CareQuality Commission

Good 🟢

Nottinghamshire Healthcare NHS Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Adult admission wards	**Bassetlaw Hospital** **Highbury Hospital** **Queens Medical Centre** **Millbrook Mental health Unit**	**RHAAA** **RHANM** **RX1RA** **RHABW**
Psychiatric Intensive Care Units and Health Based Places of Safety	**Millbrook Mental Health Unit** **Highbury Hospital**	**RHABW** **RHANM**
Services for Older People	**Bassetlaw Hospital** **City Hospital St Francis Unit** **Millbrook Mental Health Unit** **Highbury Hospital** **Duncan MacMillan House**	**RHAAA** **RHALB** **RHABW** **RHANM** **RHA03**
Long stay services	**Broomhill House** **Newark Community Rehabilitation Unit** **Mansfield Community Rehabilitation Unit** **Thorneywood Mount Rehabilitation Unit**	**RHAPK** **RHACC** **RHABL** **RHANP**
Forensic/Secure services	**Rampton Hospital** **Wathwood Hospital** **Arnold Lodge** **Wells Road Centre**	**RHA04** **RHARX** **RHAAR** **RHANA**
Children and adolescent mental health services (CAMHS)	**Thorneywood Unit** **Duncan MacMillan House**	**RHANP** **RHA03**
Learning Disability services	**Highbury Hospital** **Mansfield Community Hospital**	**RHANM** **RHABL**

Summary of findings

	Duncan MacMillan House	**RHA03**
Community based crisis services	**Millbrook Mental Health Unit**	**RHA BW**
	Highbury Hospital	**RHANM**
Adult community based services	**Duncan MacMillan House**	**RHA03**
Specialist Eating Disorder services	**Duncan MacMillan House**	**RHA03**
Other specialist services: Perinatal Rapid Liaison service	**Duncan MacMillan House** **Nottingham University Hospital**	**RHA03** **RHARA**
Community health services for adults	**Duncan MacMillan House**	**RHA03**
Community health services for children, young people and families	**Duncan MacMillan House**	**RHA03**
Community health inpatient services	**Lings Bar Hospital**	**RHANN**
End of life care	**Bassetlaw Hospice** **John Eastwood Hospice**	**RHAYL** **RHAG4**

This report describes our judgement of the quality of care at this provider. It 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.

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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 ratings for services at this provider	Good ●
Are services safe?	**Requires Improvement** ●
Are services effective?	**Good** ●
Are services caring?	**Outstanding** ☆
Are services responsive?	**Good** ●
Are 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.

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Overall summary

Nottinghamshire Healthcare NHS Trust employs nearly 9,000 staff and provides a wide range of care services from many separate locations. Despite this, the trust had a clear 'brand' with a set of values that was embedded and visible throughout the organisation.

We were impressed with the strong leadership from the Board, the executive team and senior managers. There were clear lines of authority, responsibility and accountability, senior managers, the executive team and the Board demonstrated and encouraged supportive relationships, there was a culture of collective responsibility and teams had clear objectives and worked towards achieving them. One of the vehicles to achieving this cohesion was the trust's leadership programme that ran through all the directorates. This encouraged staff to engage in discussions about the strategic direction of the trust and the challenges it faced.

The trust demonstrated to us that people using services were treated with dignity, respect and compassion. The great majority of the service users and carers that we spoke with said that staff were kind and we observed many positive and respectful interactions between staff and service users. We also saw examples across all services of the trust responding to people's spiritual, cultural and ethnic needs; including at Rampton Hospital.

At all levels, the trust actively engaged and involved people who use services in their own care and in the development of the service itself. With the exception of information about how to complain not being consistently provided in the Healthcare Partnerships division, the trust had mechanisms in place to hear and act on feedback from people who use services and the board itself received and monitored information from the analysis of complaints. We were impressed by the Recovery College and the Involvement Centre; which are both national exemplars.

The trust had good systems in place to report, record and learn from incidents and ensured that this was embedded in practice at all levels across the three divisions. Staff used past incidents as a means of learning to ensure the safety of people using services. This learning was shared with all staff.

There were good and regular training opportunities (including induction and mentoring) and the content was appropriate to staff roles, responsibilities and areas of work.

The trust had clear safety related goals that the majority of staff understood and were working towards across all three divisions. There was a culture of openness and transparency and staff understood the need for investigations in order to learn from, and develop, improved practices. The trust had identified a number of priorities in relation to safety and we concluded that they had developed after consistently reviewing data from a wide range of sources. Despite this, we identified a number of safety concerns. These included:

1. the presence of ligature points that might pose a risk to people who are at risk of suicide on wards at Broomhill House, Newark Community Rehabilitation Unit, Mansfield and Thorneywood Mount;
2. wards that did not adhere to national guidance on same-sex accommodation in the CAMHS Thorneywood service and in two of the acute admission wards; B2 at Bassetlaw and Orchid ward at Millbrook Mental Health Unit;
3. poor medicines management in the Children's Development Centre at Nottingham City Hospital campus and at Bassetlaw Hospice.

Across all of the divisions we found that care provided was evidence based and followed recognised national guidance. There were good examples of positive outcomes for people using services across the divisions. This included a significant reduction in acquired avoidable pressure ulcers, where the trust exceeded its own target.

Overall, trust staff adhered to the requirements of the Mental Capacity Act 2005 to assess capacity to consent. We visited most of the wards at each location where detained patients were being treated. In the majority of the care records we reviewed, which related to the detention, care and treatment of detained patients, the principles of the Mental Health Act (MHA) had been followed and adhered to. The long stay wards were an exception; here we found inconsistencies in the application of the MHA and a failure to undertake risk

Summary of findings

assessments of service users given leave under Section 17 of the Act. We also found that the trust did not have a robust system in place to ensure that patients in seclusion at Arnold Lodge had a four-hourly review by a doctor. There were systems and procedures in place to safeguard vulnerable people and to identify, assess and manage risks. However, the divisions varied in how they fed back safeguarding concerns and the outcome of findings from investigations.

We had a number of concerns about the learning disabilities service and concluded that they did not have a high profile within the trust. We saw examples of restrictive practices, institutional environments at Alexander House and Hucknall House and a lack of physical health checks on the Orion Unit.

In the majority of services we visited, people did not experience long waits for assessment or treatment. However, some service users did report difficulty accessing crisis mental health services at night. The crisis team offered only telephone contact at night. Those who needed immediate assessment were directed to the Emergency Department at Queen's Medical Centre; where they might have to wait a long time to be assessed by the liaison psychiatry team.

We saw that the trust had introduced night time confinement at Rampton Hospital. We concluded that its use was in line with the Department of Health High Security Psychiatric Services (Arrangements for Safety and Security) Directions 2013 and the associated guidance. However, some people who used the service, and some staff, were concerned about the provision of physical healthcare during night-time confinement. During our unannounced, night time visit to Rampton Hospital we observed two patients receiving treatment through the 'hatches' in their bedroom doors. One was given insulin for diabetes and one was provided with stoma care. We raised this with the trust which stated that it is not normal practice to provide physical healthcare through the hatch and undertook to investigate the circumstances of the care and treatment provided on this occasion.

Across the three divisions we identified that there were some concerns about the different clinical information systems, which did not enable information to be shared effectively and at the right time. This could lead to information regarding risks not being available to all staff. We found the trust recognised the difficulties and had plans in place to improve facilities and functioning of systems.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires Improvement ●

Local Services (Mental Health Services)

We found that core services provided to support people's mental health by Nottinghamshire Healthcare Trust were safe, and there were clear structures and processes in place to ensure that services were delivered in a safe and responsive manner. However, there were inconsistencies of practice in some areas and we identified areas for improvement – particularly in recording information within healthcare records. The trust considered potential risks to people, but these were not always fully documented and reviewed.

The trust had a good process for reporting and managing incidents, and the learning from these shared with staff – both at a trust and local level – to ensure the future safety of people using services.

Staff understood how to safeguard vulnerable people and how to respond appropriately to any allegations of abuse. There were appropriate arrangements in place to manage medicines safely.

In the long stay and rehabilitation services, we found there were a significant number of ligature points within wards and risks had not always been identified and managed appropriately. This meant that people were exposed to potentially unacceptable and avoidable risk. The trust's 'Risk Assessment in Health and Safety Policy' was not being implemented consistently across the service on all wards. We brought this to the attention of the trust during the inspection and they took immediate action in response to our findings.

Health Partnerships (Community Health Services)

We found that services in the Health Partnerships division were generally safe. There were systems and procedures in place to safeguard vulnerable people and children and to identify, assess and manage risks.

There were systems in place to identify, investigate and learn from patient safety incidents, but we were concerned that not all patient safety incidents were raised through the trust's online reporting system at Lings Bar Hospital. We found that in some areas there was no consistent system to feed back to staff and improve the learning from incidents and safeguarding investigations.

At Lings Bar Hospital arrangements were in place to minimise risks to people using services to prevent falls and pressure ulcers. However, we were concerned about the lack of nurses overnight on all three wards and the monitoring of medication incidents.

Summary of findings

Children and families services were generally safe, but there was a risk to safety due to poor medicines management and monitoring in the Children's Development Centre at Nottingham City Hospital campus.

At Bassetlaw Hospice there was no external supervision of their 'prescribing formulary' and there was no clear policy for the administration and checking of controlled drugs where there was one registered nurse on duty.

Forensic Division (Mental Health Services)
People we spoke with at all sites said they felt safe, and there were systems and processes in place to ensure people and staff were safe.

We were told that there is an open reporting culture and a good incident reporting process in place; for example staff newsletters identified lessons learnt from previous incidents.

All hospitals had excellent practices with regard to safeguarding and we saw that thorough assessments (in line with national guidance) took place before people who use services had contact with children.

There were systems in place to monitor cleanliness and compliance with health and safety.

We found concerns at Arnold Lodge about the timeliness of medical review for secluded people. We have been informed by the trust that action has been taken to remedy this.

Are services effective?
Local Services (Mental Health Services)

Good ●

We found that core services provided to support people's mental health by Nottinghamshire Healthcare Trust were being delivered in line with good practice guidance – for example as issued by the National Institute for Clinical Excellence (NICE). Where appropriate, we saw good examples of collaborative working with other services within the trust, stakeholders and other partners. There were systems in place to ensure that people's rights were adhered to under the Mental Health Act and staff had undertaken training and demonstrated good understanding and application of the Mental Health Act and Mental Capacity Act.

The trust used good measures to judge the effectiveness of services, including feedback from people who used them. We did find in a few units that activities were not offered to people and the physical health needs of people who used the service were not always monitored sufficiently to ensure their health and wellbeing.

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Health Partnerships (Community Health Services)

We found that people using services and families received care that was effective in the Health Partnerships Division.

The skill mix of staff within community multi-disciplinary teams was effective in delivering seamless care to people when they needed it. There was a focus on achieving positive outcomes for people using services, children and families. There were enough staff with the appropriate skills and supervision to deliver effective care. There was generally effective communication among members of the multi-disciplinary team to support the planning and delivery of patient care.

Children's and families services were targeted at particular groups which ensured children in vulnerable or minority groups were well supported. Staff resources were allocated to meet the needs of families and children. People's care records were well organised and information was easy to access.

Some staff reported problems with information technology that was used to support their work or for keeping records. However, we found the trust recognised the difficulties and had plans in place to improve facilities and functioning of systems.

Forensic Division (Mental Health Services)

From the evidence inspected and discussions with managers and frontline staff, we saw the trust was able to demonstrate people who used this service received care and treatment in line with the current best practice guidance. People's care was individual and focused on their recovery and a range of therapies was available according to their assessed needs. People told us that they had a good relationship with their doctors and the nursing staff.

People's care, treatment and support achieved good outcomes, promoted a good quality of life and were based on the best available evidence. The medium secure services participated in the Royal College of Psychiatrists Quality network for forensic mental health services scheme.

There were systems in place to monitor the quality of care provided and to check it was meeting national standards. Outcome measures were used to check progress of people using the services.

Staff told us that they felt well trained and equipped to carry out their roles. They felt supported by both their colleagues and the hospital management.

The provider complied with the Mental Health Act and was mostly compliant with the Mental Health Act Code of Practice.

Summary of findings

Are services caring? **Outstanding** ☆

During our inspection we were very impressed with the Chief Executives and Boards personal commitment to ensuring active engagement and participation with people who use the trusts service across all care pathways.

The involvement centre and recovery college were excellent examples of supporting peoples emotional needs whilst providing practical help as part of people's journey of recovery. We saw that this commitment ran throughout all areas of the trust and was supported and shared by all the staff we encountered.

Local Services (Mental Health Services)

We found that across the core services we inspected, staff demonstrated outstanding levels of care and responsiveness to people using the service and to their carers, and were skilled and sensitive in the delivery of care. Staff responded to people with patience, kindness and ensured that they were treated with dignity. We found good examples of 'person-centred care' being provided, with staff involving people at a local level in making decisions about their care and treatment. Families and carers were involved when appropriate. People using the services told us that staff were caring and supportive. Where people may have lacked the mental capacity to make decisions, this was assessed to ensure that decisions about their care and treatment were made in their best interests.

Health Partnerships (Community Health Services)

We saw many examples of caring and compassionate services across the Health Partnerships division. We received many positive comments about the quality of the care and treatment and the approach of the staff. People using services, families and carers all told us they were treated with kindness and respect and they were involved in making decisions about care and treatment. We saw many examples of people using services, families and carers being offered appropriate emotional support. Parents were provided with clear information about the service being offered to their child and the treatment they were to undergo. Services used different methods to listen to feedback from people who used their services and responded to their comments.

Forensic Division (Mental Health Services)

Overall, people who used the services described staff as caring and responsive, and said they felt safe. The care plans we looked at showed people were involved in reviewing their care and progress. We saw examples of staff making reasonable adjustments to meet people's needs. Most people said their privacy and dignity were respected. We observed staff speaking about people who used the services in a respectful manner.

Summary of findings

Secure services had outstanding levels of involvement by people using them. Each hospital had a patient forum where issues could be raised. They also had carers' forums and ran carers' days each year.

