Nottinghamshire County Council

Health Scrutiny Committee

Tuesday, 23 July 2019 at 10:30

County Hall, **West Bridgford, Nottingham, NG2 7QP**

AGENDA

1	Minutes of Last meeting held on 18 June 2019	3 - 8
2	Apologies for Absence	
3	Declarations of Interests by Members and Officers:- (see note below) (a) Disclosable Pecuniary Interests (b) Private Interests (pecuniary and non-pecuniary)	
4	NHS Property Services	9 - 16
5	Nottingham Treatment Centre	17 - 20
6	Nottinghamshire Healthcare Trust CQC Inspection	21 - 106
7	Work Programme	107 - 114

Notes

(1) Councillors are advised to contact their Research Officer for details of any Group Meetings which are planned for this meeting.

(2) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

(3) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Noel McMenamin (Tel. 0115 977 2670) or a colleague in Democratic Services prior to the meeting.

(4) Councillors are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.

(5) This agenda and its associated reports are available to view online via an online calendar - http://www.nottinghamshire.gov.uk/dms/Meetings.aspx

Nottinghamshire County Council

minutes

HEALTH SCRUTINY COMMITTEE

Tuesday 18 June 2019 at 10.30am

Membership

Councillors

Keith Girling (Chair)
Richard Butler
Kevin Greaves
David Martin
Liz Plant
Kevin Rostance
Steve Vickers
Stuart Wallace
Muriel Weisz
Yvonne Woodhead
Martin Wright (Vice-Chair)

Officers

Martin Gately	Nottinghamshire County Council
Noel McMenamin	Nottinghamshire County Council

Also in attendance

Sarah Carter	Nottingham and Nottinghamshire CCGs
Sarah Collis	Healthwatch Nottingham and Nottinghamshire
Greg Cox	EMAS
Lucy Dadge	Greater Nottingham CCG
Neil Moore	Greater Nottingham CCG
Annette MacFarlane	EMAS
Keith Underwood	EMAS

1. CHAIRMAN AND VICE-CHAIRMAN

The appointment by the County Council on 16 May 2019 of Councillor Keith Girling as Chairman and Councillor Martin Wright as Vice-Chairman of the Committee for the 2019-2020 municipal year was noted.

2. COMMITTEE MEMBERSHIP

The membership of the Committee for the 2019-2020 municipal year as Councillors Richard Butler, Kevin Greaves, David Martin, Liz Plant, Stuart Wallace, Kevin

Rostance, Steve Vickers, Muriel Weisz and Yvonne Woodhead was noted, with a change in membership of Councillor John Longden for Councillor Steve Vickers for this meeting only.

3. MINUTES

The minutes of the last meeting held on 7 May 2019, having been circulated to all Members, were taken as read and were signed by the Chair.

4. APOLOGIES

None.

5. DECLARATIONS OF INTEREST

None.

6. CLINICAL COMMISSIONING GROUP MERGER

Ms Sarah Carter, Director of Transition, Nottingham and Nottinghamshire CCGs, introduced the item, explaining that consultation on merging the six Clinical Commissioning Groups currently in Nottingham and Nottinghamshire to form a single CCG, was to formally close on Monday 17 June 2019. However, the consultation window remained open pending the submission of formal County Council response.

Ms Carter made a number of points:-

- there was consensus among existing CCGs that the merger would be beneficial – directly or indirectly – to local people, patients, GPs health and care partners. There would for example be alignment with the Integrated Care System and local authority boundary footprints and thus avoiding duplicating commissioning activities. Full details were available in the consultation document;
- a single organisation would provide a stronger, single and more consistent commissioning vision, leadership, voice and approach for the Nottingham and Nottinghamshire health and care system;
- a single organisation would also lead to significant administrative savings, with the reduction of administrative support functions such areas as finance, payroll and procurement;
- Ms Carter emphasised that the 20% savings to be applied by 1 April 2020 referred only to CCGs' administration costs – patient services, including hospitals and GPs and community services did not form part of CCG running costs and would not be affected.

During discussions, a number of issues were raised:-

- It was explained that Primary Care Networks were GP-led and catered for populations of between 30,000 and 50,000 people and would work to align health and care services to the needs of localities, addressing health

inequalities. These networks were still emerging, and engagement with patient participation groups, Healthwatch and other organisations would develop organically in due course;

- Pharmacists were already represented within both Integrated Care Provider forums and Primary Care Networks, while links to the Health and Wellbeing Boards would also be developed;
- It was explained that the 20% reduction in administration costs as a result of the proposed merger was mandated at national level. Ms Carter undertook to provide a monetary figure for the 20% reduction;
- It was confirmed that a workforce consultation had just been commenced. It was an ongoing period of significant change for all staff and the CCGs was working hard to support them;
- It was anticipated that Primary Care Networks would help patient flow through the system. For example, it could be possible to get a GP appointment at practices where there was availability, rather than having to wait longer for an appointment at a specific practice;
- Decisions on retaining and disposing of CCG estates had not yet been made, but these would depend on local lease arrangements;
- GPs would be entering a membership vote to determine whether to have a single CCG. Ms Carter expressed the view that GP concerns about retaining a local voice, having robust financial arrangements and ensuring genuine integration could be addressed;
- Ms Carter did not believe going to a single CCG was in effect recreating the old primary care trust model;
- The Chair explained that the Committee's draft response to the formal consultation was appended to the report, and, subject to any further comments received, would be submitted by Thursday 20 June 2019.

The Chair thanked Ms Carter for her attendance at the meeting.

7. EAST MIDLANDS AMBULANCE SERVICE – PERFORMANCE AND RECRUITMENT UPDATE

EMAS representatives Greg Cox, General Manager for Nottinghamshire, Annette MacFarlane, Service Delivery Manager for Nottinghamshire and Keith Underwood, Ambulance Operations Manager introduced a report, providing an update on the organisation's recruitment activity, performance against targets and issues around transportation of children following closure of A3 ward, Bassetlaw Hospital.

EMAS representatives made the following points:

- EMAS had worked with staff to redefine its priorities and values as being 'To Respond' through rolling out a new clinical model, 'To develop' more advanced skills sets for staff, and 'To collaborate', playing a full role in helping deliver the Integrated Care System;
- The organisation had recruited more than 100 staff in the past 18 months, but there were still capacity issues to address because of staff attrition;

- EMAS had met 3 of the 6 nationally-set Standards described in the report in March 2019 and this had increased to 4 of 6 in April 2019, despite an increase in daily ambulance calls. Performance in respect of Category 1 and Category 3/4 calls was on target, but more work was needed to address shortfalls in Category 2 performance.

The following points were made in discussion:

- Mr Underwood provided a further explanation of the 6 national standards. The previous national target of 8 minutes for the highest priority Category 1 patients effectively gave a binary 'pass/fail' rating. The new performance provided mean/average and 90th centile performance targets, set nationally. EMAS exceeded both targets for the highest priority patients, and for non-urgent patients, but fell below targets for Category 2 (serious but not immediately life-threatening) patients;
- The Chair requested information in respect of the percentage and numbers of responses which met the trajectory targets for each category. While he advised that EMAS was not challenged to report performance in the format requested, Mr Cox confirmed that he would undertake work to provide the information requested;
- The Chair asked that EMAS provide details of its Business Plan, as well as numbers of attacks on staff, and their impact both on individuals and on staff retention levels, to the next update meeting with the Committee
- The Nottinghamshire division of EMAS was performing well in terms of improved staff morale, with greater staff engagement through an Influence and Change Group, rewards, celebrations and recognition of staff achievements, and building career progression into roles to boost retention levels;
- The Committee welcomed the collaborative work EMAS had undertaken as part of the Integrated Care System to improve turnaround times at hospitals;
- Mr Underwood advised that there were a number of pathways into the profession, and that delicate balance needed striking between the skill sets needed for a caring profession and the need for academic rigour. He confirmed that EMAS had links with the Armed Forces in respect of recruitment;
- Mr Cox accepted the criticism by several members around the wording in the report on transportation issues of children following closure of the A3 ward at Bassetlaw Hospital. He asked to put on record EMAS' assurance that if a patient in Nottinghamshire needed an ambulance then the organisation would provide one, irrespective of age or location;
- Mr Cox acknowledged that the reconfiguration of GP practices to include a paramedic presence could place additional pressures on staff retention for EAMS, making it all the more important to enable career progression within the organisation;
- Patient engagement across the organisation was improving, but was not well-developed at divisional level. It was also stated that historically there had been issues in terms of standards and timeliness of service and patient experience for the frail elderly in care home settings, but that this was no longer the case;
- It was confirmed that a serious incident, for example a multi-vehicle crash, counted as 1 incident with 1 response;

- It was explained that EMAS had standby points and employed a 'care car' for use in rural areas, which provided initial triage for incidents before the ambulance arrival, and then remained in the area to provide continued cover while the ambulance dealt with the patient. EMAS also worked with community responder teams in rural areas.

The Chair thanked, Mr Cox, Ms MacFarlane and Mr Underwood for their attendance, and requested that they provided an update at the Committee's December 2019 meeting.

8. PATIENT TRANSPORT SERVICE

Lucy Dadge, Director of Commissioning, Greater Nottingham CCG and Neil Moore, Associate Director of Procurement and Commercial Development, providing the Committee with an update on the provision of the non-emergency patient transport service in Nottinghamshire.

Ms Dadge and Mr Moore made the following comments:

- Arriva, the providers since 2012, were withdrawing from the patient transport market, and a procurement exercise had been conducted. The successful bidder was ERS Medical, who would operate the service from 1 December 2019;
- Patient groups had been extensively canvassed as part of the procurement exercise, and their learning used to inform the process;
- Commissioners had looked to incentivise more pre-planned bookings and reducing on-the-day bookings, which had placed severe and conflicting demands on staff on the ground. New performance indicators looked to encourage the provider to get as many passengers within appropriate bandings as possible, improving patient flow.

A number of points were raised in the discussion which followed:

- There were very strict eligibility criteria for the service. The main potential loophole could arise as a result of patients no longer having the same ailment or condition but not reporting changes, but anecdotally these cases were few and far between;
- Providers were paid a block annual allocation for a range of requirements and abilities. For inbound journeys, waiting time was at the driver's discretion and for discharges the waiting time was 15 minutes;
- Transition arrangements were established and on track, with staffing and facilities transfer proceeding to time;
- It was emphasised that commissioners had had a strong and positive working relationship with the current providers

The Chair thanked Ms Dadge and Mr Moore for their attendance, and invited them to attend the Committee's December 2020 meeting to provide an update on the service under the new providers.

9. WORK PROGRAMME

The Committee agreed the following amendments to the work programme:-

Parity of GP Services Coverage across Nottinghamshire

Add to a future meeting

Clinical Commissioning Groups' Merger

Add to a future meeting, once next steps post-consultation are known.

Bassetlaw Hospital Update

Add to a future meeting.

Frail Elderly at home

Add to a future meeting.

The meeting closed at 12.58pm.

CHAIRMAN

Nottinghamshire County Council

Report to Health Scrutiny Committee

23 July 2019

Agenda Item: 4

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

NHS PROPERTY SERVICES

Purpose of the Report

1. To introduce a presentation on the work and role of NHS Property Services.

Information

2. NHS Property Services is a government owned company with responsibility for managing a large portfolio of NHS property. Their property portfolio comprises more than 3000 properties with 7000 tenants across England with a total value of more than £3 billion, representing about 10% of the total NHS estate.

3. A recent report by the National Audit Office (NAO) indicated that more than eight years after it was created NHS Property Services still lacks the powers it needs to run its affairs effectively, and the accuracy of bills is still disputed. Almost £700 million of debt owed to NHS Property Services has been written off or is still unpaid. A new arbitration process for managing disputes has been labelled as ineffective.

4. A briefing from NHS Property Services is attached as an appendix to this report,

5. Senior representatives of NHS Property Services will attend the Health Scrutiny Committee to deliver the presentation on their organisation and its work.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the information provided.

2) Schedule further consideration, as necessary.

Councillor Keith Girling
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Briefing: Nottinghamshire County Council

Date:	12/07/19
Prepared by:	NHS Property Services
Category:	NCC: Health Scrutiny Committee

Background

NHS Property Services (NHSPS) is one of the largest property owners in the UK, acting as both landlord and service provider to 10% of the NHS estate. The company owns a £3.8 billion asset portfolio, manages 3,500 properties spread throughout England, has 7000 tenants, employs circa 5,000 people and delivers an annual income of £760 million.

NHSPS was established in April 2013 to manage properties transferred in from 161 former Primary Care Trusts and Strategic Health Authorities. Our properties range from listed buildings through to award-winning, state-of-the-art integrated health campuses. We own and manage 1,800 health centres, 300 community hospitals, 450 offices and over 70 nursing homes.

Since 2013, our portfolio has been evolving. It has been a period of tremendous change for the NHS. New models of care mean that properties must deliver much more than in the past. We use our high-level of expertise in estate management and service provision to achieve the best value and cost savings possible. We are striving to help the NHS transform into a modern health provider.

