

Nottinghamshire Healthcare NHS Trust

Perinatal services

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
Duncan Macmillan House	RHA03	Community Perinatal Mental Health Team	NG3 6AA
Nottingham University Hospital	RHARA	Margaret Oates Mother and Baby Unit	NG7 2UH

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

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

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

Summary of findings

Ratings

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

Overall rating for Perinatal Services

Good 

Are Perinatal Services safe?

Good 

Are Perinatal Services caring?

Good 

Are Perinatal Services effective?

Good 

Are Perinatal Services responsive?

Good 

Are Perinatal Services well-led?

Good 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

Perinatal services provided by Nottinghamshire Healthcare Trust were delivered in a safe and caring environment. People told us that staff were kind and interacted well with them and their families. Referrals to community teams were sometimes delayed, but the team did provide a good service.

Although some of the records were not up-to-date, staff understood the risks to people's health and welfare. Managers also had a good understanding of the service and the areas that needed more improvement.

We found that staff understood how to follow the local multi-agency policies and procedures for protecting adults and children. They worked well with other teams and agencies, both within the trust and with external organisations, such as primary and secondary healthcare. However, not all the teams were multidisciplinary. Some

groups had established good links with, for example, midwives and health visitors, but there was little involvement from occupational therapy services and there were no social workers in the teams. There was little input from clinical psychologists across the inpatient and community services, and staff told us that inpatients found it difficult to access to GPs.

People on the ward and in the community were able to provide feedback on the service, and people said that they felt involved. Staff told us that they enjoyed working in the service and felt supported by their managers. However, we heard that there had been many changes in the management structure above the ward manager level and that this had been unsettling. Most staff we spoke to, however, felt that this was improving.

Summary of findings

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

Are services safe?

Staff in the perinatal services had a good understanding and knowledge of safeguarding procedures for children and adults. The trust also had a strong process for reporting and managing incidents. We saw that staff used past incidents to learn from and ensure future safety, and that the service had been developed in order to learn from incidents. Risks were identified and managed both in the community and on the ward.

Good



Are services effective?

Staff in perinatal services had a good understanding of best clinical practice, including NICE guidelines. In addition, the community and inpatient teams had undertaken specialist accreditation programmes, including peer reviews, through the Royal College of Psychiatrists. Staff worked well together and had strong links with health visitors and midwives. There were, however, gaps in the provision of clinical psychology, occupational therapy and social work.

Good



Are services caring?

People we spoke with in the community and on the inpatient ward were very positive about the care they had received. They told us that staff treated them with respect, dignity and kindness, and we saw staff treating people well and delivering excellent care. People were involved in making decisions about their care and treatment, and their families and carers were involved when appropriate.

Good



Are services responsive to people's needs?

Perinatal services were mostly responsive to people's needs and staff understood the needs of local people. Waiting times for the community teams were affecting how quickly the service could respond, but work to review this had started. Staff could get help from interpreters when they were needed, but support from the chaplains on the inpatient ward was more limited as they were no longer based at Queen's Medical Centre.

Good



Are services well-led?

Staff told us that they felt well supported by their immediate line managers and were proud to work for the service and the trust.

Good



Summary of findings

Background to the service

Nottinghamshire Healthcare Trust provides an inpatient and community specialist perinatal service. This service consists of one inpatient ward, Margaret Oates Mother and Baby Unit, which has six beds and is based at Queen's Medical Centre. There is also one community perinatal mental health team which covers the city of Nottingham and the county of Nottinghamshire. This team is spread across two sites at Queen's Medical Centre and King's Mill Hospital.

These services have not previously been inspected by the Care Quality Commission (CQC), but Mental Health Act commissioners have previously visited the inpatient ward. We looked at the reports from these visits as part of this inspection process.

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Lelliott – Deputy Chief Inspector for Hospitals (Mental Health) Care Quality Commission

Team Leader: Jenny Wilkes, Care Quality Commission

The team included CQC inspectors and a consultant psychiatrist.

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 the 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 perinatal services of Nottinghamshire Healthcare NHS Trust between 29 April and 2 May. Before

visiting, we reviewed information from the provider and considered feedback from relevant local stakeholders including the local Healthwatch organisation, advocacy services and focus groups held with people who used the service.