Secure services held community meetings and reported on them; despite some feedback that these were not always as regular as they could have been, generally feedback was positive.

Are services responsive to people's needs?

Good ●

Local Services (Mental Health Services)

We saw evidence in people's care and treatment records of how the service had reviewed and amended their treatment to respond to their changing needs. We found that staff had a good understanding of local people's needs, and some services had been developed in consultation with them.

Waiting times in some of the community and Child and Adolescent Mental Health Service (CAMHS) teams had an impact on staff members' ability to be responsive. Records showed us that some children and young people who had been referred to specific CAMHS community services did not receive a prompt initial assessment and treatment. However, senior staff confirmed that the trust was taking action in partnership with commissioners to address these delays.

Within the crisis teams, some people said they had not had good support at night, and that after 10pm there was standard advice to go to the local A&E. In some community services, we found that waiting lists existed, but wherever possible these were small and well managed and staff worked with voluntary agencies to provide people with services. However, out of normal working hours there was little availability close to people's homes.

Systems were in place within the trust to respond to comments and complaints made about services. People and their families were encouraged to report on their experiences of the care received and how to raise any concerns that they may have.

Health Partnerships (Community Health Services)

We found that services in the Health Partnerships division were generally responsive to people's needs. Appropriate assessments were carried out to ensure people's needs were identified. Referrals between different types of services were prompt and effective. Services were accessible to the right groups in the community, and some were targeted at specific vulnerable groups. We saw that discharge from services was proactively managed, using a multi-disciplinary approach.

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Integrated care pathways in adult community health services were working well to ensure people received the care they needed from multi-disciplinary staff who worked flexibly to meet their needs.

There were systems in place to seek feedback from people who use services, carers and families about their experiences. However, information about how to complain was not consistently provided.

The trust did not effectively identify groups which may not be accessing services provided by Lings Bar Hospital or address barriers which may prevent black and minority ethnic people from accessing the service.

We had some concerns about end of life care in Bassetlaw, as the local hospice had not promoted the out-of-hours services enough to people who may require crisis care at night.

Forensic Division (Mental Health Services)

There was an effective process in place for responding to complaints; some improvements were required in how outcomes were fed back to the people who had complained. Investigations included people who used the service and staff and we saw reports from previous investigations which showed this.

We saw, and were told by people who used the services, that people's physical healthcare needs were met. We observed good multi-disciplinary working among the different professional groups of staff.

Medium secure services were willing to accept people on a trial basis – for example accepting people from a high secure hospital on section 17 leave to see if medium secure was a suitable environment. Some people, who had been transferred from prison, were supported to return to prison if they chose to do so

While it was evident care was delivered in line with individuals' needs, there were 'blanket rules' in use at Arnold Lodge and Wells Road Centre. The number of items people could purchase from the shop, including food and drinks, was restricted; the provider had not assessed individuals to determine what risks existed for them in being able to freely purchase items from the hospital shop.

Are services well-led?
Local Services (Mental Health Services)

Good ●

We found that the core services provided by the trust were well-led and that staff felt well supported by their immediate line manager. All staff were aware of the senior leaders within the trust and thought that communication from 'board to ward and community' was effective. The trust had systems in place to ensure that

information was communicated to staff in the trust and most staff were aware of board-level leadership and the overall vision of the trust. However, some told us that they had no involvement and felt somewhat detached from the issues around governance.

We also saw some good examples of locally based leadership and there were clear structures in place to support the management of the teams. Staff had appraisals and regular supervision sessions with their managers to effectively manage their performance. Staff felt they had good access to training and development opportunities. They told us they were in good teams and that they felt they were delivering good care.

There were robust systems in place for monitoring the quality of the service, although this could be improved in some of the community child and adolescent mental health services (CAMHS) to ensure a prompt response to referrals and assessments.

Health Partnerships (Community Health Services)

We found that services in the Health Partnerships division were well-led. The trust board members were visible to staff, approachable and there was awareness among staff of the trust's ethos, vision and priorities. Staff felt listened to, valued and supported by their line managers, they were engaged in the process of developing services. There were very good arrangements to provide regular supervision for staff in the relevant areas which supported them in their role.

There was a respectful culture in the service which was demonstrated by staff listening to each other and we saw many positive examples of team working.

Staff were encouraged to raise issues and work collaboratively to improve the efficiency of the service and patient outcomes, and we saw examples of this in the different local areas. The governance structure was effective in identifying risks and improving services.

Forensic Division

There were processes in place for providing staff with appraisals and regular supervision to ensure safe and effective provision of care. Staff we spoke with told us they had received an annual appraisal and regular clinical supervision, though some improvements could be made in the provision and recording of managerial supervision. Staff also told us they felt well supported by their manager and could raise any concerns they had and these would be addressed. The governance of the organisation assured the delivery of high quality person centred care and promoted an open and fair culture.

People who used services and staff had regular contact with senior members of staff, such as the modern matrons, and their dedication and passion for their role was also evident in the focus groups of senior staff across secure services.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Lelliott, Deputy Chief Inspector Hospitals (Mental Health and Substance Misuse), CQC

Team Leader: Jenny Wilkes, Interim Head of Inspection, Care Quality Commission

The team included inspectors, inspection managers, Mental Health Act commissioners, a pharmacist inspector and two analysts. We also had a variety of specialist advisors which included consultant psychiatrists, consultant forensic psychiatrists, junior doctors, psychologists, senior nurses, student nurses, nursing assistants, advocates, social workers, senior managers including heads of nursing and quality, assistant directors and lead governor members, nurse consultants, advanced nurse practitioners, district nurses, health visitors, tissue viability nurses and occupational therapists.

The team also included seven Experts by Experience who have personal experience of using or caring for someone who uses the type of services we were inspecting. Four of the experts were included in the inspections of the mental health/learning disability services. Three experts by experience were part of the teams inspecting the community health services.

Why we carried out this inspection

We inspected this trust as part of our Wave 2 pilot comprehensive mental health and community health services 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?

Before our inspection visit, we reviewed a range of information we hold about the core services and asked other organisations to share what they knew. We also held a focus group with a local mental health group, facilitated by a voluntary organisation. We carried out announced visits to all core services and additional specialist services on 29, 30 April and 1 May 2014.

During the visit, we held focus groups with a range of staff who worked within the service, including nurses, doctors, therapists and managers at all levels. We observed how people were being cared for and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core services we visited. We carried out an unannounced visit during the night of 7 May 2014 at Rampton Hospital and a visit on the evening of 19 May 2014 to the crisis service based at Queens Medical Centre. We visited the trusts substance misuse services which we found to be safe, effective, caring, responsive and well led but we have not been able to complete a core service report or incorporate our findings into the provider report.

Information about the provider

Nottinghamshire Healthcare NHS Trust is an integrated healthcare provider and provides community health care and mental health care including high secure services. The population served by the trust is 1,090,495 within

Summary of findings

Nottingham City and Nottinghamshire but some of the services offered have a national (England and Wales) or regional basis (East Midlands and South Yorkshire). The trust has a total of 1,169 consultant led beds including 359 high secure beds across its sites with a bed occupancy level of 88% between October and December 2013.

Nottinghamshire Healthcare NHS Trust was first registered with CQC on 1 April 2010 and has 42 locations from which it provides services and which are registered with CQC.

The trust provides the following core services:

Mental Health

- Adult admission wards
- Psychiatric intensive care units and health based places of safety
- Services for older people
- Long stay services
- Forensic/secure services
- Children and adolescent mental health services
- Learning disability services
- Community based crisis services
- Adult community based services
- Specialist eating disorder services
- The trust also provides other specialist services that we also inspected:
- Perinatal services, (mother and baby) Inpatient and Community)

Community Health Services

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

The trust splits its services into the following three divisions:

- Local Services include: Adult Mental Health Services, Mental Health Services for Older People, children and adolescent mental health services (CAMHS), Crisis based services and Specialist services.
- The Health Partnerships Division of the trust provides community health services to the people of

Nottinghamshire and Bassetlaw through a partnership model, working closely with primary care colleagues. Services in Nottinghamshire are provided by County Health Partnerships and services in Bassetlaw through the Bassetlaw Health Partnerships.

- Forensic Services Division is responsible for providing services to people in contact with forensic services. The Forensic Services Division includes: Rampton Hospital, Arnold Lodge, Wathwood Hospital, Wells Road Centre, Low Secure and Community Forensic and Offender Health.

Nottinghamshire Healthcare NHS Trust has been inspected on 17 occasions since it was registered. These inspections have occurred at 11 locations which are all currently registered with and regulated by CQC.

Of these registered locations, Duncan Macmillan House (Trust Headquarters) has been inspected once, Highbury Hospital three times, City Hospital St Francis Unit twice, HMP Hatfield once, HMP Lindholme once, HMP Moorland once, HMP Stocken twice, Mansfield Community Hospital twice, Millbrook Mental Health Unit twice, Rampton Hospital once and Thorneywood Unit once. The reports of the inspections at the 11 locations were published between December 2011 and January 2014.

We have previously issued compliance actions (this is when there is a breach of Health and Social Care Act regulations) against five locations and the trust took positive steps to respond, with follow up visits demonstrating full compliance with regulations. The latest inspection of Highbury Hospital in October 2013 resulted in three compliance actions being issued relating to Consent to Treatment, Care and Treatment and the Management of Medicines. We reviewed the trust's compliance with regulations relating to these areas at Highbury Hospital during this inspection. We found the trust had met the compliance actions from th October 2013 inspection.

During this inspection, we did not inspect the trust's offender healthcare services (prisons). CQC has a separate method of inspecting offender healthcare which includes joint visits with Her Majesty's Inspectorate of Prisons (HMIP) and those reports can be found on the HMIP website.

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What people who use the provider's services say

We spoke with a number of people during our inspection. The majority of the people we spoke with were very happy with the quality of the care and treatment they were receiving, with the approach of the staff and told us that they felt involved in decisions about their care.

Community Mental Health Patient Experience Survey 2013

This survey was conducted to find out about the experiences of people who receive care and treatment. Those who were eligible for the survey were receiving specialist care or treatment for a mental health condition, aged 18 and above and had been seen by the trust between 1 July 2012 and 30 September 2012. There were a total of 256 responses, which was a response rate of 31%.

Analysis of data from the Community Mental Health Patient Experience Survey 2013 shows that the trust was performing 'about the same' as other trusts in eight areas and better in one area, 'talking therapies'.

Friends and Family Test

The Friends and Family Test seeks to find out whether patients would recommend their care to friends and family. The most recent results for the first quarter of 2014 indicate that 75% of patients would recommend the service to family or friends.

A patient survey carried out by Age UK in November 2013 showed patients were satisfied with the care they received at Lings Bar Hospital and rated the overall quality of care received at Lings Bar Hospital as either excellent or good.

Integritas Community Focus Group

Before the inspection, Integritas facilitated a focus group so that people who use, or have used, the services provided by the trust, could share their experiences of care. This group provided a wide range of responses to the five questions we always ask about services.

The majority of people felt safe when they were in hospital, but felt less safe when they left the hospital as they were not given enough help or support.

Most of the people felt that services were not effective and those that had a good outcome had found support through peer support groups, therapeutic communities or had paid for counselling.

The majority of people at the focus group thought that the services were not caring as staff lacked compassion. These reports were not confirmed by the inspection team which observed compassionate care in nearly all service areas.

Some people felt that services were responsive to their needs but there was a lot of negative feedback about the responsiveness of the crisis service and not feeling listened to.

Some people felt that the services were well led but there was a lot of negative comments about not knowing how to complain and being labelled as a troublemaker if you did complain. People felt that this might mean you do not get the treatment you need.

Comment Cards

There were 82 comment cards returned.

- 41 (50%) were from service users in Health Partnerships (Community Health Services). 38 were positive. 11 were negative.
- 31 (37%) were from Forensic Services patients. 18 were positive. 20 were negative.
- 8 (9%) were from Local Services (Mental Health Services) patients. 7 were positive. 3 were negative
- 3 (3%) did not specify a service.
- 8 (9%) specified a lack of staff as an issue.
- 65 (79%) of the comments were positive about the trust and staff
- 35 (42%) of the comments were negative about the trust and staff. Some comments contained both negative and positive elements.

Summary of findings

Good practice

Trustwide

- The Involvement Centre, which enables service users and carers to influence the development of services, and the Recovery College, which provides recovery focused educational courses, are both national exemplars.
- The trust leadership development programme had contributed to a vision and set of values that are shared throughout the trust.
- Most trust staff recognised and knew members of the executive team.
- We observed positive and respectful interactions between staff and service users in all clinical areas that we visited.

Local Services (Mental Health Services)

- There were excellent working arrangements with the police in the health-based place of safety at the Jasmine Suite.
- The school adjacent to the child and adolescent mental health inpatient unit, which is provided in partnership with the local authority, had been rated as 'Outstanding' by Ofsted at their last inspection in May 2013.
- The paediatric liaison service based at the Queens Medical Centre was an innovative and excellent service. It provided and promoted a joined-up approach to physical and mental health care for young people and their families.
- We saw strong leadership on all of the older people's mental health wards. Ward managers were visible and had clear plans to encourage leadership training for all grades of staff in their teams.
- The mental health admission wards for adults of working age had good links with care coordinators in community mental health teams and a discharge coordinator worked at the interface between the acute wards and the crisis team to facilitate early discharge.
- Community mental health teams provided a range of evidence-based psychological therapies on a group and individual basis.
- Non-medical prescribing practitioners provided clinics for rapid assessment and treatment of people, that was accessible in their local community mental health team.

- The Eating Disorder Drop-In Service (EDDIS), which was provided jointly with other stakeholders, was an innovative and effective service that addressed the needs of the local population.
- The perinatal services had good local links with midwives, health visitors and obstetricians.