Role

The NHSPS aims to manage, maintain and improve NHS properties and facilities, working in partnership with the NHS to create a safe, efficient and sustainable and modern healthcare and working environments. The Service has three main roles:

1. **Acting as a landlord to manage the estate -** agreeing and recording the basis on which its tenants occupy buildings (rental agreements), billing them, collecting payments and chasing outstanding debts.

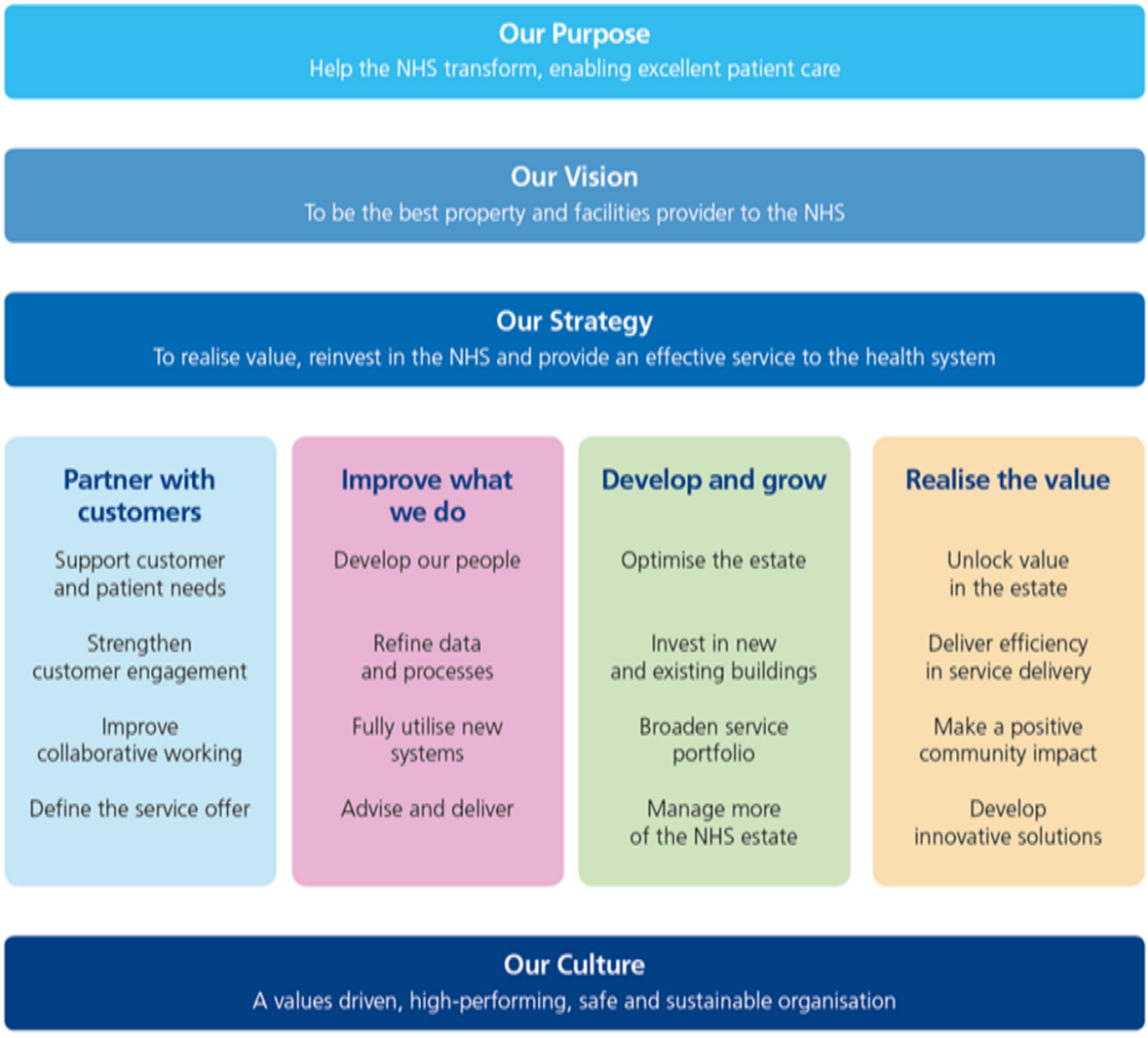
2. **Providing strategic estates management -** modernising facilities, buying new facilities, selling facilities the NHS no longer needs and releasing surplus public land for housing, maximising the use of current facilities, and managing relationships with leasehold landlords.

3. **Providing support and facilities management services -** compliance with relevant regulations including health and safety, maintenance, electrical, cleaning and catering services. It provides a mixture of in-house and outsourced services, managing both the internal and external environments that surround its properties

Strategy

NHS Property Services is helping to build a better National Health Service so that it can deliver excellent patient care. Our strategic intent is to realise value, reinvest in the NHS estate and provide effective services to our customers and patients in England. Our strategy focuses on the delivery of four strategic goals:

1. **Partner with Customers -** reflecting our ambition to provide greater support to the NHS through collaboration to ensure that our property and facilities expertise is shared with our customers and stakeholders to the collective benefit of the healthcare system.
2. **Improve what we do -** delivering continuous improvement with a stronger focus on cross-functional working and harnessing our business collateral.
3. **Develop and grow -** continuing to grow into a more successful and expansive business, supporting a larger portfolio and a wider service and client base.
4. **Realise the value -** optimising value opportunities for our customers, our shareholder and the wider healthcare system.



Future opportunities

NHSPS has implemented a transformation programme, investing in business critical challenges including data, systems and people. Building on this, the company strategy has focused on delivering opportunities to manage the estate more effectively and deliver value back to the NHS. These include:

- **Pro-active leasing programme** - provide more tenants with security of tenure, manage the true costs of the NHS estate and secure rental income
- **Innovative new occupational models** – introduction of the Vacant Space Handback Scheme, to allow commissioners to cut the cost of empty space leaving them more to spend on frontline care. Introduction in April 2019 of 'Open Space' room booking system to allow flexible booking of space
- **Supporting the wider health estate** – support projects across the NHS and health economy beyond our own portfolio such as office strategies for the Department of Health (DHSC), NHS Improvement and NHS England; and development support to DHSC to support key Trust property transactions
- **Disposal pipeline** - over 70 properties, with a value of £45m for 2019/2020 and continue to build a sustainable disposal pipeline
- **Development schemes** – identified nine large value development schemes which will deliver new clinical space and realising latent development value in excess of £100M
- **Key worker housing** - NHSPS is working with the NHS Property Board on proposals for the provision of key worker housing on surplus NHS land
- **Capital investment** – since inception, over 500 construction projects delivered each year, including backlog maintenance, and robust capital investment programme for 2019/2020 of £85M approved.
- **FM transformation** – engaged in new initiatives to become consistent, compliant and reduce costs whilst maintaining high quality FM services. These include; the new automated FM platform (which logs, plans and monitors FM issues), a review into our core, non-core and non-FM Services, and the provision real-time reporting which will enable us to develop SLAs and KPIs.
- **Annual Charging Schedule (ACS)** - introduced more detailed ACSs for 2019/20 and are implementing an Annual Charging Schedule check-in with customers. Proposed plans include a new charging model for FM and service charges and rolling out reporting metrics against agreed KPIs and SLAs for FM services to enable customers to measure our delivery performance.
- **Bottom-up budgeting -** this year NHSPS has reset all our budgeting, visited all properties in our FMDI (Facilities Management Data Initiative) and reviewed all services being provided at each site and reset all our costs accordingly. This is being followed up with more accurate ACS, which we will be reviewing and agreeing with our customers at future meetings.

Key achievements

Since NHSPS was founded, key achievements include:

- **Finance –** since 2013/2014 operational costs after depreciation have been driven down for our customers saving £211 million over four years
- **Surplus property disposals -** since 2013/14, NHSPS has sold 367 properties which has delivered £330 million in sales proceeds for reinvestment in the estate
- **Cross Government targets –** 5,934 Housing Units will be facilitated by the release of surplus land as part of the NHS Property Services disposals programme
- **Customer Satisfaction -** customer satisfaction scores have risen from 3.0 out of 10 in 2014/2015 to 7.5 in 2018/2019
- **Future NHS estate –** working with STPs in 2018 to help structure and deliver the 44 STEP prioritised estate strategies required by the Department to support the capital bidding process.

NAO report

In June 2019, the National Audit Office released a report into the NHSPS and the main conclusions were:

- NHSPS has succeeded in improving the professional support required, collecting data, streamlining contracts and identifying market rental rates.
- NHSPS requires extra powers from the Department to fulfil its original intention and work effectively
- Many NHS organisations and GPs regard paying for their premises as optional, with almost £700 million either written off or still unpaid.

Nottinghamshire CCGs

There are six CCGs covering the Nottinghamshire area. Across the area, NHSPS has ownership of 34 health centres/surgeries/clinics, 8 hospitals, 5 offices and 4 other properties.

- Nottingham West CCG – 3 health centres/surgeries/clinics
- Nottingham North & East CCG – 6 health centres/surgeries/clinics and 1 office
- Bassetlaw CCG - 3 health centres/surgeries/clinics, 5 hospitals, 1 office and 1 other.
- Mansfield & Ashfield CCG - 11 health centres/surgeries/clinics, 2 hospitals, 2 offices and 2 others (hospice and car park).
- Newark & Sherwood CCG - 3 health centres/surgeries/clinics and 1 other (residential – non-medical)
- Rushcliffe CCG - 8 health centres/surgeries/clinics, 1 hospital and 1 office.

NHSPS currently has 8 employees from Asset Management and 551 from Facilities Management working in this geographical area.

Whyburn Medical Centre

In September 2018, following a complaint from the customer regarding increased FM and service chagers with a request for detailed information, a specialist team within NHS Property Services engaged with the practice to resolve these issues.

In October 2018, NHSPS engaged with the GP practice alongside other stakeholders (NHSE and LMC) to discuss their concerns. The GPs raised issues relating to: occupancy, increased charges and NHSPS's legal right to charge for FM, clarity on the level of outstanding debt, payment history and evidence of payment/invoices to back up FM and service charges. NHSPS agreed to produce detailed year on year analysis of FM and service charges dating back to 2015/2016 and in addition providing information relating to cleaning inspections, utility charges, rates and other contract costs where available.

Engagement took place in October and November 2018 with the GP practice and NHSPS including the completion of the agreed ~~to~~ report. In November 2018, following a negotiation (the terms of which are confidential), a settlement was put forward by the GP Practice for the period up to 31 March 2018. This was accepted by NHSPS and a confidentiality agreement was entered to by both parties.

In December 2018, the GP Practice served notice to vacate the property and concurrently they terminated their APMS contract with the commissioner.

Across January and February 2019, a number of further calls took place with the GP Practice to agree a settlement for the period between 1 April 2018 - 31 May 2019, again this was subject to a confidentiality agreement.

NHSPS took every potential step to engage with and provide the GP Practice with the requested information, to explain charges and entered into a confidential settlement agreement with the GP Practice.

Nottinghamshire County Council

Report to Health Scrutiny Committee

23 July 2019

Agenda Item: 5

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

NOTTINGHAM TREATMENT CENTRE

Purpose of the Report

1. To introduce a briefing on the current position regarding the Nottingham Treatment Centre.

Information

2. The Treatment Centre contract was awarded to Nottingham University Hospitals (NUH) late last year, and was subject to several legal challenges from the previous contract holder, Circle. NUH will take over operational responsibility for the Treatment Centre from 29th July.

3. While the detail of the legal challenge is not a matter for Health Scrutiny, Members will wish to receive reassurance about the handover – particularly around issues of safety and patient experience.

4. Lucy Dadge, Executive Director of Commissioning, Nottinghamshire CCGs and Dr Keith Girling, Medical Director, NUH will attend to brief the Health Scrutiny Committee and answer questions as necessary.

5. A written briefing from the commissioners and NUH is attached as an appendix to this report.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the information provided.

2) Schedule further consideration, as necessary.

Councillor Keith Girling
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Plans for continuity of services at Nottingham Treatment Centre

Plans to transfer patients to a new provider at the Nottingham Treatment Centre are being agreed by local NHS organisations.

Circle Nottingham Limited's contract to deliver the services at the Treatment Centre ends on 28th July 2019. Nottingham University Hospitals NHS Trust (NUH) will take on delivery of services from 29th July. Both parties are working together on plans for a smooth transfer of services.

Circumstances of the contract award

The CCGs were intending to award a contract in December 2018; the contract award was delayed due to a legal challenge issued by Circle. At a hearing in May the court ruled that the contract should be allowed to proceed and a contract was awarded to NUH on 23rd May 2019 with a commencement date of 29th July 2019.

The much shortened timescale for mobilisation has been determined by the multiple legal challenges from Circle. Despite these constraints, teams across NUH, the CCG and Circle have been working hard on the mobilisation plan in order to ensure that there is a safe transfer of services between Circle and NUH.