During the inspection, we spoke with staff, people who used the services in the community and on the ward, and their family members. We also observed how people were treated on the ward and we reviewed records held.

What people who use the provider's services say

Before the inspection, we used focus groups to speak to people who used the service. During the inspection, we spoke with people who were on the ward and their family members, as well some people who used the community services.

We found that people were very positive about their experiences of care and we saw that staff were kind to and interacted well with patients.

Summary of findings

Good practice

- People received care that they found to be kind and compassionate.
- Good local links had been developed with midwives, health visitors and obstetricians.
- Staff were supported by managers, groups and specialist supervision.
- Staff could undertake specialist training to support them in their roles.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve:

- The trust should ensure that records in the perinatal community team are up-to-date.
- The trust should consider how better access to community GPs is provided on the Margaret Oates Mother and Baby Unit for children.
- The trust should consider how access to the occupational therapy input and structured activities on the Margaret Oates Mother and Baby Unit could be improved.

Nottinghamshire Healthcare NHS Trust

Perinatal services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)

Community Perinatal Mental Health Team

Margaret Oates Mother and Baby Unit

Name of CQC registered location

Duncan Macmillan House – Trust Headquarters

Nottingham University Hospital

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 on the ward, and in the community, had received training specifically related to the Mental Health Act (1983) and the Mental Health Act Code of Practice. Information we received and collected on the ward indicated that there was an understanding of the responsibilities of ward staff in relation to people who were detained under the Mental Health Act. However, we did not

find evidence that one person who was detained had been offered an Independent Mental Health Advocate (IMHA). We found that there was information prominently displayed regarding access to advocacy services and there was information available for detained and informal patients about their rights on the ward. However, we found that, in the notes of two patients who had been admitted to the ward informally, it had been indicated that they had been persuaded to stay on the ward.

Mental Capacity Act and Deprivation of Liberty Safeguards

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

in the community teams and had attended training to ensure that they had the requisite knowledge. This training was completed online and was a part of the mandatory trust training.

Are services safe?

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

Summary of findings

Staff in the perinatal services had a good understanding and knowledge of safeguarding procedures for children and adults. The trust also had a strong process for reporting and managing incidents. We saw that staff used past incidents to learn from and ensure future safety, and that the service had been developed in order to learn from incidents. Risks were identified and managed both in the community and on the ward.

Our findings

Community Perinatal Mental Health Team Track record on safety

We spoke with the manager of the community perinatal mental health team who had a good understanding of the current risks in the service. Past incidents were discussed at team business meetings to ensure that safety issues were addressed by the staff and that staff were aware of them. Meetings were held at all levels within the team to ensure that information regarding safety and previous safety concerns were addressed at a local and divisional level.

Learning from incidents and improving safety standards

The team used a trust wide system to report incidents through the Ulysses/IR1 reporting tool. Staff we spoke with were aware of the incident reporting procedures. When staff reported incidents, managers checked the reporting and ensured that the incidents were recorded appropriately and were able to track responses to incidents. Staff were able to give us examples of learning that the team had integrated into practice as a result of previous incidents. Clinical governance meetings took place for specialist services within the trust and incidents were reported. Serious untoward incidents were a standing agenda item for these meetings which ensured that they were raised through the division.

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

Training in safeguarding children and adults was a part of the trust's mandatory training programme. Staff we spoke with had a good understanding of safeguarding processes. Most staff had completed their required safeguarding training; however staff told us that sometimes it was

difficult to "get the dates" for the training. There was no identified safeguarding lead in the service. We were told that the trust safeguarding team were responsive when concerns were raised and assisted with advice. We saw that documentation in the community teams included specific risk assessments which related to safeguarding children so that issues could be raised as alerts. The team worked with local authority social workers however staff told us that they did not always receive feedback about referrals which they had made.

Assessing and monitoring safety and risk

People who used the service were initially assessed as part of the assessment process related to the consideration of risks. We checked sixteen files in the north and south part of the Community Perinatal Mental Health Team. In most of the documentation we reviewed, risk was defined and there were robust risk management plans in place, which were a part of the care planning process. However, in four of the files in the south area of the team, we saw that no risk assessment documentation had been completed. The manager told us that doctors had adopted a practice of documenting risk assessments and risk management plans in their assessment letters. We saw letters where this was not addressed specifically which meant there were no clear and documented risk assessment and risk management plans in some of the documentation.