Healthcare Partnerships (community health services)

- There was a single point of contact to request community services.
- A record of incidents was on display on each ward so that people could see how the trust was monitoring and managing the safety of people who use services.
- The trust had exceeded its target to reduce acquired avoidable pressure ulcers.
- John Eastwood Hospice actively sought to provide specialist palliative care to people with long term conditions who did not previously have access to this type of care. They invited community matrons of long term conditions to hold therapeutic sessions in the hospice day centre and provided the services of the hospice team. The benefits of these sessions were monitored and evaluated.
- People aged over 75 years who were discharged from hospital received a follow-up appointment within 48 hours. This ensured that they had the medication they needed, and provided staff with the opportunity to advise on how to prevent their re-admission to hospital.
- A family nurse partnership team provided intensive support to teenage mothers before the child was born and for the following 22 months. This meant that very vulnerable young mothers were given support to develop their coping and parenting skills, thereby reducing dependence on other services.
- Across all children and family locations we found evidence of good collaborative working and good inter-agency working between trust staff schools and children's homes.

Forensic Division (Mental Health Services)

- We saw examples of good patient care in all of the services at Rampton Hospital. This was reflected in care plans and in feedback from people using services.

Summary of findings

In particular, the learning disabilities service stood out as an example of excellent practice, and encouraged independence and rehabilitation at a lower level of security

- Psychology services were available for throughout Rampton Hospital.
- We saw examples of outstanding practice across both medium secure units, with people who used services involved in their care. The multidisciplinary teams at both hospitals worked well together and there was an open culture for reporting incidents.
- At Wathwood Hospital, we saw that each ward had a place for staff, known as the 'hotspot', which had line of sight from all areas of the ward and was

permanently occupied by a member of staff. This contributed to safety on the ward. Wathwood Hospital used information technology and laptops well so that staff could spend more time on the ward.

- The women's services at Arnold Lodge was of a high quality. In particular, we noted that the seclusion area was used positively to help women feel safer.
- The compassion of staff working within the Personality Disorder and Development Network was excellent. Given that many people with a personality disorder often face difficulties in accessing services, we were impressed that the service allowed people who use services, as well as professionals, to refer themselves for help. We felt the team worked well together and shared sense of purpose, which was both person-centred and focused on people's therapy.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve
Local Services (Mental Health Services)

- The trust must ensure that the environment in the Lucy Wade PICU must be improved to protect people's privacy and dignity.
- The trust must make arrangements for gender segregated living accommodation or 'female only' communal areas within the CAMHS inpatient Thorneywood unit.
- The trust must ensure that in the services for people with a learning disability or autism, people who use the service are treated in the least restrictive environment.
- The trust must ensure that in services for people with a learning disability, people's support plans detail how staff are to safely support each person.
- The trust must ensure that in the services for people with a learning disability, people's physical health is monitored in Orion unit.
- The trust must ensure that in the services for people with a learning disability or autism, Section 17 leave forms are specific to individuals and the specific period of leave.

- The trust must ensure that all records in the services for people with a learning disability or autism are accurate and fit for purpose.
- We found a significant number of ligature points within all the long stay wards at Broomhill House, Newark Community Rehabilitation Unit, Mansfield and Thorneywood Mount with the exception of Bracken House. These included a non-collapsible shower rail at Newark Community Rehabilitation Unit
- The trust must ensure that Orchid ward at Millbrook Mental Health Unit and B2 ward at Bassetlaw Hospital are compliant with the requirements for same sex accommodation.

Healthcare Partnerships

- The trust must ensure that there is safe medicines management in the Children's Development Centre at Nottingham City Hospital. There was no local policy for medicines management and there were no pharmacy or departmental audits to check that medicines had been managed appropriately and administered accurately and safely.
- The trust must ensure that there are strong systems in place to tell people who use services about the complaints procedure in the community health setting.

Forensic Division (Mental Health Services)

Summary of findings

- The trust must ensure the welfare and safety of patients at Arnold Lodge by means of appropriate arrangements for four hourly medical reviews of patients in seclusion.
- The trust must ensure there are arrangements in place to ensure reviews take place in line with the Mental Health Act Code of Practice at Arnold Lodge.

Action the provider SHOULD take to improve
Local Services (Mental Health Services)

- The trusts should ensure access to the place of safety should be reviewed to ensure people's privacy and dignity is protected.
- The trust should ensure that all the core bank and agency nursing staff who work on the CAMHS Thorneywood in-patient unit receive their level 3 safeguarding children training.
- The trust should ensure that all their CAMHS community care and treatment records are reviewed for consistency and completeness.
- The trust should continue to work with commissioners to ensure that all the beds on the Thorneywood inpatient ward are fully available for young people who need these.
- The trust should ensure that young people on the Thorneywood inpatient ward get a formal response to any complaints made about their care and treatment.
- The trust should ensure that in the services for people with a learning disability or autism, the locked door policy for Hucknall House states the reasons why doors are locked so it is clear that this is in the best interests of people who used the service.
- The trust should ensure that in the services for people with a learning disability or autism, facilities to develop people's skills in independence are safe for people to use in Alexander House.
- The trust should ensure that in the services for people with a learning disability or autism, action is taken to ensure the risks of people who use the service and staff being harmed if there were a fire are reduced.
- The trust should ensure that in the services for people with a learning disability or autism, interpreting services are available when needed.
- The trust should ensure that within older people's services, do not attempt resuscitation documentation is completed consistently.

- The trust should consider the potential risks and impact on those people needing a service when home visits are not available and the delays experienced by people waiting out of hours in the Emergency Department.
- The trust should ensure that Mental Health Act documentation is available on the long stay wards.
- The trust should ensure that risk assessments are been undertaken on the long stay wards, prior to patients commencing and returning from Section 17 leave periods.
- The trust should ensure that people are seen regularly by their consultant psychiatrist and are involved in their care plan reviews on the long stay wards.
- The trust should consider the need to encourage people who use the services for people with a learning disability or autism, in Hucknall House, to bring to the service with them their health and communication plans so that information provided by members of the multi-disciplinary team can be shared appropriately.
- The trust should consider producing the patient satisfaction survey in a format that all people who use the services for people with a learning disability or autism, can understand.
- The trust should consider improving the environments in the services for people with a learning disability or autism, in Alexander House and Hucknall House.
- The trust should ensure that staff are consistently following the trust's medicine's policy on Orchid Ward, Millbrook Mental Health Unit.
- The trust should ensure that in the community mental health teams, records on risk management are consistently reviewed and updated promptly.
- The trust should ensure that in the community mental health 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.
- 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.

Summary of findings

- The trust should consider how it should work with the acute trust and local clinical commissioning groups, to develop an environment in the emergency department that meets the needs of those people needing a service.

Healthcare Partnerships

- The trust should review the staffing requirements on all three wards at Lings Bar Hospital.
- The trust should identify a system to pick up omissions in the administration of peoples' medication.
- The trust should provide clear guidance for staff about what incidents are reportable, particularly incidents such as a 'cardiac arrest'.
- The trust should identify plans to increase staff uptake of basic life support training.
- The trusts should ensure action is taken to address barriers which may prevent Black and minority ethnic people from accessing the services at Lings Bar Hospital.
- The trust should ensure that there is consistent practice on reporting of incidents, specifically, ensuring that staff are clear about when to report incidents and that learning is shared across the whole organisation
- The trust should improve the planning for discharge of people and records of people using intermediate care beds to ensure care is delivered effectively
- The trust should review the arrangements for ordering of equipment for use in people's homes to ensure there are no unnecessary delays and ensure clinical staff have appropriate access to clinical equipment for monitoring physical health.
- The trust should ensure the policy for staff who work on their own is used consistently and actively monitored to ensure staff are protected.

- The trust should ensure arrangements for the maintenance of privacy and dignity of people in clinic settings are reviewed to ensure it is not compromised and privacy is protected.
- The trust should ensure that arrangements for work-based training and support for health visitors is in place.
- The trust should ensure it improves IT connectivity for staff as many teams reported concerns, especially when working remotely and there was a risk of information being lost.
- The trust should consider the introduction of a competency assessment framework to support the therapy support workers, occupational therapists and physiotherapists at the Children's Development Centre based at Nottingham City Hospital Campus.
- The trust should ensure that services inform parents and guardians on how to raise concerns or complaints and that this is implemented consistently across all services and that all services maintain local complaints registers to ensure local learning takes place.
- The trust should ensure that patient feedback questionnaires are readily available at all locations and are identifiable so that the trust can ensure feedback is given to the right service.
- The trust should ensure that there are consistent clinical governance arrangements across services, including internal clinical audits and parent or guardian feedback sessions.
- The trust should make their medicines policy clearer to inform nurses working on their own of their responsibilities when checking and administering controlled drugs at Bassetlaw Hospice.
- The trust should supervise the prescribing of medicines at Bassetlaw Hospice.

Nottinghamshire Healthcare NHS Trust

Detailed findings

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

Local Services (Mental Health Services)

We found that core services provided to support people's mental health by Nottinghamshire Healthcare Trust were safe, and there were clear structures and processes in place to ensure that services were delivered in a safe and responsive manner. However, there were inconsistencies of practice in some areas and we identified areas for improvement – particularly in recording information within healthcare records. The trust considered potential risks to people, but these were not always fully documented and reviewed.

The trust had a good process for reporting and managing incidents, and the learning from these shared with staff, both at a trust and local level, to ensure the future safety of people using services.

Staff understood how to safeguard vulnerable people and how to respond appropriately to any allegations of abuse. There were appropriate arrangements in place to manage medicines safely.

In the long stay and rehabilitation services, we found there were a significant number of ligature points within wards and risks had not always been identified and managed appropriately. This meant that people were exposed to potentially unacceptable and avoidable risk. The trust's 'Risk Assessment in Health and Safety Policy' was not being implemented consistently across the service on all wards. We brought this to the attention of the trust during the inspection and they took immediate action in response to our findings.

Health Partnerships (Community Health Services)

We found that services in the Health Partnerships division were generally safe. There were systems and procedures in place to safeguard vulnerable people and children and to identify, assess and manage risks.

There were systems in place to identify, investigate and learn from patient safety incidents, but we were concerned that not all patient safety incidents were raised through the trust's online reporting system at Lings Bar Hospital. We found that in some areas there was no consistent system to feed back to staff and improve the learning from incidents and safeguarding investigations.

At Lings Bar Hospital arrangements were in place to minimise risks to people using services to prevent falls and pressure ulcers. However, we were concerned about the lack of nurses overnight on all three wards and the monitoring of medication incidents.

Children and families services were generally safe, but there was a risk to safety due to poor medicines management and monitoring in the Children's Development Centre at Nottingham City Hospital campus.

At Bassetlaw Hospice there was no external supervision of their 'prescribing formulary' and there was no clear policy for the administration and checking of controlled drugs where there was one registered nurse on duty.

Forensic Division (Mental Health Services)

People we spoke with at all sites said they felt safe, and there were systems and processes in place to ensure people and staff were safe.

We were told that there is an open reporting culture and a good incident reporting process in place; for example staff newsletters identified lessons learnt from previous incidents.

All hospitals had excellent practices with regard to safeguarding and we saw that thorough assessments (in line with national guidance) took place before people who use services had contact with children.

There were systems in place to monitor cleanliness and compliance with health and safety.

We found concerns at Arnold Lodge about the timeliness of medical review for secluded people. We have been informed by the trust that action has been taken to remedy this.

Are services safe?

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

Our findings

Track record on safety

Local Services/Forensic division (Mental Health services)

All trusts are required to submit notifications of incidents to the National Reporting and Learning System (NRLS). Serious incidents known as 'never events' are events that are classified as so serious they should never happen. The trust has reported one Never Event since April 2011; a drug incident relating to mental health old age psychiatry in May 2012.

Serious incidents are those that require an investigation. Our intelligence monitoring identified that between March 2013 and February 2014, 72 serious Incidents occurred at the trust. Incidents occurred most frequently in 'ward areas' (72%).

During the inspection, the trust identified that the figure was incorrect due to our intelligence monitoring systems not recognising that the trust have seven STEIS accounts and we had only used the information from one account.

There were 2413 incidents reported by the trust to the NRLS between February 2013 and January 2014.

An analysis of the number of incidents reported to the NRLS, against the number of incidents expected to occur at a trust, based on the number of bed days, can indicate any potential under-reporting. The NRLS notification scores indicated that the reporting of patient safety incidents and the proportion of reported incidents that are harmful (incidents categorised as 'low harm', 'moderate', 'severe' or 'death') are both within the expected range.

Of the 2413 incidents occurring between February 2013 and January 2014, 71% related to the mental health setting. The remainder were categorised as relating to 'community nursing, medical and therapy service (incl. community hospital)' (22%), 'acute/general hospital' (3%), 'learning disability service' (3%) and 'general practice' (1%).

Every six months, the Ministry of Justice publish a summary of Schedule 5 recommendations which had been made by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

There were no concerns regarding the trust in the most recent report (October 2012 – March 2013).

Health Partnerships (Community health services)

A serious incident known as a never event is classified as such because they are so serious that they should never happen. The trust has reported no never events in the last twelve months for community health services.

CQC received 2413 notifications, via NRLS, between February 2013 and January 2014 Of these 540 (22%) were from the community nursing, medical and therapy service (incl. community hospital).

The National Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.

In 2011/12 the trust reported a total of 262 stage 3 and 4 pressure ulcers which included both avoidable and unavoidable pressure ulcers; this reduced to a total of 226 for 2012/13, a reduction of 14%. Improved data collection enabled the trust to understand the true incidence of pressure ulcers and this confirmed that around 99% of the trusts acquired avoidable pressure ulcers occurred within the Health Partnerships division.

In July 2012 the trust introduced a target to reduce acquired avoidable pressure ulcers by 50% by the end of March 2013. The trust exceeded this target, achieving a reduction of 68%. This continues to be a priority for improvement in 2013/14.

The trust monitors its performance as part of the national safety thermometer programme. The rates for pressure ulcers for seven out of 12 months preceding our inspection were above the England average. The local Clinical Commissioning Group (CCG), in response to two patients experiencing acquired stage 4 pressure damage on Forest Ward at Lings Bar Hospital, carried out an unannounced quality visit in February 2014. The CCG were satisfied by the actions taken by the trust.

In response to this, the health partnerships developed a strategy to tackle pressure ulcers and implemented a campaign to increase awareness. A multi-disciplinary group meets monthly to review progress against the strategy and to monitor how the trust is performing with the use of an action plan tracking system. Whilst this is being led by the Healthcare Partnerships division, we were told and observed that this is a trust wide initative.

