits and clinics safely.

We saw that medication was appropriately administered, securely stored and the keys stored safely. Medicines management was seen to be effective however staff told us no regular audits were undertaken. Two lead nurses were identified within the team as the first point of contact for medication issues. We saw that the controlled drugs register did not always contain the signatures of two nurses

Are services safe?

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

as per recommended best practice. We saw a list of nurse's signatures available in the drugs cupboard but this was in need of updating. This meant that safe prescribing practice was not being routinely implemented.

Assessing and monitoring safety and risk

We reviewed four paper based records within the team. We saw evidence of assessment, care planning and risk assessments being completed. Some consideration had been given to safeguarding and abuse issues for both adults and children in these documents. The records we were shown lacked timely review of risk assessments. This meant that other clinicians accessing records could not be sure that risks outlined were current or accurate.

Referrals to the team were predominantly received from GPs. Contact with people was in the most part done by letter, in the first instance, to offer an appointment. People's circumstances, including available support mechanisms, were considered in regard to the urgency of an appointment with further liaison with the referrer as necessary. This meant that appropriate sharing of information to ensure continuity and safety of care was observed.

We saw that staff worked jointly with other agencies and across services to promote safety. The social inclusion team were involved in weekly team clinical meetings. In records we were shown we saw that people had been referred for tenancy support and staff had liaised with children and families as necessary. Caseloads and capacity were monitored by the team manager through supervision, with discussion around discharge plans in development. We saw that caseloads had agreed limits, and the waiting list of 40 was regularly reviewed and prioritised according to risk and need by the team manager.

Understanding and management of foreseeable risks

Managers told us that risks to the service, that were identified due to capacity or staffing levels, were mitigated through formulating a business case. Senior managers were felt to be supportive to concerns raised.

Early Intervention Psychosis – Highbury Hospital Track record on safety

We found that the trust's safeguarding systems were robust and understood by staff. Staff confirmed they received training in safeguarding people, which was regularly updated. Staff we spoke with were knowledgeable about

their responsibilities in regards to safeguarding. One staff member told us, "It's an easy process and you are kept informed of developments". Staff told us they used the trusts electronic incident reporting system, 'Ulysses', for reporting any safety incidents, concerns or near misses.

Learning from incidents and improving safety standards

Feedback regarding incidents was reported in a "learn the lessons" distributed by email globally within the trust. Information was shared and discussed with staff in team meetings, if relevant to the teams work and processes. Staff gave examples of incidents they had reported. One staff member described a robust investigation in which they had been fully involved. They told us that action plans were developed from the investigations and changes to team working were implemented directly as a result.

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

Safeguarding concerns were allocated following referral to a social worker who led on organising investigations and processes. Staff told us the process was clear and organised. Health staff had undertaken safeguarding training and were involved in investigations as necessary.

Records we were shown were confusing and staff needed to look in up to three different places for different documents. For example the electronic system contained progress notes and the outline of care coordination dates and reviews but the care plan was a paper copy in the paper records. Risk assessments were stored separately in the shared drive. This meant records were difficult to follow and in three different places. We found inconsistencies in records which seemed inherent from a disjointed records management system.

The trust's lone working policy was adhered to within the team. Staff knew how to access the policy via the trust intranet site. Systems were in place for staff to be alerted to any concerns or risks regarding visits or contacts people.

Assessing and monitoring safety and risk

Records shown to us included risk assessments which gave consideration to risks to people, staff or from other people. We looked at four records and found that risk assessments had not been updated in a timely manner to reflect current risk as described in the progress notes. This meant that lack of timely review of risk assessments could place staff at

Are services safe?

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

unnecessary risk or people left susceptible to the impact of unmet needs. The team manager informed us that monthly audits were done on five random records per month. Team governance structures were based around verbal conversations with staff in supervision therefore an inconsistency in notes could be overlooked. This meant systems in place, to ensure quality in records including updates and review, were ineffective.

Staff described a good relationship with other teams with a clear understanding of how they could make referrals. They told us that they worked in partnership with other teams to move people on safely from their service. We noted in the records of one person, who was previously well engaged with the EIP team, who had been transferred to the community mental health team and had almost immediately disengaged from them. We were told no

mechanism was in place for checking if the transition had worked well and that no data was routinely collected in regard to this. This meant that the effectiveness of safe handovers and transfers were not audited routinely.

Caseloads and capacity were monitored by the team manager through monthly supervision. When we visited, caseloads were outside the national recommended caseload size for EIP Teams. The manager told us they discussed capacity and caseload management in supervision. Staff we spoke with said they had manageable caseloads and could approach the manager at any time if capacity compromised patient safety or care.

Understanding and management of foreseeable risks

Staff told us senior managers were receptive to any concerns raised. Any disruption to staffing levels, incurred due to staff sickness, was dealt with through cross cover amongst the team to fill any gaps and limited any impact upon people using services.

Are services effective?

Good 

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

Summary of findings

People had a comprehensive assessment of their needs when first in touch with the service, and staff monitored and documented the progress of their recovery after every consultation. The community teams we visited offered a range of psychological therapies and outcomes from the interventions were evaluated. The people we spoke with were complimentary about the therapy they received.