The TUPE process is underway, with circa 600 Circle staff expected to transfer to NUH in the weeks to come. Over the last few weeks Circle have held a number of staff meetings in partnership with NUH to explain the transfer process and how staff will be affected. Members of the NUH Executive Team and senior Clinical and Executive Leaders have also undertaken walk around visits and drop-in sessions to meet staff and ensure lines of communication remain open.

Individual communication is being undertaken to inform patients about their appointments and access to services going forward and a dedicated phone line will be in place for patients, should there be any questions or concerns about appointments in the weeks to come.

The CCG is also contacting local GPs to reiterate that planned appointments and procedures will go ahead unless patients are notified of specific changes directly from NUH.

Plans for safe delivery of services from day one of new contract

We are confident that NUH's updated mobilisation plan will provide safe services from day one, as well as deliver significant improvements to services in the months to come, beyond the initial mobilisation period.

NUH has prepared specialty level mobilisation plans in order to mitigate any impact on service delivery or patient experience during the transfer. CCGs have been assured that the Trust's capacity to provide safe services to patients will not be affected by the transition. Even as we work through the precise patient activity for month one, we anticipate that all of August's planned activity will be done in the Treatment Centre and at NUH. No new inpatient activity will be scheduled in the first month of the contract as we embed new ways of working and work through the staffing arrangements for the delivery of the new contract. This will not impact on patients receiving timely care and treatment, in line with national requirements (ie the 18 week referral to treatment standard).

Both Circle and NUH are co-operating and working together productively in the transition process. All parties (including CCGs) now meet weekly to review and discuss progress, with the primary aim of minimising disruption to patients.

Our priority as commissioners is to protect patient safety and to ensure patients receive timely and appropriate information about how any changes will affect them personally.

ICT Upgrades and Clinical Systems

Circle's staff are being trained on the use of Medway Patient Administration System (PAS), which will be in operation from day one of the new contract. Medway PAS is the most modern, flexible and extensible solution available which is already used by NUH and is designed exclusively for the NHS.

Further upgrades to the network and telephone systems will be deployed during the first three months of the new contract. PCs and printers at both the Treatment Centre and the Abbeyfields (back office location for the Treatment Centre) site will be replaced in line with the NUH replacement programme.

Thanks to Circle Nottingham Ltd

The CCG would like to reiterate its thanks to all the staff at Circle Nottingham who have provided dedicated service to local patients for many years.

Nottinghamshire County Council

Report to Health Scrutiny Committee

23 July 2019

Agenda Item: 6

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

NOTTINGHAMSHIRE HEALTHCARE TRUST – CARE QUALITY COMMISSION INSPECTION

Purpose of the Report

1. To introduce a briefing on the Care Quality Inspection of Nottinghamshire Healthcare Trust which took place earlier this year.

Information

2. The Care Quality Commission (CQC) inspected Nottinghamshire Healthcare NHS Foundation Trust between 22 January and 7 March 2019, with the report being published on 24 May 2019.

3. The CQC assessed the Trust across a range of domains and determined it to be inadequate for acute wards for adults of working age and psychiatric intensive care units, In addition, the inspection judged forensic inpatient or secure wards and high secure hospitals to require improvement. The Trust was rated to be 'good' across other domains.

4. The rating of 'inadequate' for acute wards and psychiatric intensive care units will be a cause of considerable concern to Members. The Trust's improvement plan is attached as Appendix A to this report and the CQC inspection report is attached as Appendix B.

5. The Healthcare Trust's new Chief Executive, Dr John Brewin, will attend the meeting to brief Members and answer questions as necessary. The Nottinghamshire County Council Corporate Directors for Adults' and Children's services, who act as commissioners for some Healthcare Trust services will also be in attendance.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the information provided.

2) Schedule further consideration, as necessary.

Councillor Keith Girling
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Nottinghamshire Healthcare NHS Foundation Trust

CQC Post Inspection Quality Improvement Tracker

CQC Ref: INS2-5169594710

CORE SERVICE	Behind schedule	Meeting expectations	Improvements delivered & Sustained
Acute wards for adults of working age and psychiatric intensive care units			
Community based mental health services for adults of working age			
Child and adolescent mental health wards			
Community mental health services for people with a learning disability or autism			
Mental health crisis services and health-based places of safety			
Forensic in-patient wards			

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Introduction

The Trust was inspected by the Care Quality Commission (CQC) during the period 22 January to 07 March 2019. The CQC published the Trust's report on 24 May 2019. The CQC rate services against five key lines of enquiry:

- Are services safe?
- Are services effective?
- Are services caring?
- Are services responsive?
- Are services well-led?

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

Governance Arrangements:

- The corporate Quality Governance Team will hold the primary copy of this Quality Improvement tracker [email: CQCGovernance@nottshc.nhs.uk]
- Each Division/Directorate will hold and maintain a working copy of the plan, colour coding the 'On Track' column using the RAG KEY above.
- Each Division/Directorate will email an updated version of the QI tracker to CQCGovernance@nottshc.nhs.uk along with evidence of the impact of the progress made on the last working day of each month.
- Dr Deb Wildgoose (Interim Director of Nursing) will host progress meetings with the Divisions/Directorates on a monthly basis to support and explore the progress of the actions
- Oversight and assurance will be provided to the Executive Leadership Team (ELT), the Quality Operational Group (QOG) the Quality Committee and the Board of Directors.
- Proposals by the Divisions/Directorates to close individual actions will be submitted to QOG. Actions will only be closed internally when the Quality Committee is assured that compliance with the Regulation has been achieved.
- The actions will remain subject to periodic scruitiny by QOG and the Quality Committee until the CQC re-inspect and confirm they are satisfied that the required standard has been met and sustained.

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

Priority Action/Code	Service Areas Affected	Area(s) for improvement	Responsible Executive Director	Divisional Programme Leads	Actions	Progress update - to be submitted on last working day of the month to CQCGovernance@nottshc.nhs.uk	Timescales for achieving required change	Assurance/Evidence	On track?
AMHIP -1 MUST DO	**Lucy Wade, Orchid, B2, Rowan 1, Redwood 1, Redwood 2**	There must be sufficient staff on wards to ensure patients have access to leave and one to one sessions with their named nurse	Dr Deb Wildgoose (Interim Director of Nursing)	Andy Latham (Interim Assoc.Dir of Nursing (Mental Health)	• A staffing review has been completed • Recruitment programme is in place • Development of a safe staffing oversight policy. • Revised Standard Operating procedure for staffing on acute wards • Effective job planning and deployment to ensure right staffing, in right place at the right time.		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.	• Completed staffing review.	
AMHIP -2 MUST DO	**Lucy Wade Ward; Orchid Ward, Rowan 1 Ward**	Physical health observations must be carried out after rapid tranquilisation in line with trust policy and national guidance.	Dr Julie Hankin (Medical Director)	Michelle Malone (Clinical Director) with support from Deb Thompson (Deputy Associate Director of Nursing)	• Link with Dr Hazel Johnson (Associate Medical Director) • Identify the nature of the problem with front line teams • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. • Test the change ideas • Implement change and sustain the improvement		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
AMHIP -3 MUST DO	**Lucy Wade Ward; Orchid Ward** **B2 Ward - adrenaline in locked cupboard**	All wards must check: • Check resuscitation equipment to ensure it is safe to use. • ensure adrenaline is fit for use and stored in a place where there is immediacy of access	Dr Julie Hankin (Medical Director)	Deb Thompson (Deputy Associate Director of Nursing)	• Link with the Quality Improvement Hub on developing a QI project on 'Managing the Clinic Room'.		QI Project plan in place by 31st July 2019, with changes being tested and impact measured throughout August, September and October 2019		
AMHIP -4 MUST DO	**B2 Ward**	Blanket restrictions on B2 ward must be reviewed so that patients are individually risk assessed for restrictions relating to accessing sleeping areas and	Dr Julie Hankin (Medical Director)	Dave Mason (Associate Director of Nursing)	• Compliance Assurance (CARe) review of B2 to identify use of blanket restrictions • Directorate least restrictive practice meetings to be		Action plan in place by 30 June 2019 with changes being tested	27/06/19: CARe review planning 21/06/19: First of the reinstated restrictive practice meetings has	

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

Priority Action/Code	Service Areas Affected	Area(s) for improvement	Responsible Executive Director	Divisional Programme Leads	Actions	Progress update - to be submitted on last working day of the month to CQCGovernance@nottshc.nhs.uk	Timescales for achieving required change	Assurance/Evidence	On track?
		bedrooms.			reinstated.		and impact measured throughout August, September and October 2019.	taken place.	
AMHIP -5 MUST DO	**All wards**	Staff must: • follow physical health care plans risk assessment • complete physical health observations For patients when required throughout their admission.	Dr Julie Hankin (Medical Director)	Emma Bennett (Physical Healthcare Matron)	Emma Bennett to link with the Quality Improvement Hub on developing a QI project plan.		QI Project plan in place by 31st July 2019, with changes being tested and impact measured throughout August, September and October 2019		
AMHIP -6 MUST DO	**Lucy Wade Ward and Rowan 1 Ward**	The privacy and dignity of patients must be protected when observations are carried out	Dr Julie Hankin (Medical Director)	Deb Thompson (Deputy Associate Director of Nursing)	• Clear statements: ○ On respecting the dignity of patients under observation including gender of staff providing supervision and knocking on doors ○ On admission that male staff will be observing both genders and vice versa. ○ On providing patients an opportunity to state their preference and record this. • Review patient rights information leaflet.		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
AMHIP -7 MUST DO	**All wards**	Effective governance structures must be in place to ensure that • Supervision and team meetings take place • Learning from incidents and complaints are recorded at ward level.	Dr Deb Wildgoose (Interim Director of Nursing)	Michelle Malone (Clinical Director) with support from Jo Horsley (Acting General	• Linked with CHRT – D and E • Establish a short term task and finish group to: • Identify the nature of the problem with front line teams • Agree change ideas to achieve the improvement		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout		

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

Priority Action/Code	Service Areas Affected	Area(s) for improvement	Responsible Executive Director	Divisional Programme Leads	Actions	Progress update - to be submitted on last working day of the month to CQCGovernance@nottshc.nhs.uk	Timescales for achieving required change	Assurance/Evidence	On track?
				Manager)	• Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. • Test the change ideas • Implement change and sustain the improvement		August, September and October 2019.		
AMHIP -8 MUST DO	**All wards**	Risk assessments that contain all relevant risk information must be in place.	Dr Julie Hankin (Medical DirectoFstafr)	Andy Latham (Interim Assoc.Dir of Nursing (Mental Health) with support of Jo Horsley (Acting General Manager)	Jo Horsley to link with the Quality Improvement Hub on developing a QI project plan to be led by Steve Daykin (Quality Improvement Facilitator)		QI plan in place by 31st July 2019, with changes being tested and impact measured throughout August, September and October 2019		
AMHIP -A SHOULD DO		The trust should ensure that information that is recorded on patients' information boards is not visible from the ward when the boards are not in use.	Dr Julie Hankin (Medical Director)	Ian Brown (Head of Divisional Compliance)	• Establish a short term task and finish group to: ○ Identify the nature of the problem with front line teams ○ Agree change ideas to achieve the improvement ○ Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. ○ Test the change ideas • Implement change and sustain the improvement		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
AMHIP -B SHOULD DO		The trust should ensure patient community meetings go ahead when planned and that these are recorded along with any actions from these meetings	Dr Julie Hankin (Medical Director)	Jo Horsley (Acting General Manager)	• Identify the nature of the problem with front line staff. • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change.		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September		

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

Priority Action/Code	Service Areas Affected	Area(s) for improvement	Responsible Executive Director	Divisional Programme Leads	Actions	Progress update - to be submitted on last working day of the month to CQCGovernance@nottshc.nhs.uk	Timescales for achieving required change	Assurance/Evidence	On track?
					• Test the change ideas • Implement change and sustain the improvement		and October 2019.		
AMHIP -C SHOULD DO		The trust should ensure that they offer a full programme of activities on all wards.	Money Della - Associate Director of Allied Health Professionals	Julie Swan (OT Lead)	• Identify the nature of the problem with front line teams and patients • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams Implement change and sustain the improvement • Involve Activity Coordinators, OT's and the LIVE Project.		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
AMHIP -D SHOULD DO		The trust should ensure that it has an action plan to eradicate dormitories at Bassetlaw Hospital and Millbrook Mental Health Unit.	Simon Crowther (Executive Director of Finance)	Kay Mulcahy - Associate Director of Estates and Facilities.	**Trust level action plan in place**		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.	Trust level action plan in place	
AMHIP -E SHOULD DO		The trust should ensure that it regularly reviews blanket restrictions, and make sure that when restrictions are in place they are necessary and individually risk assessed including those which restrict patient's access to fresh air and cutlery and crockery	Dr Julie Hankin (Medical Director)	Dave Mason (Associate Director of Nursing and Patient Experience)	Compliance Assurance (CARe) review of areas affected to identify use of blanket restrictions Directorate least restrictive practice meetings to be reinstated.		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.	27/06/19: CARe review planned 21/06/19: First of the reinstated restrictive practice meetings has taken place.	
AMHIP -F		The trust should ensure that there is access to	Dr Deb Wildgoose	Michelle Malone	• Identify the nature of the problem with front line teams		Action plan in place by		