Are services safe?

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

Learning from incidents and improving safety standards

The trust had identified the following priorities for 2013/4 in relation to safety:

- Reduce the level of harm and the number of physical assaults on people using services and staff.
- Ensure organisational learning in response to internal and external issues such as the Francis Report is embedded and sustained.
- Improve record keeping to ensure compliance with required standards.
- Eliminate acquired, avoidable stage 4 pressure ulcers and reduce the number of acquired, avoidable stage 1, 2 and 3 pressure ulcers.
- Improve medicines management to reduce medication errors.

The trust had systems in place to learn from incidents following their investigation.

There was learning on a trust wide basis. Each directorate had a governance group led by a governance lead. Each directorate had various groups where incidents were discussed, such as the 'circle' clinical governance groups, quality and risk committee and the patient safety and effectiveness committee. We were told by the heads of governance for each directorate that this varied between each directorate due to the differing needs of each service type. Each directorate fed incident reporting into the trust board. We were told that staff were kept informed about incidents and trends through a newsletter, sent out electronically, called Sharing Information about Quality Incidents Risk Research Patient Experience and Learning – or 'The Squirrel'.

The trust had clear safety-related goals that the wards were working towards. In the older people's mental health services, we saw that each ward were completing a balanced scorecard, which recorded their performance against a range of indicators. Where performance did not meet the expected standard it was risk flagged and the reason investigated.

At a previous inspection, conducted by the CQC in October 2013 at Highbury Hospital, the service had failed to meet some of the standards. This was because the trust had not always acted in accordance with the legal requirements with regard to a person's capacity to consent and care. Treatment had not always been planned and delivered in a

way that was intended to ensure people's safety and welfare, and the trust did not have appropriate arrangements in place to manage medicines. In response to this, the trust had developed an action plan to improve the safety of the service and ensure they were meeting the standards. We found that the learning from this had been shared across the service. Another area of concern had been in relation to the management of covert medication. In response, staff had received training in covert medications and pharmacy input had been increased. When we visited other wards and locations we found that this learning had been shared there as well.

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

The trust had systems in place to ensure safeguarding incidents were reported and investigated.

The trust worked closely with the two local authorities (Nottinghamshire and Nottingham City councils) and outreach teams to provide an integrated safeguarding structure. The trust were members of a Multi-Agency Safeguarding Hub (MASH), run by Nottingham City Council which incorporated strategic groups, the police and domestic violence teams in the local area. We saw evidence that the trust attended both local authorities safeguarding boards and that exception reports go to the trust board. The trust had an internal safeguarding training programme to ensure staff were up to date with safeguarding training, including an e-learning package.

Health Partnerships (Community health services)

We saw that staff followed trust policies and guidelines for medicines, analgesia management and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR). DNACPR forms contained clear guidance for staff. The forms were signed by a doctor and the reason for the decision was clearly documented. The discussions that staff had with people about the DNACPR were recorded in their notes.While staff were knowledgeable and effective in reporting safeguarding, they told us that they rarely received feedback on how safeguarding concerns were investigated or the outcomes . This meant that opportunities for learning and development from safeguarding concerns were not being optimised.

Systems to ensure safety of medicines were inadequate at the Children's Development Centre at Nottingham City Hospital. There was a lack of pharmacy support to monitor arrangements. The management team told us there had

Are services safe?

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

been no external pharmacy audit for two years and no internal pharmacy audit for nearly a year. There was no local medicines management policy guiding staff about safe medicines procedures for children and families. This represented a potential risk to patient safety. The trust could not be sure that medicines were being managed appropriately at this location.

Local Services (Mental Health Services)

Management of medication was good in the PICU wards and we saw evidence of safe administration. An audit of omitted or missed doses of medicines undertaken in February 2014 showed that there were no omitted or missed doses.

Within the community mental health teams of the older people's services, we saw that they had systems in place to manage caseloads. There was a single point of access to all community services and specialist team members based within the team. In some teams a daily duty system picked up all referrals and allocated according to need and priority. However, this was not consistently in place at all times in all of the teams. Protocols were in place for the transfer of people from working age to older adults' services and admission and discharge criteria were in place. Staff were using case load management systems and their caseloads were being audited to check they were appropriate.

In the long stay core services, we saw that staff had received appropriate training in safeguarding. The inpatient wards had an identified safeguarding lead nurse, who attended the directorate safeguarding forum, and passed on key messages to the rest of the team through ward meetings

All admissions to hospital from the community were managed through the community based mental health crisis services. The management of beds was a team function thus ensuring all admissions came through the crisis teams. The crisis service was available 24hrs a day 7 days per week. The team operated a reduced service between 9pm to 9am, which meant they did not undertake any crisis assessment but offered people, who contacted them, a telephone support and advice service.

Within the adult based community mental health services, records management was mainly 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.

Some of the wards we visited had full resuscitation trolleys and some had grab bags. These had been regularly checked by staff to ensure they were complete. We found evidence to demonstrate that safety alerts were received and actioned by the inpatient ward managers.

Staff in the perinatal services had a good understanding of children and adult safeguarding procedures. We found that services were delivered in clean and safe environments and that the inpatient services had clear environmental risk assessments to ensure the safety of people who used the service.

Assessing and monitoring safety and risk

The trust had a trust wide risk register and board assurance framework. It had structures in place to ensure that all risks were recorded and categorised. Each directorate had a risk register that fed into the trust wide risk register. Each risk was categorised and reviewed by the quality and risk committee. The trust also collected a range of performance information which was collated to produce trust wide information. The information fed into the trust's quality and risk committee up to the trust board.

Quality Experience Scrutiny Team (QUEST) is the trusts internal quality monitoring review process. There was a schedule of planned visits and also ad hoc visits are conducted. As part of a QUEST review, environmental issues may be identified and reported upon and the relevant service would develop a plan for improvement which is monitored.

The trust undertook an environmental risk assessment annually on the wards which includes ligature risks. The outcome of this audit was monitored through an action plan. We saw that not all risks had been identified through this process.

The trust had a 'whistleblowing' policy in place which staff were aware of. This policy provided staff with guidance on how they could escalate a concern they had without the need to be identified.

Are services safe?

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

Health Partnerships (Community health services)

Lone working arrangements were inconsistent. A lone working policy was in place but there were localised procedures as to how staff were protected. At Park House surgery managers were unsure whether staff were on duty and there was no assurance that they would be able to undertake all the required visits. Staff told us that where it had been assessed they should visit people using services alone there was a warning included on the persons electronic record to alert them of the assessed risk. We noted that there were few risks related to children's services on the trust wide risk register but saw that staff were clear on the systems in place to monitor and escalate risks.

Local Services (Mental Health Services)

Within the CAMHS wards, there was no physical segregation of male and female sleeping arrangements and no provision of a female only lounge on the unit. There was no ward based local policy guidance available for frontline staff on gender segregation. The young people spoken with did not express any concerns about the gender mix and staff confirmed that if there was a young person with any concerns these would be identified in their care plan. None of the care plans that we saw identified this as a concern to the young people.

On one of the learning disability wards, all staff we spoke with told us that seclusion was not used. We looked at the policy for 'Orion unit and the use of short term and long term controlled low arousal suite'. This stated that 'this should only be used for people whose risk to others is a constant feature of their presentation which is not subject to amelioration by a short period of seclusion combined with any other treatment.' We concluded that this meant that people who use services should not be using the low arousal suite unless they had already been secluded. On the inpatient wards of the older people's core service, the Deprivation of Liberty Safeguards (DoLS) were used effectively in the areas we visited.

In the long stay services each person had a risk assessment in their care records which included risks in relation to safeguarding and risk to self and others. Where a risk had been identified, a care plan had been developed with the person to reduce or manage the risk. However, we found

that risk assessments were not reviewed or undertaken prior to a patient detained under the Mental Health Act (MHA) commencing Section 17 leave or upon their return to the ward following a period of leave under Section 17 MHA.

In the long stay core services, a specific ligature audit was undertaken by the ward managers. There were a significant number of ligature risks within the long stay inpatient environments. These ligature risks exposed people to unnecessary and avoidable risk. We raised this with the trust and they took immediate action, developing robust action plans to mitigate these risks.

Within the Mansfield Community Rehabilitation Units, we were told that on occasions, people were transferred to a vacant bed on Heather Close ward from an acute ward with no prior notice due to acute bed pressures. This meant that people had not always been assessed for suitability for a rehabilitation ward by staff from the ward.

Within the community based crisis services we saw that both teams responded to people experiencing acute mental illness within 24 hours of referral. A needs and mental health assessment was completed and people could be offered a number of options including admission to hospital, home treatment, referral to a community mental health team (CMHT) or referred back to their GP. However all urgent referrals, that needed same day assessment, were sent to accident and emergency (A&E). Any risk issues identified by the staff were discussed with the multi-disciplinary team and acted upon.

In the adult based community mental health services we saw that staff worked jointly with other agencies, and across services, to promote safety. 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 which meant that capacity for staff to provide continuity of care, to keep people safe and meet their needs, was effective.

Forensic Division (Mental Health services)

We saw that in the high secure services individual risk was comprehensively assessed, and well planned, and documents seen supported this taking place. People told us they had worked on their distress signatures with staff to recognise when they needed help and to identify what to do to help them cope. There were excellent examples of pictorial information for people with learning disabilities.

Are services safe?

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

Staffing levels were reduced at night during night time confinement when people were locked in their bedrooms. The policy stated, and staff told us, they had to summon help and obtain permission from the site manager before entering a bedroom at night. This meant there was the risk of delay if there was an emergency. Most staff told us they would risk assess at the time and if it was life threatening they would decide whether or not to go in.

Understanding and management of foreseeable risks

In all of the three divisions we saw that the trust had plans in place to manage, and mitigate, any anticipated safety risks.

We saw that, in all three divisions, most staffing shortages were filled by the trust's own bank staff which meant that staff would have knowledge of the ward and the people's care needs. Staff managed foreseeable risks to care, through their assessments and knowledge of people, and felt able to respond to local staffing and emergency situations.

Health Partnerships (Community health services)

Health visitor staffing levels were being increased as part of the Health Visitor (HV) implementation plan and recruitment was ongoing. There had been collaboration with commissioners, based on public health reviews of the needs of the population locally, to scale the increase in staff resources. The effectiveness of computers to support their work was a common concern across staff in many locations.

Local Services (Mental Health Services)

We saw that in the CAMHS service although potential risks were effectively anticipated we saw that within community teams, safety and clinical risks were not being documented thoroughly on children and young people's records which created a risk of not everyone being made aware of the identified risks.

We saw that in the Ashfield learning disability community teams, the fire procedure stated that 'in the event of a fire alarm, it is essential that all fire wardens on duty respond'. It stated throughout the procedure that fire wardens were responsible for the safe evacuation of all people in the building until the fire service arrived. However, staff at the office told us that there were no current fire wardens working in the building. This meant that the planning for foreseeable risks had not been managed to ensure the safety of people who use the service and staff.

In the long stay core services there were appropriate plans in place to respond to possible emergencies which may impact on staff, people who used services and visitors. The wards had emergency first aid and resuscitation equipment on site which staff were trained to use. However; there was no system in place to ensure that regular fire drills took place on the inpatient wards.

Within the acute admission wards the trust had not adhered to national guidance on gender separation on wards. This related to ward B2 at Bassetlaw Hospital and Orchid Ward at Millbrook Mental Health Unit. The trust was therefore not promoting physical and sexual safety through the elimination of mixed sex accommodation as recommended in the Mental Health Act Code of Practice.

Forensic Division (Mental Health services)

There were some concerns raised regarding out-of-hours junior doctor cover, especially for the four hourly seclusion reviews at Arnold Lodge. We saw that the trust did not have a system in place to manage the risks associated with the late or non-attendance, of on-call doctors.

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

Local Services (Mental Health Services)

We found that core services provided to support people's mental health by Nottinghamshire Healthcare Trust were being delivered in line with good practice guidance – for example as issued by the National Institute for Clinical Excellence (NICE). Where appropriate, we saw good examples of collaborative working with other services within the trust, stakeholders and other partners. There were systems in place to ensure that people's rights were adhered to under the Mental Health Act and staff had undertaken training and demonstrated good understanding and application of the Mental Health Act and Mental Capacity Act.

The trust used good measures to judge the effectiveness of services, including feedback from people who used them. We did find in a few units that activities were not offered to people and the physical health needs of people who used the service were not always monitored sufficiently to ensure their health and wellbeing.

Health Partnerships (Community Health Services)

We found that people using services and families received care that was effective in the Health Partnerships Division.

The skill mix of staff within multi-disciplinary teams was effective in delivering seamless care to people when they needed it. There was a focus on achieving positive outcomes for people and families. There were enough staff with the appropriate skills and supervision to deliver effective care. There was generally effective communication among members of the multi-disciplinary team to support the planning and delivery of patient care.

Services were targeted at particular groups which ensured children in vulnerable or minority groups were well supported. Staff resources were allocated to meet the needs of families and children. People's care records were well organised and information was easy to access.

Some staff reported problems with information technology that was used to support their work or for keeping records. However, we found the trust recognised the difficulties and had plans in place to improve facilities and functioning of systems.

Forensic Division (Mental Health Services)

From the evidence inspected and discussions with managers and frontline staff, we saw the trust was able to demonstrate that people who used this service received care and treatment in line with the current best practice guidance. People's care was individual and focused on their recovery and a range of therapies was available according to their assessed needs. People told us that they had a good relationship with their doctors and the nursing staff.

People's care, treatment and support achieved good outcomes, promoted a good quality of life and were based on the best available evidence. The medium secure services participated in the Royal College of Psychiatrists Quality network for forensic mental health services scheme.

There were systems in place to monitor the quality of care provided and to check it was meeting national standards. Outcome measures were used to check progress of people using the services.

Staff told us that they felt well trained and equipped to carry out their roles. They felt supported by both their colleagues and the hospital management.

The trust complied with the Mental Health Act and was mostly compliant with the Mental Health Act Code of Practice. At Arnold Lodge, there were concerns about the lack of out-of-hours doctor cover and the lateness of medical reviews for secluded patients.