Staff worked well together and also worked closely with primary and secondary care health providers. There was a wealth of knowledge and skills within the teams, which was shared through best practice forums and national conferences. All staff were given regular supervision and an annual appraisal.

Our findings

Newark and Sherwood Flexible Assertive Community Treatment (FACT) Team

Gedling Mental Health Team

Rushcliffe Mental Health Team

Assessment and delivery of care and treatment

We looked at records and saw that care plans, although outcome based, had not been updated to reflect progress in achieving aims. Progress notes were comprehensive but failed to relate to the care plan in place. Records we were shown contained blanket care plans with people's names inserted into spaces in an attempt to personalise them. In some cases no evidence of involvement of the people signing, or being part of the development of the plan, was noted. One person we spoke with told us, "No care plan was ever done with me." Managers told us that care plans were reviewed after every visit but this was not evident in records. In five of the records we reviewed there was no evidence that paperwork had been reviewed since the day of assessment, which was more than three months prior. This meant that people were unable to see and contribute to any progress being made towards their recovery.

We saw evidence that comprehensive assessments were undertaken by medical and nursing staff on initial contact

and they had covered all aspects of care as part of a holistic assessment. However; in a focus group that we conducted, staff told us of their frustration at the variance in assessment documentation used across the trust.

Staff told us that on-going physical health checks were not undertaken. We saw that physical health was discussed initially but no further assessment of these needs had been offered. This meant that people's physical health and well-being as part of a holistic approach was not considered. We raised the issue with managers during our visit who clarified that there was no formal structure to review the content of care plans to identify where ongoing assessment was not taking place.

Teams offered a good range of evidence based psychological therapies. These were part of the new local initiatives, which included a Personality Disorder Group and a Distress Management Clinic. Some staff we spoke with had undertaken a Meridian family and carer therapy course and plans were in place to utilise these skills. We spoke with people who were receiving therapy in a group environment. One told us, "Doesn't want it to stop, finds it helpful". Another said, "I find mindfulness useful and CBT helpful". We saw that the therapy programmes available had a focus on recovery and re-enablement.

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

Outcomes for people using services

We saw a monthly audit tool completed by managers, covering areas such as health and safety and records, which were fed into the trust system. Feedback about performance was shared with managers for their action. In therapy groups questionnaires and personality tests were routinely undertaken to establish levels of need and measure outcomes.

Staff, equipment and facilities

Staff told us they were supported in undertaking training outside of the mandatory training. We saw a robust supervision process in place. Staff received management supervision monthly. Performance issues and caseload capacity were embedded in this process. This included

Are services effective?

Good 

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

specialist supervision, for Approved Mental Health Professionals (AMHP) and Non-medical prescribers (NMP). Senior medical staff told us they had regular organised peer group supervision.

In one team we visited they had established group supervision, with a psychologist leading, which we were told was well attended. Teams we visited had a weekly clinical meeting for case discussion and also a monthly team meeting for more team related issues, which included information sharing. We saw that preceptorship meetings were undertaken weekly for newly qualified nurses.

Multidisciplinary working

Requests for social worker input for people had to be made via a contact centre with the local authority as social work staff were no longer integrated into community mental health services, but based in the same offices. Staff told the system was effective. Social workers were involved in multi-disciplinary discussions where appropriate. Information on patients subject to the Care Programme Approach (CPA) was shared on the electronic system, which both health and social work staff could access. Documents were scanned into the Social Services database to share information about risk management and care plans. This meant that staff could access information in a timely manner.

Teams appeared detached geographically in terms of information sharing and availability, particularly regarding access to paper based information. Teams relied heavily on fax transmission for current, up to date and historical information about people referred.

Staff told us, in all the teams we visited, that capacity to meet demand was "challenging" and particularly with many new care pathways requiring specific skills to manage. Implementation of change was adopted slowly and a buddy group was being established to ensure confidence and competency of any new ways of working. This meant that systems were being developed to ensure cohesive team working. Staff in the FACT team told us communication between teams had improved with better interfaces since their reconfiguration.

In all teams we visited staff described positive relationships with other services. This meant that a multi-disciplinary approach to care and treatment was optimal. Multi-disciplinary teams were made up of, or had input from, occupational therapists, nurses, social workers and

medical staff. Social work staff focussed on enablement, short focussed work and leading on safeguarding issues. A social work representative was available for weekly allocation meetings. A good relationship was reported between CMHT, inpatient and the crisis teams.

Mental Health Act (MHA)

A recent audit had been undertaken in community teams in regard to people they cared for, who were subject to a Community Treatment Order (CTO), and areas for improvement identified with team managers working with staff to make the necessary improvements. Staff told us that social workers and AMHPs in the teams provided guidance on the Mental Health Act to support compliance. Records we were shown, for people under a CTO, were comprehensive and plans of care had been agreed with the person. We saw that they were reviewed accordingly.

We conducted a number of focus groups. In one staff told us that at times lack of, and delays in acquiring inpatient beds, caused further deterioration in the person's mental health. They described instances of community patients needing detention under the Mental Health Act, due to further deterioration in their condition, when people had initially agreed to informal admission. This meant lack of bed availability was at times impacting upon patient care and safety. Staff raised concerns regarding plans for further bed cuts.