We asked staff about their understanding of the risks to patients from the case notes and they were able to identify where the main risk areas lay. However, the lack of a risk assessment document, which highlighted the current and historic risks to individual patients, may mean that there is a risk that practitioners would not be aware of the risk histories. This was a particular concern if they were working with people not allocated, or known, to them.

Understanding and management of foreseeable risks

The community perinatal mental health team were fully staffed and had access to additional staff according to trust policy if required.

Margaret Oates Mother and Baby Unit Track record on safety

The ward manager had a good understanding of the service and was able to identify the highest risk areas for the ward. We saw that issues identified as risks had been addressed, for example, ligature risks which had been identified and managed. Staff had a good awareness of

Are services safe?

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

recent incidents in the service and actions which had been taken as a result. The service had regular business meetings where identified risks and incidents were discussed so staff were aware of them. There were no recent serious untoward incidents linked to this service.

Learning from incidents and improving safety standards

Staff were able to explain how incidents were recorded and used the trust Ulysses system to ensure that all incidents were logged. All incidents were monitored by the ward manager before they were collated centrally by the trust. Staff had regular meetings and supervision where incidents were discussed in order to embed learning. We checked the minutes of business meetings and supervision sessions and saw that learning from incidents, comments and complaints was embedded. The ward manager attended a service level clinical governance meeting which addressed incidents from other service areas and within other departments in the trust ensuring learning took place across different services. The manager who attended was then responsible for making sure that the information was fed back to all staff.

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

Care was delivered in a clean and hygienic environment and the ward had an infection control lead who was able to ensure that practice was maintained to a high standard. We observed the ward to be clean. Staff had attended training on safeguarding children and adults and the staff we spoke with were aware of the procedures to escalate and report concerns when they had them. We saw that there was a safeguarding lead identified for the ward however when we spoke with staff there was some confusion about identifying the safeguarding lead. Staff told us that they worked with local social services to make referrals related to safeguarding and concerns that they had as necessary.

We saw that there had been a recent environmental risk assessment which addressed the ward area. There was also a recent ligature risk assessment which identified areas where there was a higher risk and ensured that there were actions in place to address these identified risk areas.

Assessing and monitoring safety and risk

We checked the staffing levels and rota on the ward and saw that there were two staff on duty at all times, day and night. The staffing rota reflected the number of staff who were assessed to be necessary on the ward. However, some staff and patients told us that they felt the staffing levels were stretched at times. We checked records on the ward and saw that risks were identified and addressed. We observed a multidisciplinary meeting where identified risks were discussed with people in a clear way to ensure their involvement. We saw that records of close observation and monitoring of mothers and babies was maintained to ensure that practice in this area was safe. We saw that there was good use of risk assessments in managing risks to people on the ward.

Staff we spoke with on the ward had a good understanding of the needs of the current inpatients. We spoke with the consultant on the ward who told us that most people were admitted to the ward informally. We looked at the records from one person who was on the ward informally and there was no record that their capacity to understand and consent to an informal admission had been assessed. The same person's notes evidenced that they had asked to leave the ward but had "been persuaded to stay". We saw another patient, who was admitted to the ward informally, had stated "wanted to go home tonight, quite adamant at first but agreed to stay".

This meant that there may be a risk that preventing informal patients from leaving the ward, without a clear record of the reasoning, may not reflect the Mental Health Act Code of Practice which states that informal patients should not be obliged to ask permission to leave the ward.

Understanding and management of foreseeable risks

The ward was based in an acute hospital and staff had access to emergency medication and equipment when it was necessary. We saw that staff had training in emergency resuscitation for infants which was mandatory in this service. There were comprehensive contingency plans for the ward.

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

Are services effective?

Good 

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

Summary of findings

Staff in perinatal services had a good understanding of best clinical practice, including NICE guidelines. In addition, the community and inpatient teams had undertaken specialist accreditation programmes, including peer reviews, through the Royal College of Psychiatrists. Staff worked well together and had strong links with health visitors and midwives. There were, however, gaps in the provision of clinical psychology, occupational therapy and social work.