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

Priority Action/Code	Service Areas Affected	Area(s) for improvement	Responsible Executive Director	Divisional Programme Leads	Actions	Progress update - to be submitted on last working day of the month to CQCGovernance@nottshc.nhs.uk	Timescales for achieving required change	Assurance/Evidence	On track?
SHOULD DO		psychological therapies for all patients who require this	(Interim Director of Nursing)	(Clinical Director)	and patients • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams Implement change and sustain the improvement		30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
AMHIP -G SHOULD DO		The trust should ensure that all staff can open all anti barricade door systems in case of emergency.	Kay Mulcahy - Associate Director of Estates and Facilities.	Ian Brown (Head of Divisional Compliance)	• Identify the nature of the problem with front line teams and patients • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams Implement change and sustain the improvement		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
AMHIP -H SHOULD DO		The trust should ensure that staff work with patients to create fully holistic and recovery focused care plans and that staff record when they have offered patients a copy of their care plan	Dr Deb Wildgoose (Interim Director of Nursing)	Deb Thompson (Deputy Associate Director of Nursing)	• Link to be made with the Quality Improvement Hub on developing a QI project plan • Identify the nature of the problem with front line teams and patients • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams Implement change and sustain the improvement		QI plan in place by 31st July 2019, with changes being tested and impact measured throughout August, September and October 2019		
AMHIP -I SHOULD DO		The trust should ensure that staff record the date that they open patient's medication that becomes short dated once opened when opened	Dr Julie Hankin (Medical Director)	Deb Thompson (Deputy Associate Director of Nursing)	• Link with the Quality Improvement Hub on developing a QI project on 'Managing the Clinic Room'.		QI plan in place by 31st July 2019, with changes being tested and impact measured throughout August, September		

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

Priority Action/Code	Service Areas Affected	Area(s) for improvement	Responsible Executive Director	Divisional Programme Leads	Actions	Progress update - to be submitted on last working day of the month to CQCGovernance@nottshc.nhs.uk	Timescales for achieving required change	Assurance/Evidence	On track?
							and October 2019		
AMHIP -J SHOULD DO	All wards	The trust should ensure that they offer adequate support to newly qualified nurses.	Dr Deb Wildgoose (Interim Director of Nursing)	Julian Eve (Associate Director of Learning and Development) Jo Horsley (Acting General Manager)	• Evidence base shows first year is critical as to whether they remain inpost/nursing career. • Identify the nature of the problem with newly qualified nurses • Explore what works for existing staff in terms of transition from student to autonomous practitioner. • Review induction of newly qualified nurses • Discuss and agree change ideas to achieve the improvement needed • Identify, lead and implement changes • Review efficacy of changes		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.	Beth Grimditch (Quality Practice Improvement Facilitator) in post to support preceptors	
AMHIP -K SHOULD DO	All wards	The trust should ensure that patients have pro re nata (PRN) care plans in place for medication that had been prescribed for patients to take regularly	Dr Julie Hankin (Medical Director)	Claire Nowak (Lead Pharmacist)	• Staff need enough information to understand when to administer when required medicines as intended by the prescriber. • Identify the nature of the problem and any gaps in recording what is required of staff. • If gaps are found, discuss and agree change ideas to achieve the improvement needed • Identify, lead and implement changes • Review efficacy of changes		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.	Covered in suite of care plans	
AMHIP -L SHOULD DO	All wards	The trust should ensure that there are safeguarding processes in place that protect patients from financial abuse from staff and that staff undertake activity in line with policy.	Dr Deb Wildgoose (Interim Director of Nursing)	Julie Gardner (Associate Director of Social Care)	• Identify the nature of the problem and any gaps in recording what is required of staff. • If gaps are found, discuss and agree change ideas to achieve the improvement needed • Identify, lead and implement changes		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout		

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

Priority Action/Code	Service Areas Affected	Area(s) for improvement	Responsible Executive Director	Divisional Programme Leads	Actions	Progress update - to be submitted on last working day of the month to CQCGovernance@nottshc.nhs.uk	Timescales for achieving required change	Assurance/Evidence	On track?
					• Review efficacy of changes		August, September and October 2019.		
AMHIP -M SHOULD DO		The trust should review bed usage, capacity and readmission rates. The trust should monitor the number of times a bed is not available to a patient when they return from leave.	Dr Julie Attfield (Executive Director of Mental Health Services)	Chris Aswell (Associate Director – Local Partnerships Mental Health)	• An Out of Area plan is already in place. • Expand the collation of data to cover the number of times a bed is not available to a patient returning form leave.		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.	OOA action plan in place.	
AMHIP -N SHOULD DO	All wards	The trust should ensure that wards share best practice with each other so that where processes work well they are implemented across the wards to achieve consistency.	Dr Deb Wildgoose (Interim Director of Nursing)	Michelle Malone (Clinical Director) with support from Jo Horsley (Acting General Manager)	• Establish a short term task and finish group to: • Identify the nature of the problem with front line teams • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. • Test the change ideas • Implement change and sustain the improvement		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
AMHIP -P SHOULD DO	All wards	The trust should ensure that staff are familiar with the trust's vision and values.	Dr David Brewin (CEO)	Clare Teeney (Director of Human Resources)	There is a trustwide action plan in place to support the culture changes required.		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.	CQC inspection report states they are assured that the trust had a clear vision and set of values with quality and sustainability as the top priorities. There is a trustwide action plan in place to support the culture changes required.	

Community based mental health services for adults of working age

Priority Action/Code	Service Areas Affected	Area(s) for improvement	Responsible Executive Director	Divisional Programme Leads	Actions	Progress update - to be submitted on last working day of the month to CQCGovernance@nottshc.nhs.uk	Timescales for achieving required change	Assurance/Evidence	On track ?
AMHC -1 MUST DO	**All services**	Every location must comply with guidance on • the correct storage of medication • room temperature monitoring • fridge temperature monitoring • The safe storage of medication when taken out into the community.	Dr Julie Hankin (Medical Director)	Claire Nowak (Lead Pharmacist) supported by: Tim Constable (Operational Manager) Tracey Taylor (Operational Manager)	Link with the Quality Improvement Hub on developing a QI project on 'Managing the Clinic Room'. The provision of digital fridges		QI plan in place by 31st July 2019, with changes being tested and impact measured throughout August, September and October 2019	Provision of digital fridges approved.	

Child and adolescent mental health wards

Priority Action/code	Service Areas Affected	Area(s) for improvement	Responsible Executive Director	Divisional Programme Leads	Actions	Progress update - to be submitted on last working day of the month to CQCGovernance@nottshc.nhs.uk	Timescales for achieving required change	Assurance/Evidence	On track ?
CAMHS-1 MUST DO	**All areas**	All staff must safeguard patient's information so that it cannot be seen by visitors to the ward or other patients.	Dr Julie Hankin (Medical Director)	Ian Brown (Head of Divisional Compliance)	• Establish a short term task and finish group to: ○ Identify the nature of the problem with front line teams ○ Agree change ideas to achieve the improvement ○ Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. ○ Test the change ideas • Implement change and sustain the improvement		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
CAMHS-A SHOULD DO		The trust should continue to act to resolve the building issues including the heating and alarm system	Simon Crowther (Executive Director of Finance)	Kay Mulcahy - Associate Director of Estates and Facilities	**LOCAL ACTION PLAN IN PLACE**		Action plan in place with changes being tested and impact measured throughout August, September and October 2019.	**LOCAL ACTION PLAN IN PLACE**	
CAMHS-**B** SHOULD DO		The trust should make sure that each patient who needs them has a personal emergency evacuation plan that is updated when they move around wards including the seclusion room.	Caroline Brookes (Head of Emergency Preparedness Resilience and Response)	Deb Thompson (Deputy Associate Director of Nursing)	• Identify the nature of the problem with front line teams • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. • Test the efficacy of the changes made		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
CAMHS-C SHOULD DO		The trust should consider the risks of a patient being able to access the smoke alarm in the seclusion room by standing on the bed.	Simon Crowther (Executive Director of Finance)	Rachel Towler (General Manager)	**LOCAL ACTION PLAN IN PLACE COVERING ENVIRONMENTAL ISSUES**		Action plan in place with changes being tested and impact measured	**LOCAL ACTION PLAN IN PLACE COVERING ENVIRONMENTAL ISSUES**	

Child and adolescent mental health wards

Priority Action/code	Service Areas Affected	Area(s) for improvement	Responsible Executive Director	Divisional Programme Leads	Actions	Progress update - to be submitted on last working day of the month to CQCGovernance@nottshc.nhs.uk	Timescales for achieving required change	Assurance/Evidence	On track ?
							throughout August, September and October 2019.		
CAMHS-D SHOULD DO		The trust should make sure that the temperatures of all medication fridges are within the recommended range for safe medicines storage	Dr Julie Hankin (Medical Director)	Claire Nowak (Lead Pharmacist) supported by: Rachel Towler (General Manager)	Link with the Quality Improvement Hub on developing a QI project on 'Managing the Clinic Room'. The provision of digital fridges		QI plan in place by 31st July 2019, with changes being tested and impact measured throughout August, September and October 2019	Provision of digital fridges approved.	
CAMHS-E SHOULD DO		The trust should ensure that all staff have opportunities for specialised training in eating disorders and the needs of patients admitted to psychiatric intensive care units.	Dr Deb Wildgoose (Interim Director of Nursing)	Rachel Towler (General Manager)	• Identify the extent of the problem, the gaps and why it may have happened. • Agree change ideas to achieve the improvement • Identify, lead and implement changes with relevant teams to increase staff awareness to embed and sustain change. • Test the efficacy of the changes made		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
CAMHS-F SHOULD DO		The trust should consider how staff scan patient's paper records into the electronic patient records system to ensure the information can be used effectively by all staff.	Dr Julie Hankin (Medical Director)	Rachel Towler (General Manager)	• Identify the nature of the problem with front line teams • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. • Test the efficacy of the changes made		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
CAMHS-G SHOULD DO		The trust should consider training other staff than doctors in phlebotomy to	Dr Julie Attfield (Executive	Rachel Towler (General	• Identify the extent of the problem, the gaps and why it may have happened.		Action plan in place by 30 June 2019		

Child and adolescent mental health wards

Priority Action/code	Service Areas Affected	Area(s) for improvement	Responsible Executive Director	Divisional Programme Leads	Actions	Progress update - to be submitted on last working day of the month to CQCGovernance@nottshc.nhs.uk	Timescales for achieving required change	Assurance/Evidence	On track ?
		increase the number of staff who can carry out patients' blood tests**.**	Director) for Local Partnerships - Mental Health Services)	Manager)	• Agree change ideas to achieve the improvement • Identify, lead and implement changes with relevant teams to increase staff awareness to embed and sustain change. • Review the efficacy of the changes made		with changes being tested and impact measured throughout August, September and October 2019.		
CAMHS-H SHOULD DO		The trust should fix the parental controls on the Wi-Fi so that patients have access to the Internet when appropriate.	Simon Crowther (Executive Director of Finance)	Fulloway Kathy - Head of Health Informatics	• Identify the extent of the problem and review why this has happened. • Depending on the outcme, agree the change ideas to achieve any improvements needed. • Identify, lead and implement changes with relevant teams to increase staff awareness to embed and sustain change. • Review the efficacy of any changes made		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
CAMHS-I SHOULD DO		The trust should ensure that all patients and their carers have information provided to them about the service and how to comment on it in an accessible format.	Julie Grant (Head of Communications)	Rachel Towler (General Manager)	• Identify the nature of the problem with families, carers and patients to ensure the information provided meets their needs and is available in accessible formats. • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. • Test the efficacy of the changes made with families and carers		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
CAMHS-J SHOULD DO		The trust should clearly communicate with the staff who is responsible for issues involving the building so staff know who to report these to and how these are being managed.	Dr Julie Attfield (Executive Director) for Local Partnerships - Mental Health Services)	Rachel Towler (General Manager)	**LOCAL ACTION PLAN IN PLACE COVERING ENVIRONMENTAL ISSUES**		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September	**LOCAL ACTION PLAN IN PLACE COVERING ENVIRONMENTAL ISSUES**	

Child and adolescent mental health wards

Priority Action/code	Service Areas Affected	Area(s) for improvement	Responsible Executive Director	Divisional Programme Leads	Actions	Progress update - to be submitted on last working day of the month to CQCGovernance@nottshc.nhs.uk	Timescales for achieving required change	Assurance/Evidence	On track ?
							and October 2019.		