City Recovery Team

Assessment and delivery of care and treatment

The City Recovery Team offered a range of evidence based psychological therapies. Groups included recovery groups and a Bi-Polar Disorder group. Two members of staff had recently undertaken a Meridian behavioural family therapy course and plans were in place to utilise this to improve patient outcomes. Staff we spoke with clearly focussed on best outcomes of recovery for people they cared for.

In four records we saw that most care plans and assessment documents were fully completed and reviewed; however other care plans were minimal and contained generic prepopulated statements. This meant that variations existed between staff within the team in regard to completion of documentation. We saw little evidence of physical health monitoring in records although they had been considered on assessment. Staff told us that no physical health checks were undertaken. We saw that

Are services effective?

Good 

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

physical health was mentioned but no further assessment of these needs had been offered. This meant that people's physical health and wellbeing was not routinely addressed as part of a holistic approach.

Staff were able to discuss issues around consent and capacity and how to undertake or organise an assessment for people as necessary. Mental Capacity Act and Deprivation of Liberty Safeguards were part of the mandatory training programme. We saw that mandatory training within the team had, in the main, been completed.

Outcomes for people using services

We saw a monthly audit tool completed by managers covering areas, such as health and safety and records, which was fed into the trust system. Feedback about performance was shared with managers for their action. Areas for improvement were addressed in supervision and team meetings. All proposed action was checked and audited by the team manager.

Staff had attended a recovery conference in March 2014 which included contributions from people using services and their carers. Staff told us this was a good opportunity to share ideas and learning from other teams. Learning was used to help the team develop.

Staff, equipment and facilities

Staff told us they were supported in undertaking training outside of the mandatory training. A robust supervision process was in place. Staff received management supervision monthly. Performance issues and caseload capacity were embedded in this process. Teams we visited had a weekly allocation meeting for case discussion and also a monthly team meeting for more team related issues, which included information sharing from the wider trust. One staff member told us, "The team is well-led and very efficient, they expect high standards".

Multidisciplinary working

Requests for social worker input for patients had to be made via a contact centre with the local authority as social work staff were not integrated into the team. Social workers were involved in multi-disciplinary discussions where appropriate. Information on patients, subject to the Care Programme Approach, was scanned into the electronic system which both health and social services staff could access.

The team was made up of occupational therapists, nurses, psychologists, support workers and psychiatrists. Social work would be asked to become involved if enablement or safeguarding issues were identified. Staff described a good relationship with other teams within the trust. This meant that a multi-disciplinary approach to care and treatment was optimised.

Mental Health Act (MHA)

A social work representative attended the weekly allocation meeting. Staff had access to social workers and advanced mental health practitioners who could provide any guidance on the Mental Health Act, as required, to support compliance. Records we were shown, for people under a CTO, were comprehensive with evidence of people's involvement and multi-disciplinary review.

Early Intervention Psychosis – Highbury Hospital Assessment and delivery of care and treatment

Records we were shown contained outcome based care plans. In one of the four records we looked at the care plan did not reflect current need, or care delivery, as outlined in the progress notes. We saw that care plans were developed with people's involvement. In records we saw comprehensive assessment of need was completed over an initial three month period in order to fully understand every aspect of the people's life.

Some staff we spoke with had undertaken a Meridian behavioural family therapy course and plans were in place to utilise this to improve patient outcomes. We spoke with people who were receiving therapy in a group environment. One told us, "Doesn't want it to stop, finds it helpful". Another said, "I find mindfulness useful and CBT helpful." Therapy programmes available had a focus on recovery and re-enablement.

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

Outcomes for people using services

A range of evidence based tools and education materials were used with people to establish understanding about their illness. These tools were used to help people recognise triggers and patterns to their symptoms. Health promotion was central to the team's work, for example

Are services effective?

Good 

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

issues impacting upon well-being such as drug or alcohol use. Data was collected on a regular basis in regard to outcomes and demographics of people using the service. This was shared with the governance department and staff.

Staff, equipment and facilities

Staff told us they were supported in undertaking training outside of the mandatory training. We saw a robust supervision process in place. Staff received management supervision monthly. Performance issues and caseload capacity were embedded in this process. This included specialist supervision, for staff providing psychological therapies and non-medical prescribers. Managers told us that specialist training for EIP staff was actively encouraged and sought externally. Three clinical meetings took place weekly and covered a range of issues including caseload issues, complex cases and discharge planning.

Multidisciplinary working

We saw the teams approach to assessing and coordinating care ensured that people's needs were understood and

continue to be met over a period of time. EIP staff worked with people for up to three years as per national guidance. Information on patients subject to the Care Programme Approach was shared on the electronic system which both health and social work staff could access. Documents were scanned into the Social Services database in order to share information. The multi-disciplinary team was made up of nurses, support workers, occupational therapists, psychiatrists and a psychologist.

Mental Health Act (MHA)

Staff told us that they had access to social workers and advanced mental health practitioners, within the wider trust, to provide guidance on the Mental Health Act to support compliance. We did not look at records that related to people subject to elements of the Mental Health Act.

Are services caring?