Our findings

Community Perinatal Mental Health Team

Assessment and delivery of care and treatment

Staff were aware of the most recent, relevant NICE guidance. Information about the latest clinical research and policy was disseminated by email to all staff. Capacity to consent to care and treatment was addressed as part of the assessment process and we saw that this was documented. Physical health needs were addressed and documented to ensure that these needs were addressed during people's care with the team.

Outcomes for people using services

The community perinatal team used Health of the Nation Outcome Scales (HoNOS) to monitor outcomes for people. There were a number of audits which were carried out in order to ensure that service needs were identified and could be used to improve the effectiveness of service delivery. For example the service had introduced record keeping audits. The team manager had begun asking the community psychiatric nurses to self-audit their records so that they could identify areas of strong and weak practice as a learning tool for themselves.

The community perinatal mental health team had taken part in the Royal College of Psychiatry accreditation scheme for community perinatal services and had received positive and useful feedback in this area. This meant that the service was committed to developing and benchmarking against similar services in England.

Staff, equipment and facilities

Staff in the community perinatal mental health team had access to regular supervision. As well as monthly

managerial supervision, the team had regular group supervision facilitated by a clinical psychologist. Three of the nurses in the team had six-weekly supervision, with a cognitive behavioural therapist, and two of the nurses in the team had additional support and supervision from a psychotherapist based in the Children and Adolescent Mental Health Service (CAMHS) team. Capability and competence would be addressed through managerial supervision however the manager told us that this had not been an issue in the staff team.

Staff in the team told us that they had access to internal and specialist training related to their practice. One member of staff told us that they had been supported to take a university degree. All staff told us that they felt the trust facilitated their continuous professional development.

Multidisciplinary working

The team consisted of doctors, nurses and a clinical psychologist with links built with midwives and health visitors which ensured information was shared. Staff also told us that they had built good working relationships with many GPs in the area in which they work. However, the team did not have a social worker based in it. We asked about the way the team liaised with social services and were told that sometimes it could be difficult to get hold of social workers. At times, when staff in the team made referrals, they do not get feedback. There was a clinical psychologist in the team who provided some input to people.

Staff in the team told us that it could be difficult to discharge people to other adult mental health teams in the trust due to the pressures that those teams were experiencing. This meant that at times the community perinatal mental health team retained the care responsibilities for people who would otherwise be referred to adult mental health services. This then had an impact on waiting times for new patients to be seen.

Mental Health Act (MHA)

Staff in the community perinatal mental health team received training related to the Mental Health Act as a part of their core mandatory training.

Margaret Oates Mother and Baby Unit

Assessment and delivery of care and treatment

Staff we spoke with had a good understanding of the current, relevant NICE guidance relating specifically to

Are services effective?

Good 

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perinatal mental health services and to general mental health services in an inpatient setting. The ward manager used team meetings, supervision and emails to ensure that up to date clinical information and research was disseminated to the staff team. Medical staff told us that they worked together to ensure that they were aware of the most recent clinical information and that this was how they ensured that best practice was maintained. We looked at a sample of records on the wards and saw that assessments were completed on admission which ensured that people's needs were documented. We saw that care plans were further extended after 72 hours. The ward used FACE assessment tools (a commercial toolset which had been developed specifically for perinatal services) to ensure that the needs of patients were documented. Physical health needs were recorded on assessment documentation to ensure that they were addressed. Babies accommodated with their mothers also had care plans and the support of a nursery nurse.

Outcomes for people using services

The ward used a number of outcome measures to determine the effectiveness of the service which they delivered. As well as HoNOS, an outcome measure which determines the progress of therapeutic intervention, the ward also used the Bethlem Mother-Infant Interaction Scale (BMIS) to measure progress and outcomes for patients through the service. The service used FACE tools (which was a toolkit developed for perinatal services and embeds outcome measures) and audits these. However, the collection of this data was not being used to its optimum as staff reported they were not compatible with RiO which is the trust electronic database system.