Are services effective?

Our findings

Assessment and delivery of care and treatment

The trust had an effective clinical audit strategy in place which was monitored by the clinical audit and effectiveness committee, feeding into the trust board. The trust participated in national audit and had CQUIN targets for the upcoming year. Local audit programmes were in place that were linked to local NICE compliance, local risk, complaints and trends identified through incident reporting.

Health Partnerships (Community health services)

At the John Eastwood Hospice we noted people received a holistic assessment of their needs and care was provided within end of life care national and local guidelines. Specialist palliative care nurses used the distress thermometer to measure patient's psychological wellbeing, at different stages of their care. We saw that there were outstanding examples of care being given that meant that people receiving services were able to determine and receive the care they wished to at the end of their life.

At all children and family locations, and teams, we found care provided was evidence based and followed recognised and approved national guidance. Within the Local Services (Mental Health services) there were clearly defined and embedded systems, processes and operating procedures that reflected national guidance and professional guidance such as, monitoring of infection control and patient led assessments of the care environment (PLACE).

Local Services (Mental Health Services)

We saw that young people, who required admission to an inpatient bed, were assessed by their own specialist CAMHS psychiatrist in conjunction with the CAMHS consultant responsible for the inpatient beds. We noted that bed management meetings took place between the trust and NHS England specialist commissioners on a monthly basis to ensure the effective use of this service.

In the learning disability inpatient wards we visited, there was a mixed picture regarding the use of physical health checks and access to a GP for people using services. In some wards, there was good evidence of people who use services having regular health checks, but on Orion Ward, it

was clear that physical health checks and recording of these were not being completed. The lack of monitoring and recording of people's physical health needs could have a detrimental impact on their health and wellbeing.

Within the older people's services clear care bundles for assessments were in place, were implemented and monitored and were in line with key national targets. The assessment packages were consistent across services and were monitored and reviewed monthly. Standard risk assessment tools, such as the MUST (malnutrition universal screening tool) were used. We spoke with nursing and medical staff who displayed a good understanding of clinical guidelines, for example, NICE (National Institute for Health and Clinical Excellence) guidelines regarding the use of psychotropic medication for people with dementia. The wards we visited were following best practice guidelines on managing risks and improving the wards. The dementia outreach team was providing specialist advice and assessment for people with challenging behaviour in care homes. The team used multi-disciplinary working to provide support to people, and had developed an innovative approach to care. The Intensive Recovery Intervention Service (IRIS) offered intermediate care support to people, with the intention of supporting them to live successfully in a community setting. It supported people from 7am to 10pm seven days a week.

In the long stay services staff on the wards were clear about the implementation of evidence-based research and guidelines into their working practice. The services had implemented a recovery based model of care on all the wards to assist people in their recovery. On Newark community rehabilitation unit, the overall standard of the care plans we looked at was outstanding. We found good evidence to show that people were involved in developing their care plans with staff. People's care was reviewed through the Care Programme Approach (CPA) process annually and Multi-Disciplinary Team (MDT) meetings. We did find however, on Broomhill House, a lack of evidence that people were seen by their consultant psychiatrist regularly or involved in their care reviews. This meant it was not possible to determine that some people's views had been taken into account within the review process.

Within adult based community mental health services we saw that care plans, although outcome based, were not updated to establish progress towards recovery with people, although notes completed following each

Are services effective?

consultation showed clear evidence of therapy, care and treatment being provided. People's physical health care, although at times considered in records, was not considered further as part of their overall health and wellbeing. This meant that inconsistencies in recording and planning care for people existed.

People who used the specialist eating disorder service received care and treatment in line with the current best practice guidance. Records seen showed us that people's specialist physical healthcare needs were being addressed by the person's General Practitioner and, where necessary, by admission to the local acute NHS trust.

Staff in the inpatient and community perinatal services were clear about the implementation of evidence-based research and guidelines into their working practice. The services used a range of patient and clinical outcomes to measure the effectiveness of their practice and ensure that there was scope to improve.

Forensic Division (Mental Health services)
In the Forensic Division (Mental Health services) we saw that in the medium secure services, Wathwood Hospital had implemented the 'Productive Mental Health Ward' system which we were told had improved efficiency.

Outcomes for people using services
Nottinghamshire Healthcare NHS Trust supports the primary vision for integrated care which identifies potential opportunities to deliver improved outcomes for people. The trust maintains that integration must be focused on the person, not the system, and should support innovative reconfigurations that promote best practice and address barriers to integration.

The following provides some detail of how the trust had applied this within their clinical divisions.

Overall the Health Partnerships division were meeting all their CQUIN targets and were working with the commissioners to discuss how to monitor this in the future.

Local Services (Mental Health services) were meeting their CQUIN and had successfully achieved their target for providing physical health check to people with mental health conditions.

The Forensic Services division also continued to meet their physical healthcare and wellbeing targets.

In order to promote new or improved initiatives, to support the integrated healthcare needs of patients, the trust had hosted an Integrated Healthcare Summit and launched an Integration Challenge programme on 17 April 2012. The Integration Challenge was aimed at encouraging staff, people who use services and carers to look at how the trust could ensure their services were integrated to meet people's mental and physical healthcare needs. This trust-wide initiative was an alignment with the national agenda and supported a vision that is patient focussed, clinically led and inclusive.

Our Intelligent Monitoring analysis identified that during 2012/13 Nottinghamshire Healthcare NHS Trust participated in the following audits:

- The National Prescribing Observatory for Mental Health (POMH) – four audits.
- The National Audit of Psychological Therapies.
- National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH).

As an outcome of the participation in these audits, a number of changes were made to clinical guidelines.

The trust participates in peer review and service accreditation.

Health Partnerships (Community health services)
Within the end of life care service, people using services were asked by volunteers for their feedback, the results showed that people who used the day care unit found the experience to a positive one. One person spoke of having renewed meaning to their lives and the ability to take part in family life.

The trust was developing integrated care teams, which meant people were placed at the centre of their care, and the teams could include community matrons, community nurses, physiotherapists, occupational therapists, mental health support workers and social workers. All community staff worked together well to deliver a good quality of care.

Local Services (Mental Health Services)
We saw that in the older people's services the length of stay in inpatient areas was monitored and plans were in place to reduce this where appropriate. Each ward had a target it was working towards and this data was monitored centrally. On ward B1 there was a clear focus on brief

Are services effective?

inpatient assessment and treatment in the service, with an emphasis on people returning to the community as soon as possible. This was because the trust was aiming to manage people in the community as much as possible.

The length of stay for people using the acute admission wards was monitored and reviewed weekly by a multi-disciplinary team if it went over the 50 day limit. Some wards were often running at full or over full bed occupancy. Staff confirmed that bed managers monitored the re-admission rates of people and would look at triggers leading to their re-admission.

Staff within the community based crisis service had the knowledge and training to skilfully assess people in crisis and provided the right intervention to address their needs. They had good systems in place that allowed them to work collaboratively with other services, such as the admission wards, to deliver the best outcomes for people.

In the specialist eating disorder services, records and other evidence showed us that the trust were involved in the monitoring and measurements of quality and outcomes for people. These results were evaluated by the care team and monitored by senior staff. Evidence was seen of other person reported outcome measures (Proms) in individual care and treatment records as part of the evaluation of the care being provided by this service. We noted that the service measured outcomes for people by using the Health of the Nation Outcome Scales (HoNOS). Evidence was noted of positive outcomes as recorded in individual treatment satisfaction surveys completed by people at the end of their treatment programmes.

Millbrook Clinic and Queens Medical Centre ECT suites are part of the ECT Accreditation Scheme and were accredited as excellent.

Both the inpatient and community perinatal services had taken part in accreditation schemes through the Royal College of Psychiatrists. Staff also undertook peer reviews of other services nationally as a part of this programme which ensured that there was a cross-fertilisation of specialist knowledge and encouraged the service to develop best practice.

Forensic Division (Mental Health services)

Both Arnold Lodge and Wathwood Hospital are part of the Forensic Quality Network. Wathwood Hospital was voted best medium secure unit in the country by the Quality Network, a peer review system facilitated by the Royal College of Psychiatrists.

Staff, equipment and facilities

Patient Environment Action Team (PEAT) was an annual assessment of inpatient healthcare sites in England with 10 or more inpatient beds, and was replaced from 1 April 2013 by PLACE (Patient-Led Assessments of the Care Environment)

These self-assessments are undertaken by teams of NHS and independent heath care providers and patient assessors (members of the public who must make up at least 50% of the team). Twenty-three locations at this trust had PLACE assessments in 2013.

All new staff had a trust induction and were then able to shadow experienced staff. Staff we spoke with were positive about arrangements to mentor and support both new and more experienced staff. Staff we spoke with were positive about training opportunities. They told us that there was access to mandatory training and that the content was appropriate to their roles and responsibilities.

Health Partnerships (Community health services)

The community staff we spoke with confirmed that staffing arrangements usually met the needs of people they supported. Managers told us that it was difficult to recruit suitable staff and there were occasions when, as a result of this, vacancies were left unfilled. Community nurses told us that cover for sick leave, maternity leave and study leave was not always provided.

We spoke with some staff that had disabilities which meant they should have workplace support plans in place. While staff told us they were supported well in the workplace some had workplace support plans in place, others did not.

Staff told us that a number of IT systems were in use and in some areas only paper records were being used. The types of systems in use varied in different localities. Staff reported inconsistent access to IT systems particularly when working in community settings. We saw that in one community service it took staff 15 minutes to access the patient's notes.

Are services effective?

Staff told us this was usual. Where a number of healthcare providers were involved in a patient's care there was a risk of communication delay or breakdown as systems were not compatible.

Local Services (Mental Health Services)

Within the CAMHS community teams' staff spoken with confirmed that they were equipped with mobile phones. Some staff were piloting a new system of recording care and treatment episodes via the use of a 'digi pen'. This enabled the effective recording of assessments, care plans and treatment episodes onto the trust's electronic record system and meant that young people received a paper copy immediately after assessment.

We saw on Hucknall inpatient unit, a learning disability ward, that the environment was not comfortable but institutional in appearance which did not promote people's wellbeing when accessing a short stay service.

In older people's services we saw that supervision of staff within the wards was done regularly and in a robust manner. Nursing staff received both clinical and managerial supervision. The supervision sessions followed a set structure and included feedback on learning and audits. Each ward had an environmental care co-ordinator to support the management of the ward. This meant managers were supported to put the Releasing Time to Care Agenda, into practice. This is a programme that focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care.

In long stay core services we saw that staff were provided with opportunities to undertake training and professional development relevant to their role. They were able to undertake additional qualifications and felt supported to do so by the trust. Staff attended regular supervision meetings and felt well supported by their manager.

The care planning pathway was reviewed across all of the acute admission ward sites. Staff told us that the lack of training and placements on wards had resulted in staff being unclear how to complete care plans. The trust had recently revised the new paperwork but training in how to write care plans had not yet resulted in consistent practice.

We saw records within the Specialist Eating Disorder service that demonstrated to us that the trust had

completed the required risk assessments and maintenance on the equipment used by the service. Adjustments had been made to meet the access needs of people with mobility difficulties and those with a sensory impairment.

Forensic Division (Mental Health services)

Within the Forensic Division (Mental Health services) we saw that in the High Secure services in the newer parts of the hospital the facilities and décor supported a therapeutic environment. This was less evident in the older parts. Intercoms were available in people's bedrooms and seclusion rooms in most areas but there were some areas where intercoms were not installed and staff and people reported they spoke through the hatch and shouted to communicate. This had a negative impact on privacy and dignity. Not all seclusion rooms had en-suite facilities.

There were interpretation services available and we accessed a signing interpreter when we spoke with people in the deaf services.

We saw there was a shop where people could purchase a wide variety of foods, magazines and a small range of clothing.

In the medium secure services, Wathwood Hospital had a small farm, with some animals, and a polytunnel for growing plants. There was a farm shop which was staffed and run by people who use services with staff support. The hospital also ran a restaurant which the people who use services had chosen to call, "Section 17". This was a working restaurant and people could work in both the kitchen and restaurant. Families, carers and other visitors were able to eat there and the restaurant had won an award.

Staff from the low secure services told us that the Management of Violence and Aggression training, for The Wells Centre, was now carried out onsite instead of at the high security hospital, Rampton. Several staff across the units felt this had resulted in the training being much more relevant to the needs of people who were cared for in a low secure setting.

Multi-disciplinary working

Health Partnerships (Community health services)

People who used services in the Healthcare Partnerships division had access to teams, with the appropriate levels of skill mix, to ensure safe clinical care from those best trained to meet their individual needs. We saw that there were

Are services effective?

good multi-disciplinary team arrangements in place to provide support and treatment. All staff we spoke with talked positively about changes to the integrated community care teams, which included occupational therapist and physiotherapists working alongside community nurses.

Local Services (Mental Health Services)
We saw that the trust worked effectively with other providers and partners in the provision of the CAMHS service. We saw evidence of close and collaborative working with the community CAMHS service, local authorities, schools, General Practitioners (GP) and local Youth Offending Teams (YOT). Evidence was seen of close working relations with the adult mental health service. This included the provision of advice and the reviewing of young people being cared for on an adult acute admission ward.

In the older people's, service, assessments on wards were generally multi-disciplinary in approach with involvement from medical, nursing and specialist teams including occupational therapists, speech and language therapists, pharmacists, dieticians, physiotherapists and clinical psychologists. Information sharing between wards and community services was taking place however in some cases information was not shared regarding an admission or discharge. One reason for this was the lack of an electronic information system.

In the mental health community based crisis services, we were told that the crisis home treatment team was not multi-disciplinary. There was no social worker, occupational therapist or psychologist in the team. Staff told us of the difficulties they had accessing psychological therapies for the people they were supporting.

We saw, and were told, that in adult community mental health based services requests for social worker input for people using services 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 people, subject to the Care Programme Approach, was scanned into the electronic system which both health and social services staff could access.

Within the specialist eating disorder service close links were noted with third sector partners including local self-help and individual advocacy groups such as Beating Eating Disorders (BEAT).We observed close links with the

local acute NHS trust. This included providing support and advice to staff caring for people who required physical health care treatment as a result of the side-effects of their eating disorder.