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

Summary of findings

People told us that they were treated with dignity and respect, and we saw that they had access to appropriate literature and information. Staff were skilled and knowledgeable, and spoke to people in a way that was empathetic, clear and simple, without the use of jargon. They were also flexible in their approach to people's needs, often providing support on social and domestic issues. We also saw that each team used a different approach to identifying carer support needs. Staff in the Early Intervention Psychosis Team had adopted innovative and engaging ways to promote the service to young people and engage carers.

Our findings

Newark and Sherwood Flexible Assertive Community Treatment (FACT) Team

Gedling Mental Health Team

Rushcliffe Mental Health Team Kindness, dignity and respect

We spoke with nine people using services and two carers. People and their carers were very complimentary about the care and treatment they received. One person told us, "Nurses have a non-judgemental point of view". Another said, "The support I have had has been really good". They told us they felt listened too and included in each stage of the care they received. We observed a contract being formulated between a nurse and a person using the service which covered areas such as confidentiality, expectations and aims for progress.

One person told us, "The doctor always respects my confidentiality, gives me choice and I feel able to be honest and able to speak openly. They talk to me directly and always ask my husband questions". We observed several interactions between staff and people. Language used was empathetic, clear and simple without the use of jargon. Compassion, warmth and positive engagement with people was seen. Privacy and dignity was maintained, with people being offered a private room in which to wait if preferred. Staff were passionate about their role and patient focussed.

In two records we looked at, no mention or assessment of the person's cultural needs was included. This meant that staff had not considered cultural or personal preferences are part of a holistic assessment.

People using services involvement

We observed a 'Distress Management' Clinic. At the outset outcomes and aims were clearly outlined with full involvement from people. These were reviewed at end of the session. Prior to people's attendance they were sent a questionnaire to complete to their gauge level of need and the impact of this upon daily living activities.

One person we spoke with understood their medication, its use and described side effects demonstrating clear education provided around this. They also had a clear understanding about their mental illness. We observed a home visit and the person did not have a clear understanding about medication and side effects. During another visit we observed relapse signature work being undertaken with people. They told us that they had been in receipt of care for some years but this was the first time relapse signs had been discussed with them. This meant that there was lack of a consistent approach to people's involvement and education about their illness.

Staff were flexible in their approach to people's needs. For example, due to lack of provision of another appropriate service, we saw staff were supporting people with retirement issues and concerns about extradition. Staff told us that their role was variable with the aim of assisting people towards recovery.

Staff were clear about how to secure advocacy services for people. Information available about the service included how to access advocacy services. Appropriate literature and information was seen that people were routinely provided with throughout their treatment. These were available as necessary in a variety of accessible formats.

Emotional support for care and treatment

We met or spoke with seven people and two carers who used the service and received many positive comments. Staff we met with told us that people's carers were involved in their assessment and care planning. In a number of records we looked at, no evidence was seen of carer's involvement, when a carer had been identified. One record

Are services caring?

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

identified a person who lived on a part time basis with their carer and documented discussion was held about carer support availability. This meant a variation of the consideration of carer support needs was evident.

The group therapy sessions we observed saw homework given to people and the group facilitator addressing any emotional support people may need at the close of the session. They were provided with information regarding relevant websites, support groups and carer support available to them outside of the group. Content also included education about managing emotions and the creation of a crisis plan towards the end of the course. Within the teams a carer lead was identified and they were able to share best practice, and a more in-depth knowledge, of availability of support mechanisms available for carers.

City Recovery Team

Kindness, dignity and respect

We spoke with a user of the service. They spoke highly about the support staff provided to them. They told us they felt listened too and included in each stage of the care they received. Staff told us that privacy and dignity was maintained with patients always offered a private room in which to wait if preferred. In the main people would come to the base to be seen but staff told us they would see people at home according to their preference. Staff were passionate about their role and spoke positively about the people they cared for.

In two of the records we looked at there was no mention or assessment of the person's cultural needs. This meant that staff did not consistently consider cultural needs as part of a holistic assessment.

People using services involvement

Staff we spoke with knew how to access advocacy services for people. Staff were supporting people with a range of social issues and enabling them to access local support and advisory services. Staff told us that their role was varied but always with consideration of assisting people towards recovery.

Appropriate literature and information was routinely provided to people throughout their treatment. These were available as necessary in a variety of accessible formats. Information available about the service included how to access advocacy services.

Emotional support for care and treatment

Staff we met with told us that people's carers were involved in their assessment and care planning. We saw evidence of this in records we were shown. We spoke with staff and they told us the philosophy of the team was recovery and they encouraged active involvement of people in planning their care needs. People were provided with support to access community services. Information on websites, support groups and carer support was routinely provided. The team ran a number of groups and content included a range of recovery focussed education material about their illness and helping people to identify relapse triggers.

We saw that people were supported in all aspects of their well-being such as accessing tenancy support and benefits information.

Early Intervention Psychosis – Highbury Hospital

Kindness, dignity and respect

We observed interactions between staff and people and saw an excellent example of compassionate and sensitive engagement. Throughout the process staff checked the person had a clear understanding. Language used was empathetic, clear and simple without the use of jargon. The staff we spoke with were passionate about their role.

People using services involvement

We observed people being given a choice of follow up appointments in their preferred location. Staff provided an information pack on the person's first appointment and encouraged them to make contact in the meantime if issues arose. Staff we spoke with were clear about how to access advocacy services for people.