The service was a member of the Quality Review Network for Perinatal Mental Health Services run by the Royal College of Psychiatrists. This meant it had completed a recognised accreditation programme which involved a peer review from clinicians who specialised in perinatal mental health. Staff from the service also participated in peer reviewing other perinatal mental health services nationally, which ensured that there was a cross-fertilisation of specialist knowledge and encouraged the service to develop best practice.

Staff, equipment and facilities

There were two staff on duty on the ward at all times. One member of staff would always be a qualified nurse and the other member of staff would usually be a health care

assistant or a nursery nurse. We saw that staff were supported through regular supervision and team meetings ensuring information was shared and that they felt supported on the ward. However, we saw that at times regular supervision had been cancelled due to the need to prioritise the clinical need on the ward. This meant team meetings were not even taking place once a month. We were told by staff that people on the ward identified staffing as an issue because the activity programme was dependent on the staff who were on duty to deliver it. This was the first thing that was cut when there was a higher need for nursing input on the ward.

Staff had access to internal and external training within their specialisms and there were additional mandatory training modules which supported work in perinatal services. For example, all the staff on the ward had attended additional training regarding breast feeding, paediatric life support, SIDS (Sudden Infant Death Syndrome) and management of medicines.

The ward manager told us that the trust had a policy and framework to manage staff performing poorly. However, there had not been a need to use this. They told us that, when necessary, performance had been managed through supervision.

The ward did not have direct access to a garden space. However, there was a small balcony which was used by people on the ward for container gardening. There were separate areas within the kitchen for the preparation of food for babies who were on the ward and each patient had space within the kitchen for their food and food preparation items to be stored.

The ward had access to an electrical breast pump which assisted patients to express milk and which helped to manage the impact that medication could have on their milk when it was accessed at a different time of day.

As the service was based in Queen's Medical Centre, the facilities management was delivered locally.

Multidisciplinary working

The team on the ward consisted of consultant psychiatrists, nurses, nursery nurses and health care assistants as well as junior doctors. However, there was no occupational therapy time allocated to the ward. This meant that the only access patients had to an occupational therapist was

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.

for specific assessments. Occupational therapists were not involved in running any groups for patients on the ward and any groups or activities were run by the staff team who were based on the ward.

There was no social worker attached to the team. However, the ward manager told us that they worked with local social services when necessary to ensure that there was input. The ward manager had initiated some shadowing visits of staff to the local child protection team to gain a better understanding of the interactions between health services and social care services.

The staff team raised concerns about access to GPs on the ward. They told us that previously they had been able to refer children to paediatricians based at Queen's Medical Centre however, due to a change in the referral processes, these had to be made through a GP and the ward did not have access to a community GP. Subsequently they would try and ask parents to take their children to GPs to facilitate referrals when they were needed. When there was a need for urgent attention, they would take the children to accident and emergency. However, sometimes they took

children to accident and emergency for treatment which was not considered to be an emergency because there were no other routes to the service. This meant that there was a gap and inefficiency in the processes which would enable children on the ward to be treated through the most appropriate route.

We saw that the service maintained close and regular links with midwives and health visitors. The ward manager also told us that they had strong links with obstetricians.

Mental Health Act (MHA)

We were not accompanied by a Mental Health Act Commissioner on this visit. We saw that staff had completed training regarding the Mental Health Act and had an awareness of how it operated on the ward. We saw that there was information available about patients' rights for detained patients and patients who were admitted to the ward informally. We looked at the records for one person who was detained under the Mental Health Act and there was not a record that they had been offered an advocate.

Are services caring?

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

Summary of findings

People we spoke with in the community and on the inpatient ward were very positive about the care they had received. They told us that staff treated them with respect, dignity and kindness, and we saw staff treating people well and delivering excellent care. People were involved in making decisions about their care and treatment, and their families and carers were involved when appropriate.

Our findings

Community Perinatal Mental Health Team Kindness, dignity and respect

We spoke with people and families who used the service and all the people we spoke with were very positive about the community perinatal mental health service. Feedback included people telling us “they have listened to me as a human being and supported and guided me to manage my illness”, “the care I had surpassed anything that I thought I would be offered. I thank them for my recovery and the fantastic support network”, “My CPN is wonderful” and “I come from a background where mental health is a taboo subject, this experience has changed my view, I have a positive perspective of mental health now”.