Within the perinatal service there were some examples of strong multi-disciplinary working and strong links with midwifery and health visitors. However, there were no social workers in the team, either on the ward or in the community. There was little psychology time available for people on the ward, little occupational therapy input and none in the community team. Staff on the inpatient ward told us that sometimes they had difficulties referring babies to paediatricians because they did not have access to a community GP on the ward. This meant that sometimes the service did not have systems in place to deliver the most effective care to people who use services.

Forensic Division (Mental Health services)
We attended and observed a ward round taking place in the low secure services. While we saw there was representation of different professions, this range was limited to a consultant psychiatrist, staff nurse, occupational therapist and secretary. We were told that psychology input to one ward round was intermittent, however this varied from ward to ward. There was no dedicated social worker as part of the multi-disciplinary working, which the staff felt was important to have. This was also part of discussions in the social worker focus group. Staff told us they hoped to secure a dedicated social work provision for the inpatient service in the future.

Mental Health Act (MHA)
We visited the majority of the wards at each location where detained patients were being treated. In the majority of the care records reviewed, relating to the detention, care and treatment of detained patients, under the principles of the Mental Health Act (MHA) had been followed and adhered to.

There were effective systems and processes in place to ensure that people who were detained under the MHA understood and were empowered to exercise their rights.

We found that staff worked in accordance with the MHA Code of Practice in relation to the hospital based places of safety. There were appropriate proformas and systems to

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ensure staff worked within the MHA Code of Practice. For example to record key demographic details, issues such as transfers between the police and place of safety and the outcome of the use of the place of safety.

Within the learning disability service, we saw in records we sampled that there was clear evidence that people who were detained under the Mental Health Act 1983 had their rights explained to them. This was produced in an easy to read leaflet to enable all people who used the service to have an understanding. People had information in an accessible format about how to contact an Independent Mental Health Advocate (IMHA) and about their rights to a tribunal. We saw that referrals were made to advocates to ensure people were supported.

Within the long stay core service, we found inconsistencies in the application of the Mental Health Act (MHA) across the service. We found that risk assessments were not reviewed or undertaken prior to a patient detained under the MHA commencing leave or upon their return to the ward following a period of leave under Section 17 MHA. We found the recording of patient's rights under Section 132 was not always completed at regular intervals. We identified concerns regarding the treatment monitoring of patients detained under the MHA by their Responsible Clinician (RC) on Broomhill Ward. We looked in the care records of all patients detained under the MHA on this ward and there was little or no evidence to show that patients were regularly seen and reviewed by their RC.

Are services caring?

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

Summary of findings

During our inspection we were very impressed with the Chief Executives and Boards personal commitment to ensuring active engagement and participation with people who use the trusts service across all care pathways.

The involvement centre and recovery college were excellent examples of supporting peoples emotional needs whilst providing practical help as part of people's journey of recovery. We saw that this commitment ran throughout all areas of the trust and was supported and shared by all the staff we encountered.

Local Services (Mental Health Services)
We found that across the core services we inspected, staff demonstrated outstanding levels of care and responsiveness to people using the service and their carers, and were skilled and sensitive in the delivery of care. Staff responded to people with patience, kindness and ensured that they were treated with dignity. We found good examples of 'person-centred care' being provided, with staff involving people at a local level in making decisions about their care and treatment. Families and carers were involved when appropriate. People using the services told us that staff were caring and supportive. Where people may have lacked the mental capacity to make decisions, this was assessed to ensure that decisions about their care and treatment were made in their best interests.

Health Partnerships (Community Health Services)
We saw many examples of caring and compassionate services across the Health Partnerships division. We received many positive comments about the quality of the care and treatment and the approach of the staff. People using services, families and carers all told us they were treated with kindness and respect and they were involved in making decisions about care and treatment. We saw many examples of people using services, families and carers being offered appropriate emotional support. Parents were provided with clear information about the service being offered to their child and the treatment they were to undergo. Services used different methods to listen to feedback from people who used their services and responded to their comments.

Forensic Division (Mental Health Services)
Overall, people who used the services described staff as caring and responsive, and said they felt safe. The care plans we looked at showed people were involved in reviewing their care and progress. We saw examples of staff making reasonable adjustments to meet people's needs. Most people said their privacy and dignity were respected. We observed staff speaking about people who used the services in a respectful manner.

Secure services had outstanding levels of involvement by people using them. Each hospital had a patient forum where issues could be raised. They also had carers' forums and ran carers' days each year.

Secure services held community meetings and reported on them; despite some feedback that these were not always as regular as they could have been, generally feedback was positive.

Our findings

Kindness, dignity and respect
The trust provided good evidence to demonstrate to us that people using services were treated with kindness, dignity, respect, compassion and empathy. This was supported by our discussions with front line staff and the family members of people who used the service.

Health Partnerships (Community health services)
People using services and relatives we spoke with said that staff were kind, treated them with respect and met their individual needs. We observed that people were afforded dignity and empathy by the community teams responsible for the delivery of their care.

Local Services (Mental Health Services)
In older people's services we saw that the interaction between people who used the service and staff members

Are services caring?

was positive and that staff responded to people with patience, kindness and ensured that they were treated with dignity. We observed many examples of staff engaging with people in a kind and respectful manner on all of the wards.

For the long stay core services, in all the inpatient wards we visited, we observed care being delivered with consideration, dignity and compassion. People who used the service told us that they were satisfied with the care which they had received and felt supported and well-cared for by staff. People valued their relationships with staff and experienced effective interactions with them. There was a mutual respect between staff and people who used the service.

In the community based crisis services, we spoke with people who had either used the service or had a family member who had. They told us the support they received was variable and the main form of treatment was dependent on medication. Some people told us they had had very good staff who they felt had helped them to make good progress and to recover. Their experience of out-of-hours was mixed in that they spoke to staff that were supportive and helpful. They also spoke to staff that did not treat them respectfully or with understanding and impersonally advised them to go to A&E if they needed urgent care and support.

In the adult based community mental health services people told us they were treated with dignity and respect. We observed care being delivered with consideration, using language that was empathetic, clear and simple without the use of jargon.

On the perinatal inpatient ward, we observed care being delivered with consideration and compassion. We spoke with people who used the service who told us that they were satisfied with the care which they had received.

Forensic Division (Mental Health services)

Within the Forensic Division (Mental Health services) at Arnold Lodge Medium Secure Unit, a multi-faith room was available for people, who were using the services. We were told by the hospital management that there was a wide range of provision available. This ranged from Muslim (with an arrow on the multi-faith room floor pointing to Mecca), through to Christian, Buddhist, Hindu and Pagan. This meant that patients' faith needs could be met.

People using services involvement

The trust had effective systems in place for involving people using services and their relatives. They did this by collecting people's views and being reactive to people's input. We met with the patient engagement and involvement team who informed multiple methods used to gather people's views and those of the various patient and carer led groups within each directorate, that fed directly into the trust board level.

Nottinghamshire Healthcare NHS Trust has a dedicated patient feedback website. The website collates three patient feedback databases into one online portal:

- The trust's 12 question patient experience survey.
- Patient Opinion stories.
- Patient Advice and Liaison Service (PALS) data.

Some adaptations have already been implemented. For example:

- An acute mental health ward is now training 12 student volunteers to capture feedback as they take the tea trolley around the ward.
- Lings Bar Hospital (Physical Rehabilitation) has a volunteer who visits each ward to capture patient and carer experiences. This is fed back to ward managers, for real-time changes or longer term actions. A hairdresser is now being provided for the hospital as a 'quick win' in direct response to patient feedback.
- The Forensic Enhanced Personality Disorder Unit at Rampton High Security Hospital are working with Patient Opinion and have run two patient forums. They are developing a protocol and training for capturing patient experience data in a high security setting.

The Friends and Family Test (FFT) seeks to find out whether patients would recommend their care to friends and family.

Nottinghamshire Healthcare NHS Trust has adopted the FFT across its divisions (except Offender Health) and includes its scores in monthly Patient Voice reports and quarterly involvement and experience reports.

Since April 2013 the trust has seen its FFT score increase and for January-February 2014 the score was 75. Scores are published quarterly for all divisions/services on the trust's feedback website. Scores can range from -100 to 100, with a higher score indicative of better performance.

Are services caring?

Health Partnerships (Community health services)

Adults with long-term conditions were involved in, and central to, making decisions about their care and the support needed. We observed that staff checked the person's understanding of the treatment required. We saw in a physiotherapy clinic at Park House that in addition to explaining problems and treatment, the physiotherapist used a model to explain the problems the person was experiencing. The person spoke positively about their experience and was confident about undertaking the required exercises.

People were consulted about their care but were not always provided with copies of their care plans. Some staff told us they printed out copies of care plans and gave them to people who used the services. Other staff were unaware if it was possible to print out copies and said people were not offered copies of their care plans. Therefore, there were no consistent procedure in place to ensure people who use services were given copies of their care plans

Local Services (Mental Health Services)

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

Across the adult admission wards, where English was not someone's first language, staff could access an interpreter through the Mental Health Act office. A staff member described an example where they had accessed an interpreter for one person for ward rounds and regularly invited their family members into the service.

Within the specialist eating disorder service we saw good examples of individual involvement in those records reviewed and of active participation by people in their psychologically based therapies. This demonstrated to us that people received person centred treatment according to their individual needs. In the community team, people provided feedback verbally but this was not consistently recorded.

Forensic Division (Mental Health services)

In the medium secure services, Wathwood Hospital involved people who use services as much as possible in the running of the hospital. There was a patients' forum which met fortnightly and staff told us about 50% of people who use services attended. People who use services told us about attending the forum and that it was attended by the hospital manager and the modern matron. Minutes of the forum were available across the hospital.

Emotional support for care and treatment

The trust had developed a service called 'The Involvement Centre' and we spent some time sitting within the centre observing the activities and talking to people who were there at that time. We were told that the centre is not a clinical service but works with carers, volunteers and people who use services. People at the centre talked about the positive way in which the centre had played a role in their recovery and described their personal journeys. They told us how they were influencing the development of changes to services and making sure that people who use services and their carers are at the centre of decision making about their care and treatment. The people who use services were able to tell us about their engagement with the board and they were able to describe the trust's challenges in service improvement. Involvement volunteers told us about the 'Communities of Interest' and how they have presented at conferences about the work that they have completed. Communities of Interest bring together groups of people with a shared interest, understanding or who want to work together to shape or improve services. This provided people who use services and carers both practical and, emotional support as well as support towards their recovery.

Another initiative developed to provide emotional support was the Recovery College. The college offers a wide range of recovery focused educational courses aimed at supporting people in recognising their talents and resources and to manage the mental health challenges they experience. They also aim to support people to achieve the things they want to. It operates as a traditional college and students enrol and are supported to develop a learning plan. The mother of a student who had been unwell for ten years spoke to us about the success of the college in her son's recovery. She described how people were valued and treated as people, how the ethos of the college assisted her son to recover but also allowed her as a carer to start her journey of recovery. We saw a number of prospectuses for the college throughout the trust's locations and the college is provided in a number of settings as the geographical catchment area is too large to accommodate students in one setting.

Are services caring?

Health Partnerships (Community health services)
People who use services and their relatives told us they were supported emotionally particularly when their condition changed. One relative told us how the community team had "gone the extra mile" to respond to the deterioration of their relative who required end of life care to ensure their condition could be managed at home.

The inclusion of mental health nurses, within integrated community adult service teams, meant that people's psychological and mental health needs were taken into account. We saw that assessments and care plans considered people's' views and expectations, demonstrating that people's perceptions and emotions were considered when planning care.

Local Services (Mental Health Services)
Within the CAMHS services young people were positive about the education service provided by the unit. We saw that they attended this service four days a week based upon individual risk assessments. We saw a wide variety of educational activities being provided. We noted that this educational establishment had been rated 'Outstanding' by OFSTED at their last inspection in May 2013.

With the Older People's services we saw that staff demonstrated a high level of emotional support to people on the ward at an individual level and took time to explain and support people in a sensitive manner. The community teams had a number of processes for supporting carers. When an initial assessment was completed by the community team, a process was in place to refer carers to social services for an assessment.

In the adult admission wards all of the people we spoke with were very positive about the attitude of the staff and the support they had received.

Within perinatal services we saw that the community team and the inpatient service services provided information to people who used the service and their family members in written form and that care was delivered in a way which ensured that people were supported.

There were no adapted modules for people with a learning disability in the Recovery College which meant that this group of people were not able to engage as effectively.

Forensic Division (Mental Health services)
The forensic services were part of the Nottinghamshire Healthcare Recovery College and offered courses to people who use services following an adult education model. The courses on offer were, 'aiming to break down barriers' and all of the courses had at least one person with lived with the experience of mental health.

Are services responsive to people's needs?

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

Summary of findings

Local Services (Mental Health Services)

We saw evidence in people's care and treatment records of how the service had reviewed and amended their treatment to respond to their changing needs. We found that staff had a good understanding of local people's needs, and some services had been developed in consultation with them.

Waiting times in some of the community and Child and Adolescent Mental Health Service (CAMHS) teams had an impact on staff members' ability to be responsive. We saw that there was a minimum of two and a maximum of 12 months between initial referral and allocation date. Records showed us that some children and young people who had been referred to specific CAMHS community services did not receive a prompt initial assessment and treatment. However, senior staff confirmed that the trust was taking action in partnership with commissioners to address these delays.

Within the crisis teams, some people said they had not had good support at night, and that after 10pm there was standard advice to go to the local A&E. In some community services, we found that waiting lists existed, but wherever possible these were small and well managed and staff worked with voluntary agencies to provide people with services. However, out of normal working hours there was little availability close to people's homes.

Systems were in place within the trust to respond to comments and complaints made about services. People and their families were encouraged to report on their experiences of the care received and how to raise any concerns that they may have.

Health Partnerships (Community Health Services)

We found that services in the Health Partnerships division were generally responsive to people's needs. Appropriate assessments were carried out to ensure people's needs were identified. Referrals between different types of services were prompt and effective. Services were accessible to the right groups in the community, and some were targeted at specific vulnerable groups. We saw that discharge from services was proactively managed, using a multi-disciplinary approach.