We saw that appropriate literature and information was routinely provided to people throughout their treatment. These were available as necessary in a variety of accessible formats. Each year EIP staff had a stall at fresher's week at the local university. They handed out a variety of items focussed on drawing attention to their service for young people who may be experiencing mental health issues. For example fridge magnets and mobile phone cleaning cloths. This meant information and contact numbers were made available in accessible forms tailored to younger adults.

Emotional support for care and treatment

Staff positively engaged family, friends and carers who supported people using their service. The manager told us they had run a number of care courses in the past. On the evening of our visit to the team they were having a 'Family

Are services caring?

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

and Friends Evening'. Staff told us this was an opportunity to meet the team and find out what they do, whilst giving people an opportunity to share experiences. We were told the plan was to also re-launch the carer's educational course by asking people and their carers what subjects mattered most to them. Times, location and length of

sessions were to be established according to carer needs. Past courses had been less well attended due to such issues. This meant that the needs and wishes of carers were considered in planning support for care and treatment of people using the service.

Are services responsive to people's needs?

Good 

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

Summary of findings

We found that people's preferences for receiving care close to home were not always met out of hours, and they often had to travel some distance for assessment or treatment. However, waiting lists, which overall were small, were managed effectively. Information about how to access help was also provided for people waiting for a service, and the teams had good links with voluntary agencies to access services for people. In addition, local people were encouraged to have their say in how services were developed.

Our findings

Newark and Sherwood Flexible Assertive Community Treatment (FACT) Team

Gedling mental health team

Rushcliffe mental health team

Planning and delivering services

We saw that the team operated a duty system, 9-5. In the Newark and Sherwood FACT TEAM, in the main, four staff were available to cover incoming referrals, including urgent referrals. Staff told us that they prioritised work according to risk and identified need. We observed a handover at the beginning of the day and observed work being prioritised according to risk.

We identified that barriers existed for people in regard to accessing a service out of hours. Crisis teams provided telephone support but only after 9pm. People were directed in such cases to the A&E department at the Queen's Medical centre where they would receive an assessment under the Mental Health Act or assessment in the A&E department as appropriate. This meant that appropriate provision out of hours, to suit people's preferences and needs was minimal, and unlikely to meet the Crisis Support Concordat (February 2014). Staff told us that outside of the input provided by community teams, the options for support were often limited to admission to an inpatient bed out of working hours. This meant that access to care at home, or as close to home as possible for people was not always available, particularly out of hours.

We saw that people needing an inpatient bed had to travel a distance from their families, in some cases this was up to 20 miles away. This issue was particularly problematic for people using services in the Newark and Sherwood areas.

One person we met with felt they would like more daytime activities. Support staff identified that the lack of accessible services, that provided day care or drop in facilities, impacted upon people's options for establishing networks outside of mental health services. We were introduced to a Framework worker. Framework is a registered charity and housing association that exists to tackle the causes and consequences of homelessness. They visited the community teams regularly to identify people with accommodation and housing issues and assisted them.

Despite some concerns it is noted that reconfiguration of the Newark and Sherwood service had been undertaken with public consultation at the heart of its development. The service was shaped around the perceived local need and in relationship with local commissioners.

Right care at the right time

Waiting lists were low and prioritised by the team managers, with contact made by letter with details of how to access services as an interim measure. Care and treatment provided was only cancelled when absolutely necessary and any need for cancellation explained to the person directly with alternatives offered to access support. This would mainly be through the team's duty system. Staff sickness issues were mitigated using cross cover, particularly within the Rushcliffe and Gedling teams.

Local population consultation had identified the need for rapid assessment, with an ability to treat with an increased frequency of contact. Teams we visited acted as a duty worker for a single point of access. Staff told us, at times, volume of need and capacity issues prevented delivery of a responsive, flexible service. Development of a non-medical prescriber assessment service was seen in the Rushcliffe team. Managers told us that further development of this service in all teams was planned.

Seven people we spoke with were in receipt of the numbers to call if they needed a response to an immediate crisis. One carer told us that although they were supportive, and offered an appointment in the morning, they had found the overnight period "challenging" and would have

Are services responsive to people's needs?

Good 

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

appreciated a face to face contact during the night without having to travel. This meant that flexibility of services, out of hours, did not allow for a timely response to individual's needs.

The records seen showed two people who had made contact with the team in need of assistance. Records indicated that the team's responsiveness to this had been poor with no analysis or reasoning for the extended time for visiting the person. We raised two particular people's care at the time of our visit for staff to review. This meant that people may be experiencing unnecessary waits for care and treatment. Capacity for teams to visit was given as a possible issue. Recent data the trust has collected had shown a reduction in admissions locally, but an increase in A&E attendances of people being cared for by community teams. This meant that access to services may not be as responsive as was necessary to meet people's needs.

Care Pathway

Staff told us that all members of the team were valued and respected regardless of discipline or level of seniority. We were able to observe teams working in collaboration and saw many examples of positive working relationships. Transfer of care between teams and shared care within teams was effectively managed. This enabled smooth transition between teams for the patient as part of their ongoing recovery. Staff were clear about the lines of accountability and who to escalate any concerns to.