People using services involvement

The community perinatal mental health team produced information leaflets which were specific to the services which they provided. This meant that people who used the service had relevant information and were able to access additional information which was useful to them.

The service had a process to gather feedback, via forms, from people who used the service. The manager told us that they also collected verbal feedback from people who used the service although this was not formally logged. We saw that the service had received ‘thank you’ cards from people who had used it. The trust also had a website address published where people could provide feedback about services however, as some feedback was not audited on its receipt there was a risk that patterns of feedback would not be represented in future service design.

We looked through a random sample of case notes and saw that discussions with people and their family members

were documented clearly and evidenced people being supported around choices. We saw that family members were involved in care planning where it was appropriate and the needs of children were considered.

Emotional support for care and treatment

Staff we spoke with had an understanding of the particular needs which related to people who used the community perinatal mental health services and their families, particularly their children. Family members were provided with written information about the service which we saw. By looking at case notes and in discussion with staff, we saw that people were given information and choices about their journey through mental health services and were offered robust support through their involvement with the team and with the service. One person told us that they were taken to the ward to meet the staff team who would provide inpatient care if they were admitted during their pregnancy and they told us that this was reassuring. It demonstrated that the service looked at the needs of individuals and adapted their service.

Margaret Oates Mother and Baby Unit Kindness, dignity and respect

We observed compassionate and sensitive care being delivered on the ward. We spoke with patients and their family members about the care which they received. All the people we spoke with were very positive about their experiences. For example, one person told us, regarding the staff “they are absolutely wonderful, fantastic and kind people”. Another person said “I know they are watching me and how I care for my baby but they still treat me with respect and kindness” and another person said “they always have a warm smile, they are very genuine people”. We saw that patient feedback was displayed on the ward and was very positive regarding people’s experiences of the service. Staff were aware of the need to maintain people’s dignity and we observed that interactions were respectful.

Each room had a privacy blind which was operated from outside the room so people in their rooms could not control this. However, people did not raise this as a concern with us.

People using services involvement

We observed a multidisciplinary ward round meeting where people who used the service were present. We saw that information was presented clearly and the person who was using the service was involved in discussions regarding their care plan and risk assessment. The care plans which

Are services caring?

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

we saw had been signed by people and showed that people were aware of their care plans and had received copies of them. People were given information about the service when they were admitted to the ward. We saw information leaflets which were on display on the ward and explained the service; issues regarding managing specific mental health issues which were common to the service as well as managing and understanding medication.

We saw some evidence that people and families who wished to meet with medical staff could be seen outside the ward round. However, one family member told us that they had not been able to change the time of the ward round to facilitate their working patterns.

There was a weekly meeting held with people on the ward. We read the minutes from these meetings and saw that

issues which were raised were acted upon by staff. For example, people had requested clocks in their bedrooms during one of these community meetings and this had later been actioned. This meant that people were involved in the service and were listened to.

Emotional support for care and treatment

Staff were responsive to the particular needs that people had when they used the service. We saw that one person who had been in the community, told us that they had been invited onto the ward by the consultant to reassure them, should they need admission. People's families were encouraged to be involved and there were flexible visiting hours which facilitated this. However, at times, activities did not go ahead as planned due to the need for staff to prioritise their clinical work.

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

Perinatal services were mostly responsive to people's needs and staff understood the needs of local people. Waiting times for the community teams were affecting how quickly the service could respond, but work to review this had started. Staff could get help from interpreters when they were needed, but support from the chaplains on the inpatient ward was more limited as they were no longer based at Queen's Medical Centre.

Our findings

Community Perinatal Mental Health Team Planning and delivering services

The community perinatal service was able to identify and deliver services in the communities which were served effectively. We spoke with staff who were able to show a good understanding of the local communities and the team manager had an understanding of the diverse needs of people who used the service. We saw that in assessments the physical health needs of people were addressed, and the team worked closely with GPs and secondary health care services to ensure that the identified needs were met.