Integrated care pathways in adult services were working well to ensure people received the care they needed from multi-disciplinary staff who worked flexibly to meet their needs.

There were systems in place to seek feedback from people who use services, carers and families about their experiences. However, information about how to complain was not consistently provided.

The trust did not effectively identify groups which may not be accessing services provided by Lings Bar Hospital or address barriers which may prevent black and minority ethnic people from accessing the service.

We had some concerns about end of life care in Bassetlaw, as the local hospice had not promoted the out-of-hours services enough to people who may require crisis care at night.

Forensic Division (Mental Health Services)

There was an effective process in place for responding to complaints; some improvements were required in how outcomes were fed back to the people who had complained. Investigations included people who used the service and staff and we saw reports from previous investigations which showed this.

We saw, and were told by people who used the services, that people's physical healthcare needs were met. We observed good multi-disciplinary working among the different professional groups of staff.

Medium secure services were willing to accept people on a trial basis – for example accepting people from a high secure hospital on section 17 leave to see if medium secure was a suitable environment. Some people, who had been transferred from prison, were supported to return to prison if they chose to do so.

Are services responsive to people's needs?

While it was evident care was delivered in line with individuals' needs, there were 'blanket rules' in use at Arnold Lodge and Wells Road Centre. The number of items people could purchase from the shop, including food and drinks, was restricted; the provider had not assessed individuals to determine what risks existed for them in being able to freely purchase items from the hospital shop.

Our findings

Planning and delivering services

The trust provides care over a large geographical area and a range of Clinical Commissioning Groups (CCG) commissioned the provision of care. This meant that there was a variance in each locality as to what the trust provided to people who use services. We saw there were different initiatives and services offered to people in each locality.

Health Partnerships (Community health services)

This was especially relevant for out–of-hours' services where, in most localities, out-of-hours care was offered by other agencies. However in Bassetlaw District the trust offered a range of GP and nurse-led out-of-hours' services. The use of a single point of access referral system for people using services meant they were directed towards the right service at the right time.

Local Services (Mental Health Services)

Within the PICU, we found that doors to two en suites were missing. When the viewing panes were left open or the bedroom doors opened people using the shower could be seen by anyone passing or standing outside their rooms. This did not protect people's privacy and dignity.

Within CAMHS staff told us that there were not enough locally commissioned beds to meet the needs of each young person who required admission to an inpatient bed. This was supported by trust evidence that showed a number of young people admitted to adult services or to 'out of county' provision. Senior staff confirmed that the trust was engaging actively with the commissioners of the service to address these potential concerns which are a national issue.

Within the learning disability services, staff at Hucknall House told us that the service had been under review by

the commissioners for several years as it was not clear whether this service was needed. Staff told us that, as the service was under review, they were a forgotten service and did not feel valued by the trust as a whole.

In the community based crisis services we were told that the nature of people's crisis is changing and the staff group were working to develop their skills to respond to people's needs and provide them with the appropriate care. We saw that there was a review of the crisis and home treatment service for the trust that will organise crisis and home treatment services in Nottingham to meet people's care needs.

Within adult based community mental health services we found that face to face access to urgent assessment, out-of-hours, was not accessible in a community setting or people's own home. People often had to travel up to 20 miles away in order to access inpatient bed facilities or for timely assessment of their mental health needs out-of-hours. This means that people's preferences for assessment at home, or close to home, were not always being met. We identified that barriers existed for people in regard to accessing a service out-of-hours. Crisis teams provide telephone support only after 10pm. People were directed in such cases to the A&E at the Queen's Medical centre where they would receive an assessment under the Mental Health Act or assessment in A&E 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).

The trust was planning and delivering specialist eating disorder services in response to the assessed needs of the local population. We saw that the trust provided this service in other locations throughout Nottinghamshire in line with the needs of the local population. Examples were seen of how the eating disorder drop in service had worked closely with the University of Nottingham to address identified need within the student population. This included service opening times and partnership working with the University's primary health care services.

The perinatal inpatient and community mental health services provided care which was responsive to people's needs.

Right care at the right time

The Department of Health publishes monthly data relating to Delayed Transfers of Care across 243 acute and non-

Are services responsive to people's needs?

acute NHS trusts, including both the number of delayed days and the number of patients who experienced a delayed transfer of care each month. Our analysis of our intelligent monitoring identified that delayed transfers of care, measured by both number of days delayed and number of patients experiencing delays, have been variable over the 12 months to February 2014.There was a peak in delays in December 2013, however, this was not sustained and February 2014 saw the lowest number of total days delayed of the 12 month period. On average, at the end of each month from August 2013 to January 2014, 36 patients' transfers of care were delayed. All reported delays were for non-acute patients.

Health Partnerships (Community health services)

Referral pathways were largely established and known to all staff. In all the teams we saw there was timely triage and discussions held to ensure that people received the right service to meet their needs. In multi-disciplinary teams people who use services main area of need was established, but this did not necessarily mean that other team members would not provide care or support if it was assessed the patient would benefit from their specialism. An example of this was a patient with diabetes who may require some social work or mental support from the integrated care team. Staff would work together to meet the person's needs.

Local Services (Mental Health Services)

In older people's services we saw that the inpatient service was planned with a number of specialist wards, and people with functional and organic conditions were cared for separately. Care was delivered by multi-disciplinary teams. In addition, there was input from specialist teams, such as physical healthcare, when required. However, on some of the wards, the number of consultant sessions on the ward was limited. The community mental health teams did not all have social work members of staff, although appropriate referrals were being made.

Within adult admission wards we were told, and saw, that whether admissions were planned or unplanned people using services always received a full assessment including using pre-admission information. This involved undertaking a range of mental and physical health checks.

The staff who worked within crisis services worked alongside inpatient staff to ensure people did not have unnecessary long hospital stays. Staff told us that if a person's mental health improved they could be discharged

to the care of the crisis team. A discharge coordinator attended the ward to meet people and worked with the MDT to support people's move back home into their community.

In the community based mental health crisis services people, who had used the service and their carers, told us how hard it had been to get the support they needed at night. However, people said they had received good advice that helped them manage difficult situations such as restlessness and agitation. The service operated seven days a week 24 hours a day but only telephone support was available after 10pm. Home visits were made to carry out assessment of people in crisis. The service responded to referrals within 24 hours on receipt of the referral. While the service was specifically for adults aged 18 to 65, it did respond to older adults that were known to them and younger people aged 17 to 18 years old.

Staff working within the adult community based core services identified that they had seen a recent increase in attendances for assessment in the emergency department by the Rapid Response Liaison team by people open to community mental health teams. This could be linked to capacity described by staff within the community teams to provide a response to people's urgent needs.

Within the specialist eating disorder services staff told us that people were seen as promptly as possible, and within 28 days of referral, as agreed with their commissioners. Senior staff confirmed that any delays in seeing people would be documented and raised as an exception report to the trust. They reported that such exceptions were usually due to a delay in accessing the appropriate information from other services in order to make the required assessments of clinical need.

Forensic Division (Mental Health services)

We identified some blanket restrictions at Arnold Lodge (medium secure unit) and Wells Road (low secure unit). At Arnold Lodge, while it was evident that almost all care was planned and delivered in line with people's individual needs, there were blanket rules in respect of the shop. The shop was only open twice a week. This was the only access to some items for people who did not have leave. There was a restriction on how much people who use services could buy. These restrictions were applied to all people buying anything from the shop, however did not apply to what people on approved section 17 leave could buy in the community. We were concerned that this blanket rule had

Are services responsive to people's needs?

the biggest impact on the most restricted people who were those who use services, with no leave, who were confined to the hospital and its grounds. Similar restrictions were identified at Wells Road.

Care pathway

The trust worked with a large number of other providers and the pathways into care were sometimes varied due to the complexities of county borders. People who use services and staff told us of two examples where care pathways were not clear and people experienced some delays in receiving care from this trust as other agencies were not clear how to refer to appropriate services. People were positive regarding the care received from this trust once services had been accessed, however it is a challenge for the trust that it works across many county borders and with a wide range of agencies.

Local Services (Mental Health Services)

Within the Local Services (Mental Health services) we saw that in the long stay core services all the wards accepted transfers from a range of services including the acute wards and community settings. Bracken House also accepted referrals from forensic services. Staff at Bracken House told us that as soon as people were ready to be transferred to a less restricted environment, they would be transferred to one of the open rehabilitation wards within the trust. Staff could provide follow up support to people for up to six months after they had been discharged from the wards before they were transferred to a community mental health team. This was to reduce the risk of the person relapsing post discharge.

For adult admission services pre-admission information was obtained from the community, in advance of an admission where possible, to ensure staff knew of the risk areas to a patient and how they could best support them during their stay. The service was aiming to care for more people within the community settings, where this was more appropriate. Care coordinators were brought in early to a patient's care to help facilitate their arrangements for discharge.

Within the perinatal services, the crisis pathway in the community and for those who needed admission in the evening or at weekends when the community team was not available, was dependent on generic crisis services which were not consistent across the trust.

Learning from concerns and complaints

The trust received 825 written complaints between April 2012 and March 2013, of which 221 (26%) were upheld. The figure for 2011-12 was 809 complaints with 214 (26%) upheld. The number of complaints is not always a good indicator, because a provider may actively encourage comments from people who use services.

The majority of complaints reported came from the mental health services area - 562 (68%). Sixty-nine came from the community health services (8%).

We found that the trust had taken a proactive role in ensuring that complaints and concerns were dealt with effectively. We were told that there was a better resolution of complaints at an early stage. The PALS team ensured complaints were analysed and there was feedback given at all levels in the trust regarding emerging themes. Information about informal and verbal complaints was logged on the electronic reporting system called Ulysses. Directorate responsibility for investigating formal and written complaints lay with each governance team. We were informed of recent changes to practice as a result of complaints and this showed that complaints were dealt with in a timely manner. From the information held about the trust we could see that 25% of all complaints received over the previous year had been upheld. The patient engagement and involvement team explained that this was because most complaints had multiple issues raised within them. If any aspect of the complaint was substantiated, then this would count as being upheld. Complaints were monitored through the quality and risk committee and fed into the trust board meeting. We were told that feedback around complaints was discussed at service level through staff meetings and handovers. Most of the staff we spoke with told us that information about how to complain was available and that people using services knew how to make complaints.

Health Partnerships (Community health services)

We found that information on how to make a complaint or contact PALs was not consistently available in health centres and clinics. Many people we spoke to were not aware how to make a complaint if they wished to do so.

Local Services (Mental Health Services)

Within the learning disability core service, we saw that advocacy was promoted throughout the service so that people would have support to raise concerns and complaints if they needed to. However, we found that

Are services responsive to people's needs?

Good ●

information about how to make a complaint was not always in a format that was accessible to people who used the service. Several staff we spoke with told us that complaints would be raised with them and then taken forward. This meant that if a person wanted to make a complaint about the member of staff that always supported them, this complaint might not be heard.

Within the long stay service the ward meetings had a set agenda which included complaints and feedback from people who used the service. Complaints were also discussed in the service's clinical governance meeting which took place monthly. This meant the wards ensured that learning from complaints; comments and compliments were embedded in their governance processes.

Are services well-led?

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

Trustwide

During our inspection we saw that leadership at the point of service was a key attribute of the trust. The central leadership of the trust encourage staff at all levels to develop their leadership skills and they were proud of the work undertaken around horizontal integration and distributed leadership.

We saw that the trust leadership development programme had contributed to a vision and set of values that were shared throughout the trust.

We attended the trust 'Invest to lead 5' event which was a day long conference for trust staff to discuss the context and challenges facing the trust in the future. This was one day of the trusts five day programme.

We saw that the Chief Executive ran a mentoring programme for Black and Minority Ethnic (BME) staff. In addition the trust had developed a 'dragons den' event with executives taking part in action learning sets with Band 2 staff to help them develop proposals for improving patient care.

We attended one day of a Clinical Band 2-4 development programme. We saw that the focus of event was about values, behaviours, attitudes and retention of staff. It was used as an opportunity to reflect on the last month and an opportunity to raise any issues with the director of nursing,quality and patient experience. Staff told us that it was very supportive, informal but extremely well planned.

Local Services (Mental Health Services)

We found that the core services provided by the trust were well-led and that staff felt well supported by their immediate line manager. All staff were aware of the senior leaders within the trust and thought that communication from 'board to ward and community' was effective. The trust had systems in place to ensure that information was communicated to staff in the trust

and most staff were aware of board-level leadership and the overall vision of the trust. However, some told us that they had no involvement and felt somewhat detached from the issues around governance.

We also saw some good examples of locally based leadership and there were clear structures in place to support the management of the teams. Staff had appraisals and regular supervision sessions with their managers to effectively manage their performance. Staff felt they had good access to training and development opportunities. They told us they were in good teams and that they felt they were delivering good care.

There were robust systems in place for monitoring the quality of the service, although this could be improved in some of the community child and adolescent mental health services (CAMHS) to ensure a prompt response to referrals and assessments.

Health Partnerships (Community Health Services)

We found that services in the Health Partnerships division were well-led. The trust board members were visible to staff, approachable and there was awareness among staff of the trust's ethos, vision and priorities. Staff felt listened to, valued and supported by their line managers, they were engaged in the process of developing services. There were very good arrangements to provide regular supervision for staff in the relevant areas which supported them in their role.

There was a respectful culture in the service which was demonstrated by staff listening to each other and we saw many positive examples of team working.

Staff were encouraged to raise issues and work collaboratively to improve the efficiency of the service and patient outcomes, and we saw examples of this in the different local areas. The governance structure was effective in identifying risks and improving services.

Forensic Division

There were processes in place for providing staff with appraisals and regular supervision to ensure safe and

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effective provision of care. Staff we spoke with told us they had received an annual appraisal and regular clinical supervision, though some improvements could be made in the provision and recording of managerial supervision. Staff also told us they felt well supported by their manager and could raise any concerns they had and these would be addressed. The governance of the organisation assured the delivery of high quality person centred care and promoted an open and fair culture.