People ready for discharge from inpatient wards, requiring community team follow up with a level of monitoring, were managed in the interim by the crisis team as community teams, at times, had no capacity to take on newly discharged people. Team managers confirmed there was an issue with capacity. Meetings were not routinely arranged with the crisis team to discuss people in transition and staff did undertake joint visits from time to time. We were informed the crisis team provided most of the initial face to face contact post discharge. Whilst this does provide some contact through the vulnerable period post discharge, this may fall short of the intention that a service user on leaving hospital should be engaged quickly and seen by their intended regular care team. One person using the service described transition between the wards and community, stating, "It could be smoother".

Within teams initial triage was undertaken with people being referred, either by phone or face to face, to agree upon the immediate plan of care and level of contact. This

had a degree of flexibility and was subject to change in consultation with people. One person told us, "I had a conflict of interest which staff took into account and allowed me to stay with a team who had been caring for me previously". This meant teams we visited operated with a degree of flexibility to meet patient needs.

As the generic FACT team covered the functions of the former functional teams, queries with regards to the 'gate-keeping' of admissions to determine whether a community acute care package could be provided as an alternative were asked. We were informed that the crisis response service provided this and often this was done over the telephone. Given reports, and concern over the lack of capacity or design to provide acute care within people's homes, it is unlikely that this process has a meaningful client centred outcome. No available audits of the outcome of such gate-keeping assessments were available to us at the time of the visit.

Learning from concerns and complaints

Staff were aware of the trust's complaints policy. Complaints were received directly and passed to the team manager or from the Patient Advocacy Liaison service (PALS). We saw a number of posters in reception areas used by people on how to make a complaint. Information leaflets about each service included this information as well. A waiting room we saw had information available and forms to complete, alongside a post box to place completed forms in. People we spoke with had not had the need to make a complaint but felt sure of how to take forward any issues they had.

Trust wide learning from complaints and incidents was demonstrated through the team manager sharing information with staff, and providing updates via the trust's email system. This information was included and discussed at monthly team meetings.

City Recovery Team – Stonebridge House Planning and delivering services

The team operated a duty system from 9am-5pm. Staff told us that they prioritised work according to risk and identified need. Crisis teams were able to provide telephone support but no face to face contact after 9pm. People were directed to the A&E department at Queen's Medical Centre for assessment in an urgent situation. This meant that there was limited appropriate provision, out of hours to suit people's preferences and needs.

Are services responsive to people's needs?

Good 

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

Support staff told us the lack of accessible services providing day care, or drop in facilities, impacted upon people's options for establishing networks outside of mental health services. We saw that the majority of people were seen in the community bases and clinics. People receiving medication in community were given choices as to where they received this according to geographical location. There were five medication clinics available across the county. This meant the service made appropriate provision to meet people's needs.

Right care at the right time

Forty people were on the waiting list when we visited. The team manager monitored the waiting list and prioritised referrals according to need and risk. People were sent a letter, with details of how to contact the duty worker and access services, as an interim measure. Care and treatment provided was only cancelled when absolutely necessary and any need for cancellation explained to the person directly, with alternatives offered to access support. This would be through contact with the duty worker. Discharge planning was discussed monthly with the team and in staff supervision. Good practice around discharge was also shared in a practice forum which took place fortnightly.

The team acted as a single point of access, with initial contact from a duty worker. People we spoke with were in receipt of numbers for services available for contact in a crisis, out of hours, including the Samaritans.

Care Pathway

Staff told us they felt coherency within the teams and that all members were valued and respected, regardless of discipline or level of seniority. We were able to observe teams working in collaboration and saw many examples of positive working relationships. Records seen showed transfer of care between teams and shared care within teams was effectively managed. Staff told us that they had a good relationship with other teams. This enabled smooth transition between teams for the patient as part of their ongoing recovery. Staff were clear about the lines of accountability and who to escalate any concerns to.

Therapy groups were formulated according to people's presenting needs. The team operated in a flexible manner and worked with other agencies to ensure people's needs were met.

Learning from concerns and complaints

Staff were aware of the trust's complaints policy. Complaints were received directly and passed to the team manager or came from the Patient Advocacy Liaison service (PALS). Staff told us they were confident on how to direct or advise people with any concerns or complaints.

Evidence of trust wide learning from complaints and incidents was demonstrated through the team manager sharing information with staff, and globally through updates via the trust email system. This information was included and discussed at monthly team meetings. One person using the service, we spoke to, had not had the need to make a complaint but felt sure of how to take forward any issues they had. Staff told us that people who had made complaints were kept up to date as to its progress. Investigations of complaints were completed by the service manager where appropriate.

Early Intervention Psychosis – Highbury Hospital Planning and delivering services

Staff prioritised work according to risk and identified need. We saw that the provider had employed both male and female staff from different ethnic backgrounds. This ensured staff were able to support people with their gender, cultural and personal preferences. Information was accessible on the trust's website about the purpose of the service and how to be referred into it. Referrals to this team were usually via a GP into a Single Point of Access. Referrals were also picked up following acute crisis or during an inpatient admission.