Right care at the right time

The community perinatal mental health team had received around 1000 referrals over the last six months and appointments had been offered to around 600 people. There were around 200 people allocated to the community psychiatric nurses in the team. There was some variation in waiting times from referral to appointment. The manager told us it was approximately a six week wait to see a consultant from the time of referral. Routine assessment appointments with a nurse would be seen within two or three weeks of referral. One specialist community psychiatric nurse held two clinics per week with five routine and one emergency session. This ensured that there was some access to people who had the highest need and the service was able to show some flexibility in meeting people's needs. However the length of waiting times for the service was identified as a risk area. Staff told us that when there was a need, the service ensured that home visits took place.

We looked at care plan documentation, with information about contingency planning, which people were given so they would be aware of actions to take and services to contact in case of an emergency. Staff told us that they would adapt the times of their visits to meet the needs of patients, however as the service operated between 9am and 5pm - Monday and Friday - there were limits to the availability of appointments which might, for example, need to take place after school.

Care pathway

While we were told that there were crisis care pathways into the service, some people did not receive specialist support in a crisis due to the lack of availability of crisis services in some areas. The community perinatal mental health team worked closely with inpatient services to ensure that people, who had been admitted to hospital as inpatients, were picked up and helped through their discharge when they lived in the local area. For example, nurses in the community team would attend discharge planning meetings on the ward.

The service was able to deliver some specific support to people with cultural needs. For example one community psychiatric nurse in the team had taken a specialist interest in the travelling community and had focused on this area to promote engagement and involvement with this user group.

Interpreting services were available within the team to meet the needs of people who did not speak English well enough to communicate when receiving care and treatment.

Staff told us that at times there was a delay in transferring care to other adult mental health teams in the trust due to the lack of capacity in the teams which they referred to. This in turn led to delays in accepting new referrals.

Learning from concerns and complaints

People were provided with information about the ways in which they could raise complaints and concerns regarding the service. Staff we spoke with were able to identify complaints which had been made in the service and explained how the service had learnt from them.

Margaret Oates Mother and Baby Unit Planning and delivering services

We saw that the inpatient ward had information available which was developed to serve different communities within the local areas. For example, there was information

Are services responsive to people's needs?

Good 

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

available for Asian women who used the service. The staff team had a good understanding of the needs of local communities and worked with primary and secondary health services to ensure that the identified needs of people who used the service were addressed. For example, there were strong links with health visitors and midwives in the local community and the health visitor who attended regular meetings on the ward, was a link for the county and ensured that information was shared.

Staff on the ward told us that there had not been any difficulties in beds being accessed urgently and there had not been circumstances when they had not been able to admit someone who had needed a bed.

The ward did not have full accessibility to people with physical disabilities. We asked the ward manager how this would be managed and they told us that this had not arisen in a specific case, but it would be an issue if someone with mobility difficulties needed access to a bed on the ward as it would not be possible to provide it.

Right care at the right time

The inpatient service received referrals from the community team as well as other mental health teams and primary and secondary health services. We were told that there was no 'waiting list' system and no difficulties which had been identified regarding access to beds. People who were admitted to the ward were given information about the service on admission, including contact details for the service and emergency contact details.

Care pathway

Staff in the inpatient perinatal services, were aware of the need for specific care relating to people's cultural and religious needs. For example, we were told that people had access to meals which met their cultural needs, including

halal meals and Caribbean meals. The ward manager told us that there was a chaplaincy service available in the trust. However, the chaplain was based at Highbury Hospital and needed to be booked in advance for a time to visit. Previously the ward had been able to access the services of a chaplain on the site of Queen's Medical Centre but this was no longer the case. As a chaplain no longer visited the ward routinely some people who were not able to go to the chaplaincy on the grounds of the Queen's Medical Centre, may experience a delay in meeting their specific religious and spiritual needs. We were told that in the past, an advocate had visited the ward routinely however this was no longer the case, which meant there was a risk that some people's needs may not be identified and addressed.

Learning from concerns and complaints

The trust had a complaints procedure and information was displayed on the ward informing people and family members how to make complaints. The ward manager told us that there had been few formal complaints involving the service but none recently. However, they logged what they called 'minor complaints' in a book which was available on the ward. This included issues raised, which people did not wish to address formally, through PALS or the trust's complaints policy. We looked at this log and saw it evidenced that the issues were raised and what the outcomes and learning were. We saw that some practice had changed as a result of concerns which had been raised. Complaints were discussed in the service's clinical governance meeting which took place regularly and they were also raised in team meetings held jointly between the ward and the community team. This meant that the service ensured that learning from comments, complaints, compliments and concerns were embedded in their governance processes.