Community mental health services for people with a learning disability or autism

Priority Action/code	Service Areas Affected	Area(s) for improvement	Responsible Executive Director	Divisional Programme Leads	Actions	Progress update - to be submitted on last working day of the month to CQCGovernance@nottshc.nhs.uk	Timescales for achieving required change	Assurance/Evidence	On track ?
CLDT - 1 MUST DO	**All services**	Staff must routinely provide patients and carers with information about how to raise a concern or complaint.	Dr Deb Wildgoose (Interim Director of Nursing)	Angela Jackson (Service Manager)	• Identify the nature of the problem with families, carers and patients to ensure the information provided meets their needs and is available in accessible formats. • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. • Test the efficacy of the changes made with families and carers		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
CLDT - A SHOUL D DO		The trust should ensure staff always complete care plans to address the identified needs of patients.	Dr Deb Wildgoose (Interim Director of Nursing)	Angela Jackson (Service Manager)	• Link to be made with the Quality Improvement Hub on developing a QI project plan • Identify the nature of the problem with front line teams and patients • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams Implement change and sustain the improvement		QI plan in place by 31st July 2019, with changes being tested and impact measured throughout August, September and October 2019		
CLDT – B SHOULD DO		The trust should ensure appraisal rates for all non-medical staff within the service meet its target appraisal rate.	Clare Teeney (Director of Human Resources)	Angela Jackson (Service Manager)	• Identify the nature of the problem with non-medical staff • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. • Check the efficacy of the changes made with non-medical staff		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
CLDT - C SHOULD DO		The trust should ensure staff record when they have offered or shared care plans with patients.	Dr Julie Attfield (Executive Director) for Local Partnerships - Mental Health	Angela Jackson (Service Manager)	• Identify the nature of the problem with front line staff and patients. • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams to		Action plan in place by 30 June 2019 with changes being tested and impact measured		

Community mental health services for people with a learning disability or autism

Priority Action/code	Service Areas Affected	Area(s) for improvement	Responsible Executive Director	Divisional Programme Leads	Actions	Progress update - to be submitted on last working day of the month to CQCGovernance@nottshc.nhs.uk	Timescales for achieving required change	Assurance/Evidence	On track ?
			Services)		increase staff awareness to embed and sustain change. • Check the efficacy of the changes made with frontline staff and patients.		throughout August, September and October 2019.		
CLDT - D SHOULD DO		The trust should ensure processes are in place to involve patients in decisions about the intellectual and developmental disabilities services.	Dr Julie Attfield (Executive Director) for Local Partnerships - Mental Health Services)	Vicky Romilly (Lead Speech and Language Therapist) Dr Kiran Jeenkeri (Consultant)	• Identify the barriers to involving families, carers and patients in decisions about the services. • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. • Test the efficacy of the changes made with patients families and carers		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
CLDT - E SHOULD DO		The trust should ensure the agendas and records from each professional group meeting follow a standardised framework to ensure that essential information is shared and discussed	Dr Julie Hankin (Medical Director)	Angela Jackson (Service Manager)	• Identify the nature of the problems and the risks. • Agree any change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. • Check the efficacy of the changes made with front line staff.		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
CLDT - F SHOULD DO		The trust should ensure that staff audits are effective to capture the quality of staff practice in the service.	Dr Deb Wildgoose (Interim Director of Nursing)	Angela Jackson (Service Manager)	• Identify why the outcome of audits were not consistent with the practices seen • Explore any gaps in the auditing of compliance with the Mental capacity Act. • Agree any change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. • Check the efficacy of the changes made with front line staff.		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		

Mental health crisis services and health-based places of safety

Priority Action/code	Service Areas Affected	Area(s) for improvement	Responsible Executive Director	Divisional Programme Leads	Actions	Progress update - to be submitted on last working day of the month to CQCGovernance@nottshc.nhs.uk	Timescales for achieving required change	Assurance/Evidence	On track ?
CHRT - 1 MUST DO	**Highbury Hospital Site**	Staff follow medicine management policies and procedures.	Dr Julie Hankin (Medical Director)	Claire Nowak (Medicine safety Officer) Supported by Michelle Malone (Clinical Director)	• Standard Operating Procedure for s136 suite • Pharmacy oversight of the improvement required. • Identify why there is a gap in practice • Agree any change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. • Check the efficacy of the changes made with front line staff.		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
CHRT - 2 MUST DO	**S136 – Cassidy Suite**	Places of safety must be safe and secure.	Dr Julie Attfield (Executive Director) for Local Partnerships - Mental Health Services)	Chris Ashwell (Associate Director)	**LOCAL ACTION PLAN IN PLACE**		Action plan in place with changes being tested and impact measured throughout August, September and October 2019.	**LOCAL ACTION PLAN IN PLACE**	
CHRT - 3 MUST DO	**All services**	Staffing levels must be safe when using restraint.	Dr Julie Attfield (Executive Director) for Local Partnerships - Mental Health Services)	Dave Mason (Associate Director of Nursing)	• Linked to AMHIP -1 • A staffing review has been completed • Recruitment programme is in place • Development of a safe staffing oversight policy. • Identify any gaps in staff confidence and training • Revised Standard Operating procedure for staffing in the services • Effective job planning and deployment to ensure right staffing, in right place at the right time.		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		

Mental health crisis services and health-based places of safety

Priority Action/code	Service Areas Affected	Area(s) for improvement	Responsible Executive Director	Divisional Programme Leads	Actions	Progress update - to be submitted on last working day of the month to CQCGovernance@nottshc.nhs.uk	Timescales for achieving required change	Assurance/Evidence	On track ?
CHRT - A SHOULD DO		The trust should ensure the method of recording and completion of physical health checks is consistent across the crisis and home treatment service.	Dr Julie Hankin (Medical Director)	Emma Bennett (Physical Healthcare Matron)	Emma Bennett to link with the Quality Improvement Hub on developing a QI project plan.		QI Project plan in place by 31st July 2019, with changes being tested and impact measured throughout August, September and October 2019		
CHRT - B SHOULD DO		The trust should ensure that all teams write care plans that are personalised, holistic and recovery orientated.	Dr Deb Wildgoose (Interim Director of Nursing)	Michelle Malone (Clinical Director) with support from Deb Thompson (Deputy Associate Director of Nursing)	• Link to be made with the Quality Improvement Hub on developing a QI project plan • Identify the nature of the problem with front line teams and patients • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams Implement change and sustain the improvement		QI plan in place by 31st July 2019, with changes being tested and impact measured throughout August, September and October 2019		
CHRT - C SHOULD DO		The trust should ensure staff offer patients a copy of their care plan.	Dr Deb Wildgoose (Interim Director of Nursing)	Michelle Malone (Clinical Director) with support from Deb Thompson (Deputy Associate Director of Nursing)	• Link to be made with the Quality Improvement Hub on developing a QI project plan • Identify the nature of the problem with front line teams and patients • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams Implement change and sustain the improvement		QI plan in place by 31st July 2019, with changes being tested and impact measured throughout August, September and October 2019		
CHRT - D SHOULD DO		The trust should ensure team meetings take place regularly	Dr Deb Wildgoose (Interim Director of Nursing)	Ann Wright (General Manager)	• Linked with AMHIP -7 & CHRT-E • Establish a short term task and finish group to: • Identify the nature of the problem with front line teams • Agree change ideas to achieve		Action plan in place by 30 June 2019 with changes being tested and impact measured		

Mental health crisis services and health-based places of safety

Priority Action/code	Service Areas Affected	Area(s) for improvement	Responsible Executive Director	Divisional Programme Leads	Actions	Progress update - to be submitted on last working day of the month to CQCGovernance@nottshc.nhs.uk	Timescales for achieving required change	Assurance/Evidence	On track ?
					the improvement • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. • Test the change ideas • Implement change and sustain the improvement		throughout August, September and October 2019.		

CHRT - E
SHOULD DO
		The trust should ensure that staff receive supervision and appraisal in line with their policy.	Dr Julie Attfield (Exec.Director – Local Partnerships)	Jo Horsley (Deputy General Manager)	• Linked with AMHIP – 7 & CHRT - D
					• Establish a short term task and finish group to:
					  • Identify the nature of the problem with front line teams
					  • Agree change ideas to achieve the improvement
					  • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change.
					  • Test the change ideas
					Implement change and sustain the improvement
							Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		

CHRT - F SHOULD DO		The trust should ensure the section 136 suites are appropriate for their usage**.**	Dr Julie Attfield (Exec.Director – Local Partnerships)	Chris Ashwell (Associate Director – Local Partnerships Mental Health)	**LOCAL ACTION PLAN**		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
CHRT - G SHOULD DO		The trust should ensure staff are able to raise concerns without fear of retribution	Clare Teeney (Director of Human Resources)	Jo Horsley (Deputy General Manager)	There is a trustwide action plan in place to support the culture changes required.		Action plan in place by 30 June 2019 with changes being tested and impact measured	There is a trustwide action plan in place to support the culture changes required.	

Mental health crisis services and health-based places of safety

Priority Action/code	Service Areas Affected	Area(s) for improvement	Responsible Executive Director	Divisional Programme Leads	Actions	Progress update - to be submitted on last working day of the month to CQCGovernance@nottshc.nhs.uk	Timescales for achieving required change	Assurance/Evidence	On track ?
							throughout August, September and October 2019.		

Forensic in-patient wards

Priority Action/Code	Service Areas Affected	Area(s) for improvement	Responsible Executive Director	Divisional Programme Leads	Actions	Progress update - to be submitted on last working day of the month to CQCGovernance@nottshc.nhs.uk	Timescales for achieving required change	Assurance/Evidence	On track ?
FOR – 1 MUST DO	All services	There must be enough staff to support the safe and effective care and treatment of patients.	Dr Deb Wildgoose (Interim Director of Nursing)	Dave Mason Assoc.Dir of Nursing (Forensic)	• A staffing review has been completed • Recruitment programme is in place • Development of a safe staffing oversight policy. • Revised Standard Operating procedure for staffing on acute wards • Effective job planning and deployment to ensure right staffing, in right place at the right time.		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.	• Completed staffing review.	
FOR – 2 MUST DO	All services	Staff must follow best practice when storing, dispensing, and recording the use of medicines, including rapid tranquilisation.	Dr Julie Hankin (Medical Director)	Claire Nowak (Lead Pharmacist) supported by: TBC	Link with the Quality Improvement Hub on developing a QI project on 'Managing the Clinic Room'. The provision of digital fridges		QI plan in place by 31st July 2019, with changes being tested and impact measured throughout August, September and October 2019	Provision of digital fridges approved.	
FOR – 3 MUST DO	All services	Staff must carry out physical health observations after administering rapid tranquilisation in line with trust policy and national guidance.	Dr Julie Hankin (Medical Director)	Dave Mason Assoc.Dir of Nursing (Forensic)	• Identify the nature of the problem with front line teams • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. • Test the change ideas • Implement change and sustain the improvement		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
FOR – 4 MUST DO	All services	Ward environments must be clean, secure and well-maintained.	Peter Wright (Executive Director – Forensic Services)	Hospital General managers	• Linked to FOR-7 & 9] • dentify the nature of the problem with front line teams • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams		Action plan in place by 30 June 2019 with changes being tested and impact measured		

					All services to increase staff awareness t All services o embed and sustain chan All services ge. • Test the change ideas • Implement change and sustain the improvement		throughout August, September and October 2019.		
FOR – 5 MUST DO	All services	All staff must have easy access to and know how to use emergency equipment	Dr Julie Hankin (Medical Director)	Hospital General Managers	• Linked to FOR-6 • Link with the Quality Improvement Hub on developing a QI project on 'Managing the Clinic Room'.		QI Project plan in place by 31st July 2019, with changes being tested and impact measured throughout August, September and October 2019		
FOR – 6 MUST DO	All services	All clinical equipment imust be checked in line with the trust's policy.	Dr Julie Hankin (Medical Director)	Hospital General Managers	• Linked to FOR5 • Link with the Quality Improvement Hub on developing a QI project on 'Managing the Clinic Room'.		QI Project plan in place by 31st July 2019, with changes being tested and impact measured throughout August, September and October 2019		
FOR – 7 MUST DO	All services	Effective governance arrangements must be in place to monitor and review practice; ensure environments are safe; and audits and ocmplaints	Peter Wright (Executive Director – Forensic Services)	Hospital General managers	• Linked to FOR-4 & 9 • Identify the nature of the problem with front line teams • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. • Test the change ideas • Implement change and sustain the improvement		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
FOR – 8 MUST DO	All services	Staff must use tools to monitor deterioration in patients' physical health in line with national guidance	Dr Julie Hankin (Medical Director)	Hospital General Managers	Marina Gibbs to link with the Quality Improvement Hub on developing a QI project plan.		QI Project plan in place by 31st July 2019, with changes being tested and impact measured throughout		

							All services August, September and October 2019		
FOR – 9 MUST DO	All services	Effective systems must be in place to record when changes are made to the care environment as a result of recommendations from environmental risk assessments.	Peter Wright (Executive Director – Forensic Services)	Hospital General managers	• Linked to FOR-4 & 7 • Identify the nature of the problem with front line teams • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. • Test the change ideas • Implement change and sustain the improvement		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		