Right care at the right time

No waiting list was in operation. However people could wait up to eight weeks for an initial appointment. Staff told us this could be challenging, as waiting times were a key performance indicator for EIP teams, in relation to the duration of untreated psychosis. Cases were prioritised and discussed by the MDT with contact made by letter, including details of how to access services as an interim measure. Care and treatment provided was only cancelled when absolutely necessary, and any need for cancellation explained to the person directly with alternatives offered to access support. Managers described a recent history of delays in transferring people into community mental health teams. This had meant the team had held people on the caseload over the three year limit due to other team's capacity issues, but this had been less of an issue in recent weeks.

Are services responsive to people's needs?

Good 

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

People were provided with telephone numbers for assistance if they needed an urgent response outside of working hours. EIP staff frequently liaised with the crisis team on site regarding people who may present out of hours, or at weekends, due to a deterioration in their mental health. This allowed copies of any paper records to be made available to them should the person make contact. In some instances the crisis team would visit and monitor people open to the EIP team, at their request, out of hours. This meant that when people had urgent needs these would be met with some level of knowledge about their specific needs.

Care Pathway

Staff told us they felt valued and respected regardless of their discipline or level of seniority. We spoke with staff who were able to give a clear overview of the care pathways within the team and this involved collaborative working. Transfer of care between teams, and shared care within

teams, was overall effectively managed. This enabled smooth transition between teams for the patient as part of their ongoing recovery, although no audit was undertaken after discharge to ascertain effectiveness of the transition.

People ready for discharge from inpatient wards would be seen whilst still an inpatient to begin building a rapport and relationship thus optimising engagement in community. Relationships with other teams in the trust were described as good overall.

Learning from concerns and complaints

Staff were aware of the trust's complaints policy. Complaints were received directly and passed to the team manager or from the Patient Advocacy Liaison service (PALS).

Trust wide learning from complaints and incidents was demonstrated through the team manager sharing these with staff, and globally, through updates via the trust email system. This information was included and discussed in the team's non clinical meetings.

Are services well-led?

Good 

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

Summary of findings

Overall, community teams were well-led at a local level. Staff told us that they were proud of the service they delivered, and that they felt well-supported by their immediate managers. We also observed that the team members were supportive of each other. There were systems in place to ensure that staff received information from the trust, and most staff were aware of board level leadership and the overall vision of the trust. However, some staff told us that had little or no involvement in local meetings, for example about governance, and said that they felt somewhat detached from the issues. The trust recognised staff through an annual awards scheme, which highlighted staff innovation and excellence in the delivery of care.

Our findings

Newark and Sherwood Flexible Assertive Community Treatment (FACT) Team

Gedling Mental Health Team

Rushcliffe Mental Health Team

Vision and strategy

Staff we spoke with told us they felt well supported by their managers. They spoke positively about their role and demonstrated their dedication to providing quality patient care. They told us that senior managers, and the board, engaged them, provided information and consulted with them in a variety of formats. Key messages about the trust were communicated to all managers at monthly senior management meetings and shared with the team.

We ran a number of focus groups as part of inspection and it was noted that psychologists and psychiatrists appear to provide little input into key organisational meetings. This meant that vision and values may not be developed with input from all professional groups.

Responsible governance

Staff told us that they felt well supported by their line manager. We saw all the staff in teams received a variety of clinical, managerial and group supervisions. Staff attended

regular team meetings. Trust vision was cascaded through emails and shared in team meetings. Staff told us monthly business meetings were a good arena for feedback in regard to audits, incident and developments.

Some staff groups told us that they had no involvement in local meetings with governance and stated they felt somewhat detached from the issues around governance. We saw that staff routinely received information governance training. A trust wide risk register was in place and managers told us this was an effective tool for capturing ongoing concerns.

Feedback from one of our focus groups included concerns about the use of two different recording systems. Staff told us electronic records contained only minimal information and paper records were not always accessible. This meant that risk history was not always easily available, which impacted on patient care and attending staff. Managers told us a plan for a fully electronic record system across the trust was due for completion over the next 12 months.

Monthly monitoring of records were undertaken by team managers and submitted to the governance team by managers. They receive in return bi-monthly reports to monitor their performance. Audits of records we saw were not in-depth in regard to outcomes for people contained in care plans and progress notes.

Staff attendance on training was monitored by managers. A training grid was seen and this was updated and shared with staff.

Leadership and culture

We saw a supportive culture within teams. Staff had a broad understanding of the current and future need of the organisation. We saw that staff were passionate about their work and showed a genuine compassion for people.

Focus groups were undertaken during our inspection. Staff attending these told us senior management communicated well with them without a large amount of hierarchy. One staff member told us, "Senior managers are very visible, very approachable and very aware". Others stated "We are listened to" and that, "Change does happen".

The trust had an annual OSCARS (Outstanding Service Contribution and Recognition Awards), which covered a variety of areas such as the Unsung Hero Award for clinical and non-clinical staff which recognises an individual who

Are services well-led?

Good 

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

went beyond their job description, or The Valuing Difference Award where work had been demonstrated to show how the trust reflected the diversity of communities it served. We met with a winner of an OSCAR who had set up clinics for people with personality disorder to meet local demand. This meant the trust openly rewarded and recognised good practice.