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

Staff told us that they felt well supported by their immediate line managers and were proud to work for the service and the trust.

Our findings

Community Perinatal Mental Health Team

Vision and strategy

Most of the staff we spoke with told us that they felt proud working for the trust but in particular, they felt proud working for the perinatal services within the trust. All the staff we spoke with told us that they felt supported by their managers however some staff told us that above their team manager, they did not feel that they would know who to approach. Some staff were aware of the chief executive and board level leadership through the trust and were able to identify the trust values.

Responsible governance

Staff who worked in the service were aware of their key professional roles and responsibilities within the structure of the organisation. We saw that there were a number of organisational audits which took place to ensure good governance structures. For example, the specialist service governance meeting took place regularly to ensure issues picked up through audits, incidents and other reporting mechanisms were learnt across the relevant division.

Leadership and culture

Staff told us that they felt the perinatal service was a good place to work and there was a strong and distinctive identity to the service. However, some staff were not clear about the more senior leadership and did not feel that there was consistent leadership above their immediate management within the perinatal service. Staff were positive about the service moving into a different division within specialist services and out of the adult mental health division. Staff told us this would be a more coherent place for their service to fit and felt this would be an improvement. We spoke with the team manager about support for staff and what the team was offered. There was a strong programme of different supervision which ensured that the team felt supported. Staff told us their manager was very available and supportive when required and staff felt they supported each other within the team, very well.

Engagement

Staff we spoke with were aware of internal and external whistleblowing policies and where to find them. All the staff we spoke with told us that they would feel comfortable raising concerns with their managers. The team manager told us that sometimes feedback, which was collected verbally, was not logged which meant some user feedback may not lead to wider understanding of the services and how they are delivered. However, there were forms which were distributed which ensured that people had the opportunity to provide feedback about the service.

Performance improvement

Staff we spoke with had annual appraisals and were aware of their own personal development goals. We saw that the service was undertaking a review, led by one of the consultant psychiatrists in the team, which was looking at ways in which it was performing in order to streamline and improve service delivery. This showed that the service was committed to improving its performance.

Margaret Oates Mother and Baby Unit

Vision and strategy

We spoke with staff on the ward who told us that they felt the ward and the service had a cohesive identity and they felt very much a part of the service and were proud to be a part of it. All the staff we spoke with told us they felt supported by their immediate managers.

Responsible governance

The staff we spoke with were aware of their roles and responsibilities on the ward and told us that they felt part of the ward team. We saw that there were regular meetings for staff on the ward, and in the service, where issues could be raised and addressed. Specialist services in the trust had a specific clinical governance meeting, where issues related to incidents across the trust were addressed, as well as other broader issues which were fed down to ward level by the ward manager. We saw that there were frequent audits of clinical practice which ensured that information about the ward was collated and could be monitored to improve practice.

Leadership and culture

Staff told us that they felt the culture of the service and organisation was open and that they would be comfortable raising concerns if they had them. Staff told us that the service had been moved last autumn from the adult mental health division to the specialist services division. They told us that they felt this was a 'better fit' for the type

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.

of service that was being provided and were positive about the direction the leadership was moving in. The ward manager told us that corporate support was strong in areas such as human resources. We saw that the medical and nursing team worked well together as a cohesive unit.

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 provide feedback to their managers.

We saw that people's views were gathered through feedback on the ward and on discharge from the ward. There was a comments box on display on the ward and surveys which related to feedback were on display. There

was also an art display which featured feedback in the ward area. People we spoke with told us that they felt they were able to provide feedback about the service and felt listened to by the service and the organisation.

Performance improvement

Staff had annual appraisals where their personal and professional development goals were set. We saw that there were a number of audits carried out internally which were able to benchmark where the service was in terms of development and improvement. For example, the ward manager audited records and there were a number of outcome measures which the team addressed. We saw that there were also peer reviews undertaken externally and staff were involved in reviewing other similar services to ensure that they had an understanding of the specialism. This meant that performance of the service was monitored in order to drive improvement.