FOR – A
SHOULD DO
		The trust should ensure all staff maintain accurate records of supervision	Dr Deb Wildgoose (Interim Director of Nursing)	Hospital General managers with support from Rachel Chamberlain, Deputy Matron	• Establish a short term task and finish group to:
					  • Introduce supervision tree template
					  • Identify the nature of the problem with front line teams
					  • Agree change ideas to achieve the improvement
					  • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change.
					  • Test the change ideas
					  • Implement change and sustain the improvement
							Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		

FOR – A SHOULD DO		The trust should ensure all staff have access to regular team meetings	Dr Julie Hankin (Medical Director)	Hospital General Managers	• Identify the nature of the problem with front line staff. • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. • Test the change ideas • Implement change and sustain the improvement		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
FOR – A SHOULD DO		The trust should ensure all seclusion facilities have a working clock to enable patients to orient themselves to the time of day.	Dr Julie Hankin (Medical Director)	Hospital General Managers	• Identify the nature of the problem with front line staff. • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams to increase staff awareness to		Action plan in place by 30 June 2019 with changes being tested and impact		

					embed and sustain change. • Test the change ideas • Implement change and sustain the improvement		measured throughout August, September and October 2019.		
FOR – A SHOULD DO		The trust should ensure appropriate mitigations are in place to support staff to maintain sight of all areas of the wards	Dr Julie Hankin (Medical Director)	Hospital General Managers	• Identify the nature of the problem with front line staff. • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. • Test the change ideas • Implement change and sustain the improvement		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
FOR – A SHOULD DO		The trust should ensure staff respect patients' privacy and dignity when being nursed in seclusion	Dr Julie Hankin (Medical Director)	Hospital General Managers	• Clear statements: ○ On respecting the dignity of patients under observation including gender of staff providing supervision ○ On providing patients an opportunity to state their preference and record this. • Review patient rights information leaflet.		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
FOR – A SHOULD DO		The trust should ensure patient identifiable information is not visible between wards.	Dr Julie Hankin (Medical Director)	Hospital General Managers	• Establish a short term task and finish group to: ○ Identify the nature of the problem with front line teams ○ Agree change ideas to achieve the improvement ○ Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. ○ Test the change ideas • Implement change and sustain the improvement		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
FOR – A SHOULD DO		The trust should ensure staff review the need for falls assessments for patients who are at risk of falls and develop subsequent care plans.	Dr Deb Wildgoose (Interim Director of Nursing)	Hospital General Managers Dave Mason (Associate Director of Nursing – Forensic	• Identify the nature of the problem with front line staff. • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. • Test the change ideas				

				Services)	• Implement change and sustain the improvement				
FOR – A SHOULD DO		The trust should ensure systems are in place to ensure patients' belongings are stored safely in an organised fashion.		Hospital General Managers	• Identify the nature of the problem with front line staff. • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. • Test the change ideas • Implement change and sustain the improvement				
FOR – A SHOULD DO		The trust should ensure all patients are offered a copy of their care plan and that this is clearly recorded.	Dr Deb Wildgoose (Interim Director of Nursing)	Hospital General Managers	• Link to be made with the Quality Improvement Hub on developing a QI project plan • Identify the nature of the problem with front line teams and patients • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams Implement change and sustain the improvement		QI plan in place by 31st July 2019, with changes being tested and impact measured throughout August, September and October 2019		
FOR – A SHOULD DO		The trust should ensure all staff have easy access to occupational health support within the provider	Clare Teeney (Director of HR)	Alex Lyon (Culture and Engagement Manager)	• Identify the nature of the problem and the risks with front line staff. • Agree change ideas to achieve the improvement • Identify, lead and implement changes with frontline teams to increase staff awareness to embed and sustain change. • Test the change ideas • Implement change and sustain the improvement		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.		
FOR – A SHOULD DO		The trust should consider reviewing the current blanket restrictions placed on patients.	Dr Julie Hankin (Medical Director)	Dave Mason (Associate Director of Nursing and Patient Experience)	Compliance Assurance (CARe) review of areas affected to identify use of blanket restrictions Directorate least restrictive practice meetings to be reinstated.		Action plan in place by 30 June 2019 with changes being tested and impact measured throughout August, September and October 2019.	27/06/19: CARe review planned 21/06/19: First of the reinstated restrictive practice meetings has taken place.	
FOR – A SHOULD DO		The trust should consider reviewing the time frames allocated for handovers between shifts to ensure staff have the opportunity to hold	Dr Julie Hankin (Medical Director)	Hospital General Managers	• Identify the nature of the problem with front line staff. • Agree change ideas to achieve the improvement • Identify, lead and implement		Action plan in place by 30 June 2019 with changes being tested		

		effective handover meetings.			changes with frontline teams to increase staff awareness to embed and sustain change. • Test the change ideas • Implement change and sustain the improvement		and impact measured throughout August, September and October 2019.		

Nottinghamshire Healthcare NHS Foundation Trust

Inspection report

Duncan Macmillan House
Porchester Road
Nottingham
Nottinghamshire
NG3 6AA
Tel: 01159691300
www.nottinghamshirehealthcare.nhs.uk

Date of inspection visit: 22 Jan to 07 Mar 2019
Date of publication: 24/05/2019

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

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

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

Ratings

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

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

Summary of findings

Background to the trust

Nottinghamshire Healthcare NHS Foundation Trust is an integrated healthcare provider and provides community health care and mental health care including high secure services across 140 locations. The trust operates within a budget of £456 million. It became a foundation trust in 2015.

The population served by the trust is 1,090,495 within Nottingham City and Nottinghamshire, with some of the services offered nationally (England and Wales) or regionally (East Midlands and South Yorkshire). They have 1,872,000 patient contacts annually. The trust employs 8,800 staff.

The trust provides the following mental health core services:

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

Other services include:

- Specialist perinatal inpatient and community services (mother and baby)
- Specialist eating disorder services
- Inpatient substance misuse services
- Rapid response liaison psychiatry

The trust provides healthcare into six prisons across the East Midlands and South Yorkshire and one immigration removal centre.

The trust provides the following community health core services:

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

Other services include:

Summary of findings

- Community dental services.

Services are commissioned by:

- Newark and Sherwood Clinical Commissioning Group
- Nottingham City Commissioning Group
- Nottinghamshire Clinical Commissioning Group
- NHS England – Forensic services, Offender Health, and Dental Services
- Nottingham City Council – Substance misuse services.

The trust is part of the Nottinghamshire Integrated Care System and a Sustainability and Transformation Programme in South Yorkshire.

Nottinghamshire Healthcare NHS Trust first registered with Care Quality Commission on 1 April 2010.

The first comprehensive inspection of this trust was in May 2014 and we rated the trust as 'good' overall.

The second comprehensive inspection occurred in November 2017 and we rated the trust as good overall. We told the trust it must act to bring services into line with 25 legal requirements and this related to four core services:

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

- The trust must ensure that seclusion facilities at the Willows and Lucy Wade Unit meet Mental Health Act Code of Practice requirements.
- The trust must ensure that staff record clinic room and medicines fridge temperature checks.
- The trust must ensure that staff take the necessary action to ensure that medicines remain safe to use when fridge temperatures exceed maximum temperature ranges.
- The trust must ensure that staff check resuscitation equipment regularly.
- The trust must ensure that staff sign for medicines administered to patients.
- The trust must ensure that staff make checks of controlled drugs in accordance with trust policy and guidance.
- The trust must ensure that staff protect the privacy and confidentiality of patients at all times.
- The trust must ensure that staff share copies of care plans with patients and that this is demonstrated in patients' records.
- The trust must ensure that patients admitted to wards have access to psychological therapies.
- The trust must ensure that Section 17 leave forms are complete and staff make copies available to patients, family members and carers.
- The trust must ensure that staff provide patients with information in accordance with Section 132 of the Mental Health Act.
- The trust must ensure that staff make capacity assessments that are decision specific and evidence thorough discussions and outcomes in patient records.

In specialist community mental health services for children and young people:

- The trust must ensure that clinic rooms are clean, secure and contain equipment that is in date and suitable for the purpose for which they are being used.

Summary of findings

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

In community health inpatient services:

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

These breaches related to the following regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

Regulation 9 – person centred care

Regulation 10 – dignity and respect

Regulation 11 – need for consent

Regulation 12 – safe care and treatment

Regulation 13 - safeguarding service users from abuse and improper treatment

Regulation 15 – safety and suitability of premises.

Regulation 17 –good governance

Regulation 18 – staffing

Following the inspection in 2017, we monitored the action plans addressing the regulatory breaches.

We carried out focused inspections on wards for people with learning difficulties, child and adolescent wards and community child and adolescent services We published these reports on 23 December 2015.

We carried out focused inspections on acute psychiatric wards and psychiatric intensive care units and published this report on 14 February 2017.

We published focused inspection reports for Rampton Secure Hospital on 26 July 2016 and 26 October 2016. We published comprehensive inspection reports of Rampton Secure Hospital on 15 June 2017 and 8 June 2018.

We carried out focused inspection on Orion unit for people with learning difficulties which we published on 18 August 2018.

Summary of findings

We carried out 35 Mental Health Act monitoring visits between April 2017 and March 2018. Action plans followed the visits and monitoring took place through engagement meetings.

Overall summary

Our rating of this trust went down since our last inspection. We rated it as Requires improvement 

What this trust does

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

Key questions and ratings

We inspect and regulate healthcare service providers in England.

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

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

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

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

We inspected six core services, selected due to their previous inspection ratings or our ongoing monitoring identified that an inspection at this time was appropriate to understand the quality of the service provided.

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

What we found

Overall trust

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

- The executive team lacked confidence in in carrying out actions in between one chief executive retiring and another commencing. The chair was on various boards outside of the trust. The impact of this resulted in some loss of leadership focus and action within the trust.
- Trust executives had large and diverse portfolios and invested time in supporting the work of the local Integrated Care System, seen as a priority because it was addressing some of the challenges faced by the trust in ensuring that service development occurred in the right places. However, the executives were struggling to find the right balance between attending to internal versus external priorities. Leaders recognised that they needed to increase management and leadership capacity to deal with organisational development, IT, and the provision of business support.

Summary of findings

- The trust did not have an effective structured and systematic approach to staff engagement. Relationships between Rampton Hospital medical consultants and management had broken down. The involvement of clinical leaders in managerial decision making had significantly weakened across most areas of the organisation. The 2018 staff survey results showed that in all areas the trust was below its comparator group. Morale and staff engagement were equivalent to the worst score.
- The trust did not always follow best practice in handling of concerns raised by staff. Not all staff felt able to raise concerns without fear of retribution.
- The workforce race equality standard showed a decrease in the number of that staff who believed the trust provided opportunities for career progression and promotion and was worse than the national average.
- The trust reported a vacancy rate for all staff of 11% as of 30 September 2018. With an overall vacancy rate of 14% for registered nurses as of 30 September 2018. Between 1 October 2017 and 30 September 2018, of the (1,106,346) total working hours available, bank staff filled 24% to cover sickness, absence, or vacancy for nursing assistants. Safe staffing levels were not met consistently across three services inspected. These were the health based place of safety, forensic services, and adult acute admission wards.
- The board assurance framework included a number of risks that were considered to be high impact risks. The board has kept these risks under regular monthly review.
- We identified deficiencies in the governance of the Mental Health Act. Staff did not always explain to patients on community treatment orders what their rights were under the Mental Health Act nor did the trust audit this issue. The trust had audited the obtaining of consent to treatment of patients detained under the Act but had not acted on the findings to bring about an improvement in practice. The hospital managers were on fixed term contracts. Hospital managers hear appeals against detention under the Mental Health Act and the Mental Health Act Code of Practice stipulates their duties.
- Where cost improvements were taking place, it was not always clear they did not compromise patient safety and care. Consultants and clinical directors said consideration of clinical advice did not occur as part of the process of agreeing cost improvements and monitoring the impact on patient care. Of note, some cost improvement programmes that indicated a high impact on quality score had no recommendation as whether the programme should stop or continue, considering the impact on quality.
- Medication management was not robust. There was inconstancy in the application of the medicine policy in the correct storage of medication, temperature monitoring and routinely recording fridge temperatures and the safe storage of medication when taken out into the community.
- Staff did not always use audits and complaints effectively to make improvements to the care and treatment delivered to patients or demonstrate that staff consistently shared and discussed essential information, such as learning from incidents.
- Compromising of privacy occurred on acute ward bedrooms by male staff observing female patients without telling them. The trust had dormitories which impacted on privacy and dignity. Patient information on white boards in offices compromised confidentiality due to visibility through office windows.
- We found two services, adult acute admission wards and forensics, had deteriorated since the last inspection especially in the safe domains.

However:

- We rated 12 out of 16 services as good overall this include the previous ratings of services not inspected this time.