Engagement

One staff member told us, "I have never known an executive of the board visit the team." Staff told us the board did provide information to them about developments and gained their opinion through the annual staff survey. People were asked about their views of the service via satisfaction surveys which related specifically to the team that cared for them. These were provided to people at least every six months. This meant the trust actively sought people's opinion and participation in improving service delivery.

Staff were aware of the whistleblowing policy and that they would feel confident to report and refer concerns if it was needed. The whistle blowing policy was available on the trust's intranet site for staff to refer to.

Performance Improvement

Staff we met with understood their aims and objectives in regard to performance and learning. We saw that service developments were being monitored for efficacy and with consideration of local needs. We saw that monthly team meetings focussed on team objectives and direction, particularly through the implementation of new ways of working.

The National Confidential Enquiry noted some early signs that areas that had amalgamated functional teams, such as the FACT Team, were starting to demonstrate a higher suicide rate. We spoke with the Service Manager who told us that they were reporting on referrals and activity at present for the team. No plans were known about consideration for monitoring of such risks. Whilst this is not a clear risk it does need to be monitored. This meant that the impact on quality and safe innovation needed to be considered for this service.

City Recovery Team

Vision and strategy

Staff told us senior managers engaged, provided information and consulted with them in a variety of

formats. Language used by staff reflected a strong team with a caring attitude. Key messages about the trust were communicated to all managers at monthly senior management meetings and shared with the team.

Responsible governance

Monthly monitoring of records, referrals and health and safety issues were submitted to the governance department by the team manager. Where people were not seen within trust targets an exception report was routinely submitted to the governance team. Staff attendance on training was monitored by managers. Records we saw showed that mandatory training within the team was up to date. A trust wide risk register was in place and senior staff informed us that this was generally an effective tool for capturing factors that may affect care delivery, such as waiting lists and staff sickness.

Staff received clinical, managerial and group supervisions as required. Staff described supervision they received as meaningful and a two way process. Staff told us they received information about the trust plans and vision through email and these were discussed at team meetings.

Leadership and culture

Staff told us they were able to speak open and honestly to their manager and felt they would act on any concerns raised. Staff appeared happy in their work and had a genuine passion for people and their recovery. They described a supportive relationship with their manager. Regular team meetings were held, with minutes of the meetings completed and distributed. Meetings were held every month which all grades of staff were encouraged to attend. They covered issues such as service performance, untoward incidents, complaints and health and safety. This meant that teams were able to have a collective responsibility for areas of concern.

Engagement

Staff we spoke with were aware of the whistleblowing policy or knew where to find it if they identified a concern that had not been dealt with through other mechanisms. All the staff we spoke with felt they would be able to raise concerns and were able to provide feedback to their managers.

Are services well-led?

Good 

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

People were asked about their views of the service via satisfaction surveys, relating specifically to the team that cared for them, which asked them to rate the quality of the staff that supported them. These were provided to people at least every six months.

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

Performance improvement

Staff we met with understood their own aims and objectives in regard to performance improvement and learning, from regular formal supervision and appraisal. Staff told us they valued the supervision they received. Monthly team meetings focussed on team objectives and performance.

Early Intervention Psychosis, Highbury Hospital Vision and strategy

Staff reported to us that morale in teams was high. Key messages about the trust were communicated to managers at monthly senior management meetings. Staff spoke passionately about the work they did and found the work incredibly rewarding. They told us that senior managers and the board members engaged, provided information and consulted with them in a variety of formats.

Responsible governance

Staff received a variety of regular supervision, for example clinical, line management and professional. They told us these were well organised and meaningful. Team meetings were on a monthly basis and used as forum for sharing relevant information. Trust vision was cascaded through regular emails globally around all trust employees. The manager told us that monthly business meetings were good for feedback in regard to audits undertaken.

Staff confirmed that they had an understanding of governance issues and had received 'information governance' training. Monthly audits relating to records and training were submitted to the governance department and action plans discussed in supervision and

updated accordingly. The team manager completed surveys set up in 'Survey Monkey' an online survey tool. Data was collected and inputted regarding patient demographics and around intervention provision. We saw published data that had been collated from this. This meant that performance of the service was monitored in order to drive improvement. An audit of records, which we saw had been undertaken on five random sets of records each month. Effectiveness of the audit was questionable based on our findings.

Leadership and culture

We saw a supportive culture within teams, with staff displaying a positive regard for each other. Staff had a broad understanding of the current and future needs and goals for the organisation. Staff we met with were passionate about their work and showed genuine compassion for people. We saw a sense of collective team responsibility with good levels of supervision, support and clinical discussion in place. Staff told us they were able to raise issues without fear.

Engagement

Staff were aware of the whistleblowing policy. They told us that they had not needed to use it as could speak openly and honestly. A copy of the policy was available on the trust's intranet site.

The team actively sought seeks people's feedback by asking people to complete satisfaction surveys every three months. The questionnaires were anonymised so this meant that people were able to be open and honest about the service they received. Staff were knowledgeable about how to access advocacy services for people.

Performance Improvement

We saw that the team invested time and resources into supporting staff. Staff we met with understood their aims and objectives in regard to improvement and learning. We saw that monthly team meetings focussed on maintaining a high quality of service delivery and improving ways of working.