People who used services and staff had regular contact with senior members of staff, such as the modern matrons, and their dedication and passion for their role was also evident in the focus groups of senior staff across secure services.

Our findings

Vision and strategy

The trust had developed a two-year business plan, which was in a brochure format and available to staff in all the areas we visited. This promoted the trust's values and vision for the future and celebrated the achievements in 2013/14. The service development plans prioritised the actions to be taken and how success would be measured. The vision of the organisation was widely understood and shared by the majority of the staff we spoke with. Staff were mostly able to describe the vision as the '6 Cs' - care, compassion, competence, communication, courage and commitment.

Local Services (Mental Health Services)

In the older people's services we saw that, there was a 'vision tree' displayed on the wall of an inpatient unit. This took corporate objectives and applied them to the ward environment.

The long stay core services had robust governance structures in place which were fully embedded on most of the wards.

There was a clear vision for the adult admission services, involving an increase in community provision and working to the least restrictive way of working with people using services through the use of de-escalation, which underpinned the recovery model. These strategies for the service were clearly evident and staff had a good understanding and knowledge of these. However at

Queen's Medical Centre there was an air of anxiety over the potential closures of both wards that are currently located there. The service director for the wards confirmed this had not been confirmed yet and that there had been communication with staff on the developments so far. High level plans had been considered to move to a virtual ward in the community. However at present staff remained unclear where this left them in the trust.

Within adult based community teams key messages about the trust were communicated to all managers at monthly senior management meetings and shared with the team.

Responsible governance

Monitors Foundation Trust assessment is in two phases. Monitor completed phase 1 of their quality governance assessment framework in December 2013 and the trust had provisionally met the quality governance score required for authorisation with an indicative score of 3.0. There was however another decision that needed to be concluded in determining that trusts providing high security psychiatric services can be regulated as NHS foundation trusts.

The trust described its structures for quality governance as comprehensive. We saw that the trust embedded risk management through:

• Sub-committees of the board.

• Board Assurance Framework.

• Board Assurance and Escalation Framework.

• Compliance with the registration by the Care Quality Commission under the Health and Social Care Act 2008.

• Compliance with the Health and Social Care Act 2008 Outcomes of Care.

• Risk Registers.

• Internal Performance Management Processes.

• Policies and Procedures.

• Standing Financial Instructions and Standing Orders.

The Information Governance Toolkit is an online system produced by the Department of Health (DH) and now hosted by the Health and Social Care Information Centre (HSCIC) which allows organisations to assess themselves against Department of Health Information Governance policies and standards. It also allows members of the public to view participating organisations' Information

Are services well-led?

Governance Toolkit assessments. Each Information Governance measure has levels 0-3 assigned based on criteria that characterise compliance at each level. Level 0 is the worst, level 3 is the best. Level 2+ is considered "satisfactory". Every organisation receives their total score as a percentage of their best possible score. Nottinghamshire Healthcare's overall percentage score was 88%.

A rating of satisfactory if level 2 was met for all requirements and not satisfactory otherwise. Nottinghamshire Healthcare NHS Trust was rated satisfactory.

The board see variation as both a positive and negative quality. One area of concern that was highlighted was the health informatics system was that the performance quality data is not as reliable as it should be. The trust have taken the step of introducing a new business intelligence system 'BORIS' which they feel is a good first step, but recognised there is further work to be done.

The non-executive directors informed us that there had been extensive work on developing quality dashboards and improved data.

The trust had a Board Assurance and Escalation Framework dated December 2012. The trust's Quality and Risk committee is responsible for ensuring that all risks have defined controls and assurances and that each risk is assessed for its likelihood and impact and realistic target risk scores defined. It is also responsible for ensuring actions to maintain or achieve the target risk score are defined and implemented within the timescales agreed. It is this Committee's role to monitor whether risk controls are working. We saw that in addition to the Quality Risk committee the Executive Leadership Team also reviewed the Board Assurance Framework each month to consider whether any new or escalating risks could have an impact on the achievement of the trust's strategic objectives.

The trust had in place a Quality Strategy 2013/14 – 2018/19 which set out how the trust would deliver its vision through the positive brand. We saw that the Quality and Risk committee had overall responsibility for the quality priorities.

A Mental Health Act Managers committee meets every six months and is chaired by a non-executive director. The committee considers policy, practice and procedures in relation to the management and administration of the

Mental Health Act 1983 and related/relevant legislation, considering the trust's discharge of those functions under the Mental Health Act 1983 which have been delegated to officers. The committee reports directly to the board.

Mental Health Act administrators were appointed to monitor the legality of the detention paperwork, as well as ensure that mental health review tribunals and hospital managers' meetings took place in the appropriate timeframes.

Across the three divisions we saw that audits were completed. These provided information about how well the services were performing and what could be done to make improvements. We saw that improvements to services had been made as a result of these. Clear structures were in place to ensure that learning was embedded following incidents.

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

There was a clear governance structure in place that supported the safe delivery of the service. Lines of communication from the board and senior managers, to the frontline services were mostly effective, and staff were aware of key messages, initiatives and the priorities of the trust.

Within all community teams across the trust we saw that staff received a variety of clinical, managerial and group support and 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, incidents 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 about governance training.

Leadership and culture

Throughout our inspection visit it was clear that the trust was well-led from the executive level with strong lines of

Are services well-led?

communication from the top to the bottom and back. We attended one day of the trust 'Invest to lead 5' event which was a day long conference for trust staff to discuss the context and challenges facing the trust in the future. Staff at the event told us that they were engaged with the event and found it useful to receive information about, and engage in discussions about the trust, with the senior level managers and trust executives. The trust had a clear brand entitled 'positive about integrated health' which was embedded and visible throughout the trust. Staff told us that they identified with this branding which encompassed the ethos of the trust and the attitude of the staff.

However some medical staff we spoke with who told us that they were not engaged with senior level clinical staff within the trust and felt neglected in their directorate as a result of the trust's transition and expansion.

The chair and non-executive directors had a strong understanding of all the issues the trust were facing. They told us that there was strong leadership in both the executive and non-executive team. The trust have developed a programme called 'Board Apprentice'. This is designed exclusively for NEDs to develop talent at the highest level within the trust.

The ambition of the trust is to have good patient care and the values base is fundamental to this. We were told that the trust take the values of the NHS Constitution and apply innovation in a positive way to maximise the impact for people who use services.

The Executive Leadership Team (ELT) meets on a weekly basis. It is supported by three management committees, one for Forensic Services, one for Local Services and one for Health Partnerships. In addition, the trust has regular Executive Leadership Council (ELC) meetings at which over 150 senior clinicians and managers from around the trust meet to debate the trust's strategic direction.

All of the staff we spoke with were familiar with the name of the trust's chief executive and all staff told us that members of the board had visited their areas of work and in some areas worked alongside staff to become familiar with their role.

The trust celebrated staff achievements and successes through an 'Oscars' award programme.

The trust had achieved second place in the national Stonewall Employment index, the highest ever position by an NHS organisation and that this achievement reflected extremely positively on the culture of the organisation.

Local Services (Mental Health Services)

Within the learning disability core service, Orion Unit was amalgamated from two wards in different areas of the county in November 2013. All staff we spoke with told us that the management team had led this well so that the transition went smoothly. We saw that the amalgamated staff team worked well together. However, staff in the learning disability services told us that they believed that their services were not valued; this was particularly true for staff working in the inpatient services.

In the older people's service, leadership on the wards was outstanding. On all the wards we visited ward managers were visible and staff told us they felt supported. The staff had received appraisals and regular supervisions and had access to development programmes. Medical staff felt they could be better supported in their roles in terms of senior medical leadership. They felt their involvement in designing and delivering services could be strengthened. Many staff we spoke with told us they felt there was an open culture.

The perinatal inpatient and community services were well-led at a local level and there had been some recent changes when the services had moved from adult mental health directorate into specialist mental health services. The staff we spoke with in the community and on the ward felt that this was a positive move.

Engagement

The National Community Service Staff Survey conducted in 2013 assessed the level of staff engagement. The response rate from staff had improved from the previous year and the results also showed an overall improvement. The Health Partnerships division of the trust was rated as being within the top 20% of community trusts.

A staff voice and opinion proposal was discussed at the February 2014 trust board meeting. The trust was understood to be the only NHS organisation proposing an open and transparent web site to capture staff opinion. A report on the Staff Voice "Friends & Family" test would be presented to the June 2014 meeting of the Trust Board. The Board supported the proposed approach.

Are services well-led?

The trust's return rate for the national staff survey was noted to be 71%, the highest by any mental health trust nationally and the second highest by any NHS Trust which we concluded meant that staff were encouraged to actively engage and participate in .

Staff working across the trust told us they were able to attend clinical governance meetings and had regular meetings with their managers to ensure that their concerns were captured. Staff we spoke with on the wards and in the community felt they were able to provide feedback about the service and knew about the trust's whistleblowing policy and procedures.

The trust has a dedicated patient feedback website. Across the trust, when asked to pick the best thing and something to improve in their service, patients consistently pick "staff/ staff attitude" as the best thing and "access to services" as something to improve when using this dedicated website. The results from the website are used in monthly Patient Voice reports to the board, and quarterly involvement and experience reports.

On 18 March 2014, the BBC reported that NHS Choices had removed all but one of the reviews on its website after allegations that the system was open to abuse. BBC Newsnight found that 49% of patient reviews posted in the last year had come from staff accounts. Nottinghamshire Healthcare NHS Trust described this as an "issue of staff posting on behalf of patients", but not with "any intention to mislead or create a false impression".

Patient Opinion is an independent non-profit feedback platform for health services, which aims to facilitate honest and meaningful conversations between patients and providers.

As of 31 March 2014 there were 1,223 comments on the trust's section of the Patient Opinion website. There are 544 staff set up to review and respond to patient stories and 94 stories have led to changes.

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

We have concluded that the trust proactively engages with staff and people using services and acts on their feedback.

Performance improvement

Nottinghamshire Healthcare NHS Trust predominantly provides mental health services. Staff from the healthcare partnership division told us they had reservations about how they would fit into the wider trust when the merger occurred. However all staff reported that there had been improved access to training and they felt the merger had been a positive one.

In the older people's core services both the inpatient and community teams had clear objectives, which all staff were working towards as part of their performance development.

Within the long stay services internal and external audits took place on the inpatient areas. We saw evidence which showed that action had been taken in response to the outcome of some of these. The wards had fully implemented the new care pathway and care plan documentation which was being rolled out across all the rehabilitation wards to improve the quality of the service provided.

In the adult based community mental health services 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.

We saw examples of how the trust had recognised the achievements of the specialist eating disorder service. We noted that the 'eating disorders drop in service' had been a finalist in the 2013 Mental Health team of the year competition that was open to Mental Health Services throughout the country. The team had also been featured in the trust's 'Positive' magazine and had been used as an exemplar service to the rest of the trust.

Within the Forensic Division (Mental Health services) the majority of staff we spoke with as part of our focus groups were positive about how the trust supported them to develop professionally. Staff told us about how they received supervision and how this supervision could be delivered in different ways. Staff told us objectives for improvement were identified in their annual appraisal and all staff were aware of the cost improvement plans.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 19 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010** Complaints **How the regulation was not being met:** Suitable arrangements were not in place within the Health Partnerships division to ensure that people who use services were informed about the provider's complaints procedure. Regulation 19(1)(2)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010** Assessing and monitoring the quality of service provision **How the regulation was not being met:** The service did not protect people using services against the risks of inappropriate or unsafe care and treatment, by means of implementing effective operation of systems such as the provision of a local medicines management policy specific to the service. Regularly assessing, monitoring and auditing the quality of medicines management within the service. This was at the Children's Development Centre at Nottingham City Hospital. Regulation 10 (1) (a) (2) (c) (ii)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	**Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010**

Compliance actions

Care and welfare

How the regulation was not being met:

A female patient, on B2 ward at Bassetlaw Hospital, was placed in a single room within an all male area of the ward. The design of the ward meant, the female patient would have to walk through an area occupied by men to reach the toilets or bathrooms in the female area of the ward. We were also told that the female patient would use the male toilet at night.

Staff were not therefore effectively monitoring the use of gendered facilities.

People's support plans did not sufficiently detail how staff were to safely support each person in the learning disability services.

There was insufficient monitoring and recording of people's physical health needs in Orion unit.

The provider did not always follow the appropriate guidance in respect of good practice for seclusion reviews at Arnold Lodge.

Regulation 9 (1) (a) (b) (i) (ii) (iii)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010
Treatment of disease, disorder or injury	Assessing and monitoring the quality of service provision
	How the regulation was not being met:
	The trust had not made arrangements for gender segregated living accommodation or 'female only' communal areas within Thorneywood inpatient ward.
	Regulation 10 (1)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010
Treatment of disease, disorder or injury	Safeguarding

Compliance actions

How the regulation was not being met:

There were no care plans or risk assessments in place on Orion Unit to demonstrate why staff were using the low arousal suite and how staff were to support the person to minimise any risks to their safety and wellbeing.

Regulation 11 (2) (a) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 20 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010 Records **How the regulation was not being met:** Section 17 leave forms were not specific to individuals and the specific period of leave. Records for people who used the service did not include detail to guide staff in how to support the person if they became aggressive and needed staff to physically intervene to ensure their safety and that of others. Regulation 20 (1) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010 Safety and suitability of premises **How the regulation was not being met:** The trust's 'Risk Assessment in Health and Safety Policy' stated that ligature risk assessments should be undertaken in each in-patient ward on an annual basis. Some wards at Broomhill House, Newark Community Unit, Mansfield Community Unit and Thorneywood Mount Unit had not completed an annual ligature risk assessment in line with the trust policy. We found ligature risks on all the wards we visited with the exception of Bracken House. These risks were not always identified and managed appropriately across the service. Regulation 15 (1)(a)(c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010
Treatment of disease, disorder or injury	Respecting and involving
	How the regulation was not being met:
	At the Millbrook mental health unit (Lucy Wade) doors were missing from the ensuite in two rooms leaving people in full view from the viewing pane or when the bedroom door was open.
	Regulation 17(1)(a)