Summary of findings

- Fit and proper person checks were in place. Public governors were actively involved in the operation of the trust and took part in the programme of board visits to services.
- Leadership development opportunities were available, including opportunities for staff below team manager level.
- The trust had a clear vision and set of values with quality and sustainability as the top priorities. The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in Integrated Care System plans. The trust had planned services to take into account the needs of the local population.
- Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care.
- The ward/service team and division had access to feedback from patients, carers and staff and were using this to make improvements.
- There were organisational systems to support improvement and innovation work.
- The trust demonstrated a commitment to research and partnership with universities. There was involvement in national projects such as reducing restrictive interventions including black and minority ethnic restraint. The National Institute for Health and Care Excellence have recognised the trust's restrictive practice training manual and the trust will be a pilot site for the new NHS Equality Delivery System 3.

Are services safe?

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

- We rated five out of 16 services as requires improvement and two as inadequate in the safe key question. Our rating took into account the previous ratings of services not inspected this time.
- For two of the services that we inspected on this occasion, we had concerns about the quality of the environment. In the child and adolescent wards there was a low wall between the communal areas that could be a risk to patients and staff safety if a patient climbed onto it. The wards had problems with the heating system and safety alarm directed staff to the wrong ward. The trust was working with contractors to resolve the issues. Staff did not make sure that all of the forensic wards were kept clean.
- Medication management was not robust. There was inconstancy in the application of the medicine policy in the correct storage of medication, temperature monitoring and routinely recording fridge temperatures and the safe storage of medication when taken out into the community.
- Staff did not always follow the trust's policy around monitoring patients' physical health after administering rapid tranquilisation medication in the acute and forensic services.
- The trust did not meet safe staffing levels across three services inspected. These were the health based place of safety, forensic services, and adult acute admission wards. The trust risk register listed staffing as a major risk and the trust had a robust recruitment and retention strategy in place.
- We found blanket restrictions in place across acute admission wards.

However:

- In five services inspected, the clinical premises where staff saw patients were safe and clean. Staff followed best practice in infection control.
- Staff assessed and managed risk well. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.

Summary of findings

- In all services inspected staff followed good practice with respect to safeguarding. Staff understood how to protect patients from abuse and exploitation and worked well with other agencies to do so. Staff had training on how to recognise and report abuse and or exploitation and they knew how to apply it. There was an identified named nurse and doctor for child protection.
- The community teams we inspected had manageable caseloads and patients had crisis plans in place.

Are services effective?

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

- In all services we inspected staff assessed the physical and mental health of all patients on admission. Staff developed individual care plans which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs.
- In all services we inspected, staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They supported patients to live healthier lives.
- In all services we inspected staff used recognised rating scales to assess and record severity and outcomes. They also took part in clinical audit, benchmarking, and quality improvement initiatives.
- All clinical teams included or had access to the full range of specialists needed to meet the needs of patients under their care. Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff with appraisals, supervision, opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from all disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The clinical team had effective working relationships with other relevant teams within the trust and with relevant services outside the organisation. They engaged with them early in the patient's admission to plan discharge.
- Staff in all services understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff in all services supported patients to make decisions about their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- We rated three out of 16 services as requires improvement for the effective domain. Our rating took into account the previous ratings of services not inspected this time.
- In three services the quality of care plans was mixed. Care plans were not always personalised, holistic and recovery oriented. In some services staff either did not give, or did not record that they had given patients copies of their care plans.
- In two services staff did not always record or undertake appropriate physical healthcare checks.
- In two services staff either did not record staff supervision in line with the trust's policy, or the rates of supervision were low.
- In two services staff did not monitor adherence to or audit the use of the Mental Capacity Act to identify areas for improvement.

- In two services there was limited access to psychological therapies, due to a low number of psychologists.

Are services caring?

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

- We rated 13 out of 16 services as good and two as outstanding for the caring domain. Our ratings took into account the previous ratings of services not inspected this time.
- In all services, staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment, or condition.
- In all services staff involved patients and carers when planning care and actively sought their feedback on the quality of care provided. Staff ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers fully and appropriately in assessments and in the design of care and treatment interventions.

However:

- Staff on the acute admission wards did not always ensure the privacy and confidentiality of patients. The privacy blinds of patients' doors were left open including when patients were asleep and male staff observed female patients through blinds without informing them. On three wards information boards that contained patient details were visible from the ward.
- At the time of our inspection, the trust did not provide information in an accessible format in the child and adolescent mental health service. Some parents we spoke with had not received general information before their child's admission including visiting times and how to make a complaint.

Are services responsive?

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

- We rated five out of 16 services as requires improvement in the responsive domain. Our rating took into account the previous ratings of services not inspected this time.
- The trust did not always protect patients' privacy and dignity in their delivery of care and treatment. There were dormitories on B2 ward at Bassetlaw Hospital and Orchid ward. In another service patients were not always able to make a phone call in private.
- In one service staff did not routinely provide patients and carers with information about how to raise a concern or complaint. In another service staff did not always use complaints as an opportunity to learn or make improvements to the quality of care they delivered.
- In the acute admission wards families and patients could not always access the family room because staff used this as a health based place of safety for patients when the designated suite was in use.
- In the acute admission wards beds were not always available locally when needed. However, the trust had commissioned 16 male and 16 female acute beds to reduce the number of out of area placements and ensure more people received care and treatment close to their home area. There were 314 out of area placements between October 2017 and September 2018. Bed occupancy was at 104% across the service. Patients' beds were not available to them when they returned from leave. The wards used the health based places of safety at Highbury Hospital and Millbrook Mental Health Unit when they could not find a bed. Staff called these 'step up beds.'

However:

Summary of findings

- Staff planned and managed discharges well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway.
- In the child and adolescent mental health and forensic services the design, layout and furnishings of the wards supported patients' treatment.
- Services met the needs of all patients who use the service, including those with a protected characteristic under the Equality Act (2010). Staff helped patients with communication, advocacy, and spiritual support.
- Three services treated concerns and complaints seriously, investigated them, learned lessons from the results and shared these with the whole team and the wider service.
- Staff supported patients to engage with activities and work opportunities within the wider community and encouraged patients to maintain relationships with people that mattered to them.

Are services well-led?

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

- We rated two services as requires improvement in the well-led domain and one as inadequate. Our rating took into account the previous ratings of services not inspected this time.
- Overall the safety of services had deteriorated since our last inspection. In acute wards and psychiatric intensive care units our rating went down from requires improvement to inadequate. In forensic inpatient services our rating for safe went down from good to inadequate.
- The executive team lacked confidence in carrying out actions in between one chief executive retiring and another commencing. The chair was on various boards outside of the trust. The impact of this led to some loss of leadership focus and action within the trust.
- There was a disconnect between operational staff and the board in the communication of messages and a lack of consultation and engagement. Relationships between Rampton Hospital medical consultants and management had continued to deteriorate since our last two inspections in 2017 and 2018. Staff did not feel equally respected, supported and valued across all sectors within the trust. The 2018 staff survey results showed in all areas the trust sat below its comparator group and towards the lower end of the scoring range. Morale and staff engagement were equivalent to the worst score.
- The board assurance framework included a number of risks that were considered to be high impact risks. The board had kept these risks under regular monthly review. Staff and clinical engagement and culture was not specifically defined as one of the organisations top risks despite the deterioration in staff survey results and engagement culture of the organisation since the last inspection.
- The handling of concerns raised by staff did not always met with best practice. Not all staff felt able to raise concerns without fear of retribution.
- The workforce race equality standard showed a decrease in the number of that staff who believed the trust provided opportunities for career progression and promotion and was worse than the national average.
- Where cost improvements were taking place, it was not always clear they did not compromise patient safety and care.
- Staff did not always manage medicines well in five of the services that we inspected on this occasion for example: - medicine fridge temperatures on a ward in the child and adolescent service and an adult community mental health team were higher than recommended for safe storage on several occasions but staff had not reported this to the pharmacy team to resolve. Staff in the crisis service did not always follow trust guidelines in relation to medicines

management. Staff in the forensic services did not always follow best practice when storing, dispensing, and recording the use of medicines. One adult community mental health did not follow safe storage of medication guidance when taking medicines out into the community. On three wards staff did not record the date that they had opened patient medications.

- Sharing the lessons learnt through audits or complaints to change practice did not consistently happen. We found issues raised in previous inspections had not consistently changed mental health observation practice in forensic services. Checks of resuscitation equipment had not consistently occurred in three services. Physical health checks following rapid tranquilisation did not occur in four services.

However:

- We rated 13 out of 16 services as good in the well-led domain. Our rating took into account the previous ratings of services not inspected this time.
- The trust had a clear vision and set of values with quality and sustainability as the top priorities. The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders.
- In all the core services we inspected leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed. In five of the services leaders were visible in the service and approachable for patients and staff.
- All teams had access to the information they needed to provide safe, effective care and used that information to good effect.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well in five of the services we inspected.
- Staff in all services engaged actively in local and national quality improvement activities.
- Fit and proper person checks were in place. Public governors were actively involved in the operation of the trust and took part in the programme of board visits to services.
- Leadership development opportunities were available, including opportunities for staff below team manager level.
- There were organisational systems to support improvement and innovation work. There was a strong programme of staff training.
- The trust demonstrated a commitment to research and partnership with universities. There was involvement in national projects such as reducing restrictive interventions including a black and minority ethnic restraint project. The National Institute for Health and Care Excellence had recognised the trust's restrictive practice training manual and the trust will be a pilot site for the new NHS Equality Delivery System 3.

Ratings tables

See guidance note 8 then replace this text with your report content.

Outstanding practice

Community mental health services for people a learning disability or autism

We a saw good evidence of the trust engaging with the Stopping Over-Medication of People with a Learning Disability, Autism, or Both pledge for healthcare providers. This included the establishment of a working group that had met regularly since September 2018. Actions have included ensuring Stopping Over-Medication of People with a Learning Disability, Autism, or Both is publicised in local pharmacies, psychiatrist led training sessions for GPs and learning lessons from the experience of other trusts in implementing the pledge.

Summary of findings

Staff in the epilepsy service worked across Nottinghamshire to provide a comprehensive service for adults with epilepsy and learning disability. Staff provided appointments in neurology outpatient clinics and at community visits. The service provided training to staff within the trust and staff and carers from external organisations. Within this service, staff and patients had developed a range of easy read leaflets and accompanying short films. The leaflets and films included information about the service, living well with epilepsy and having diagnostic tests. The trust made these available on its website.

Forensic inpatient or secure wards

The trust supported patients to access an extensive range of vocational opportunities. For example, at Wathwood Hospital, patients were offered vocational opportunities within the farm shop which was open to the public at weekends and patients had made statues and garden ornaments that members of the public could purchase. Patients also participated in the running of a restaurant which was open to the public at specific times.

The trust used innovative technology to support patients effectively. For example, Wathwood Hospital were piloting the use of electronic devices to record patient observations. At Arnold Lodge, the trust had introduced a communication wall to support patients in the seclusion suite of the male mental illness service, called the Cowall.

Trust wide

A clinical development unit was developing to support future capacity and capability across the local healthcare system and trust. The provision of technical, statistical, clinical, and public health expertise helped the unit support the development of clinical information for staff.

The trust had started to enable clinicians to access the GP repository clinical care electronic system, to undertake checks against the serious mental illness database which will show whether interventions had been offered in primary care.

Peer flu vaccination schemes had increased the uptake of flu vaccinations by providing vaccinations within the workplace.

The trust held a regional “Patient feedback matters” conference to discuss their approaches to patient feedback. It demonstrated through its electronic platform survey results in 2018 in which it received 180,062 responses about its service of which 25,859 comments stated what the trust could do better and 67,919 comments said what the trust did well. Care opinion responses resulted in 296 patient stories leading to change.

Areas for improvement

Action the trust MUST take to improve

Trust wide

- The trust must review the governance structures to ensure adequate oversight of key performance areas across the organisation including clinical / staff engagement, the shared learning and lessons across all staff groups and cost improvement programmes. **Regulation 17.**

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

- The trust must ensure there are enough suitable and qualified staff on the ward. There should be sufficient staff on the ward to ensure patients have access to leave and one to one sessions with their named nurse. **Regulation 18 (1).**
- The trust must ensure that staff carry out physical health observations after rapid tranquilisation in line with trust policy and national guidance. **Regulation 12 (1) (2) b.**
- The trust must ensure that staff carry out checks of resuscitation equipment on all wards to ensure it is safe to use and ensure adrenaline is fit for use and stored in a place where there is immediacy of access. **Regulation 15 (1) e.**

Summary of findings

- The trust must ensure that it reviews blanket restrictions on B2 wards so that patients are individually risk assessed for restrictions relating to accessing sleeping areas and bedrooms. **Regulation 9 (1) a b c.**
- The trust must ensure that staff follow physical health care planning and complete physical health observations for patients when required throughout admission. **Regulation 12 (1) (2) b.**
- The trust must ensure that staff ensure the privacy of patients on the ward when observations are carried out. **Regulation 10 (2) a.**
- The trust must ensure that it has effective governance structures to ensure that supervision and team meetings take place and that learning from incidents and complaints are recorded. **Regulation 17 (2).**
- The trust must ensure risk assessments are in place and that they contain all relevant risk information. **Regulation 12 (1) (2) b.**

Community-based mental health services of adults of working age

- The trust must ensure that every location complies with guidance on the correct storage of medication, temperature monitoring and routinely recording fridge temperatures and the safe storage of medication when taken out into the community. **Regulation 12(1,2) g.**

Child and adolescent mental health wards

- The trust must ensure that all staff safeguard patient's information so that it cannot be seen by visitors to the ward or other patients. **Regulation 17 (1) (2) c.**

Community mental health services for people with a learning disability or autism

- The trust must ensure staff routinely provide patients and carers with information about how to raise a concern or complaint. **Regulation 16 (2).**

Forensic inpatient or secure wards

- The trust must ensure there are enough staff to support the safe and effective care and treatment of patients. **Regulation 18 (1).**
- The trust must ensure that staff follow best practice when storing, dispensing, and recording the use of medicines, including rapid tranquilisation. **Regulation 12 (1) (2) g**.
- The trust must ensure that staff carry out physical health observations after administering rapid tranquilisation in line with trust policy and national guidance. **Regulation 12 (1) (2) b.**
- The trust must ensure the ward environments are clean, secure and well-maintained. **Regulation 15 (1) (a) (c) (e).**
- The trust must ensure that all staff have easy access to and know how to use emergency equipment. **Regulation 12 (1) (2) (a) (b) (c) (e)**.
- The trust must ensure all clinical equipment is checked in line with the trust's policy. **Regulation 15 (c) (e)**.
- The trust must ensure that effective governance arrangements are in place to ensure systems are set up to monitor, review and improve practice as well as providing assurance that the ward environments are safe at all times. This includes ensuring audits and complaints are used effectively to identify issues and encourage improvement **Regulation 17 (1) (2) (a).**
- The trust must ensure that staff use tools to monitor deterioration in patients' physical health in line with national guidance. **Regulation 12 (1) (2) (a) (b).**

Summary of findings

- The trust must ensure that staff follow the trust's policies and procedures for the use of observation. **Regulation 12 (1) (2) (a) (b)**.
- The trust must ensure systems are effective in implementing and recording when changes are made to the care environment as a result of recommendations from environmental risk assessments. **Regulation 12 (1) (2) (a) (b).**

Mental health crisis services and health-based places of safety

- The trust must ensure staff follow medicine management policy. **Regulation 12 (2)(g).**
- The trust must ensure the places of safety are safe and secure. **Regulation 15 (1)(c).**
- The trust must make sure that staffing levels are safe. **Regulation 18 (1).**

Action the trust SHOULD take to improve

Trust wide

- The trust should consider how it will strengthen its clinical leadership and engagement of clinical staff, building up relationships with the Rampton Hospital consultants. **Regulation 17 (2) e.**
- Leaders should consider the level of support needed to balance internal portfolios with the work needed to take part in the Integrated Care System.
- The trust should continue to work on developing a culture that enables staff to raise concerns without fear.

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

- The trust should ensure that information that is recorded on patients' information boards is not visible from the ward when the boards are not in use. **Regulation 10 (2) a.**
- The trust should ensure patient community meetings go ahead when planned and that these are recorded along with any actions from these meetings. **Regulation 10 (2) b.**
- The trust should ensure that they offer a full programme of activities on all wards. **Regulation 9 (a).**
- The trust should ensure that it has an action plan to eradicate dormitories at Bassetlaw Hospital and Millbrook Mental Health Unit. **Regulation 15 (c).**
- The trust should ensure that it regularly reviews blanket restrictions, and make sure that when restrictions are in place they are necessary and individually risk assessed including those which restrict patient's access to fresh air and cutlery and crockery. **Regulation 9 (1) (a b c).**
- The trust should ensure that there is access to psychological therapies for all patients who require this. **Regulation 9 (a).**
- The trust should ensure that all staff can open all anti barricade door systems in case of emergency. **Regulation 12 (2) (b).**
- The trust should ensure that staff work with patients to create fully holistic and recovery focused care plans and that staff record when they have offered patients a copy of their care plan. **Regulation 9 (1) (a b c).**
- The trust should ensure that staff record the date that they open patient's medication that becomes short dated once opened when opened. **Regulation 12 (2) (g).**
- The trust should ensure that they offer adequate support to newly qualified nurses. **Regulation 18 (2) (a).**

Summary of findings

- The trust should ensure that patients have pro re nata (PRN) care plans in place for medication that had been prescribed for patients to take regularly. **Regulation 12 (2) (g).**
- The trust should ensure that there is a notice on all wards explaining to informal patients how to leave the ward. **Regulation (13) (7) (b).**
- The trust should ensure that there are safeguarding processes in place that protect patients from financial abuse from staff and that staff undertake activity in line with policy. **Regulation (13) (2).**
- The trust should review bed usage, capacity and readmission rates. The trust should monitor the number of times a bed is not available to a patient when they return from leave. **Regulation 17 (2) (a).**
- The trust should ensure that wards share best practice with each other so that where processes work well they are implemented across the wards to achieve consistency. **Regulation 17 (2).**
- The trust should ensure that staff are familiar with the trust's vision and values.

Child and adolescent mental health wards

- The trust should continue to act to resolve the building issues including the heating and alarm system. **Regulation 15 (1) (c, e).**
- The trust should make sure that each patient who needs them has a personal emergency evacuation plan that is updated when they move around wards including the seclusion room. **Regulation 12 (2) (a).**
- The trust should consider the risks of a patient being able to access the smoke alarm in the seclusion room by standing on the bed. **Regulation 12 (2) (a, b, d).**
- The trust should make sure that the temperatures of all medication fridges are within the recommended range for safe medicines storage. **Regulation 12 (2) (g).**
- The trust should ensure that all staff have opportunities for specialised training in eating disorders and the needs of patients admitted to psychiatric intensive care units. **Regulation 18 (2) (a).**
- The trust should consider how staff scan patients paper records into the electronic patient records system to ensure the information can be used effectively by all staff. **Regulation 17 (2) (c).**
- The trust should consider training other staff than doctors in phlebotomy to increase the number of staff who can carry out patients' blood tests**. Regulation 18 (1).**
- The trust should fix the parental controls on the Wi-Fi so that patients have access to the Internet when appropriate. **Regulation 12 (2) (e).**
- The trust should ensure that all patients and their carers have information provided to them about the service and how to comment on it in an accessible format. **Regulation 9 (3) (g).**
- The trust should clearly communicate with staff who is responsible for issues involving the building so staff know who to report these to and how these are being managed. **Regulation 15 (1).**

Community mental health services for people with a learning disability or autism

- The trust should ensure staff always complete care plans to address the identified needs of patients. **Regulation 9, (3) (b).**
- The trust should ensure appraisal rates for all non-medical staff within the service meet its target appraisal rate. **Regulation 18, (2) (a).**

Summary of findings

- The trust should ensure staff record when they have offered or shared care plans with patients. **Regulation 9, (3) (b).**
- The trust should ensure processes are in place to involve patients in decisions about the intellectual and developmental disabilities services. **Regulation 9, (3) (f).**
- The trust should ensure the agendas and records from each professional group meeting follow a standardised framework to ensure that essential information is shared and discussed. **Regulation 17, (2) (a).**
- The trust should ensure that staff audits are effective to capture the quality of staff practice in the service. **Regulation 17, (2) (f).**

Forensic inpatient or secure wards

- The trust should ensure all staff maintain accurate records of supervision. **Regulation 17 (1) (2) (d).**
- The trust should ensure all staff have access to regular team meetings. **Regulation 17 (2).**
- The trust should ensure all seclusion facilities have a working clock to enable patients to orient themselves to the time of day. **Regulation 15 (1) (e).**
- The trust should ensure appropriate mitigations are in place to support staff to maintain sight of all areas of the wards. **Regulation 12 (1) (2) (a) (b).**
- The trust should ensure staff respect patients' privacy and dignity when being nursed in seclusion. **Regulation 10 (2) (a)**.
- The trust should ensure patient identifiable information is not visible between wards. **Regulation 10 (2) (a).**
- The trust should ensure staff review the need for falls assessments for patients who are at risk of falls and develop subsequent care plans. **Regulation 12 (1) (2) (a) (b).**
- The trust should ensure systems are in place to ensure patients' belongings are stored safely in an organised fashion. **Regulation 17 (1).**
- The trust should ensure all patients are offered a copy of their care plan and that this is clearly recorded. **Regulation 9 (3) (a) (b) (c) (d).**
- The trust should ensure all staff have easy access to occupational health support within the provider. **Regulation 17 (2) (b).**
- The trust should consider reviewing the current blanket restrictions placed on patients.
- The trust should consider reviewing the time frames allocated for handovers between shifts to ensure staff have the opportunity to hold effective handover meetings.

Mental health crisis services and health-based places of safety

- The trust should ensure the method of recording and completion of physical health checks is consistent across the crisis and home treatment service. **Regulation 9 (a).**
- The trust should ensure that all teams write care plans that are personalised, holistic and recovery orientated. **Regulation 9 (a) and (c).**
- The trust should ensure staff offer patients a copy of their care plan. **Regulation 9 (3) (g).**
- The trust should ensure team meetings take place regularly. **Regulation 18 (2)(a).**
- The trust should ensure that staff receive supervision and appraisal in line with their policy.

Summary of findings

Regulation 18 (2)(a).

- The trust should ensure the section 136 suites are appropriate for their usage**. Regulation 12 (2) (f).**
- The trust should ensure staff are able to raise concerns without fear of retribution. **Regulation 16 (2).**

Action we have taken

We found areas for improvement including 25 breaches of legal requirements that the trust must put right. We found 55 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

What happens next

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

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔🡐	🡅	🡅🡅	🡇	🡇🡇
Month Year = Date last rating published					

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ➔🡐 May 2019	Good ➔🡐 May 2019	Good ➔🡐 May 2019	Requires improvement 🡇 May 2019	Requires improvement 🡇 May 2019	Requires improvement 🡇 May 2019

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

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Jul 2014	Good Jul 2014	Good Jul 2014	Requires improvement Jul 2014	Good Jul 2014	Good Jul 2014
Community health services for children and young people	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2017
Community health inpatient services	Requires improvement ↓ Jan 2018	Requires improvement ↓ Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Requires improvement ↑ Jan 2018	Requires improvement ↓ Jan 2018
Community end of life care	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Overall*	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018

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

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate ↓ May 2019	Requires improvement →← May 2019	Requires improvement →← May 2019	Requires improvement →← May 2019	Inadequate ↓ May 2019	Inadequate ↓ May 2019
Long-stay or rehabilitation mental health wards for working age adults	Requires improvement Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Forensic inpatient or secure wards	Inadequate ↓↓ May 2019	Good →← May 2019	Good →← May 2019	Requires improvement →← May 2019	Requires improvement ↓ May 2019	Requires improvement ↓ May 2019
Child and adolescent mental health wards	Good May 2019	Requires improvement May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019
Wards for older people with mental health problems	Good Jul 2014	Good Jul 2014	Outstanding Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Wards for people with a learning disability or autism	Good ↑ Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018
Community-based mental health services for adults of working age	Good ↑↑ May 2019	Good ↑ May 2019	Good →← May 2019	Good →← May 2019	Good ↑ May 2019	Good ↑ May 2019
Mental health crisis services and health-based places of safety	Requires improvement ↓ May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019
Specialist community mental health services for children and young people	Requires improvement →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018
Community-based mental health services for older people	Good Jul 2014	Good Jul 2014	Outstanding Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Community mental health services for people with a learning disability or autism	Good ↑ May 2019	Good →← May 2019	Good →← May 2019	Requires improvement ↓ May 2019	Good →← May 2019	Good →← May 2019
Substance misuse services						
High secure hospital	Requires improvement →← Jun 2018	Good ↑ Jun 2018	Good →← Jun 2018	Requires improvement →← Jun 2018	Good ↑ Jun 2018	Requires improvement →← Jun 2018
Overall	Requires improvement →← May 2019	Good →← May 2019	Good →← May 2019	Requires improvement ↓ May 2019	Requires improvement ↓ May 2019	Requires improvement ↓ May 2019

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

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

Inadequate 

Key facts and figures

The acute wards and psychiatric intensive care units for adults of working age were provided over three sites in Nottinghamshire. The trust had a total of seven acute wards and one psychiatric intensive care unit. For this inspection we visited the following eight wards:

An acute inpatient ward at Bassetlaw Hospital in Worksop:

- B2 ward with 24 beds for both male and female patients.

Two acute inpatient wards at Millbrook Mental Health Unit at Kingsmill Hospital in Mansfield:

- Orchid Ward - 25 beds for male patients
- Lucy Wade Unit - 16 beds for female patients

Four acute inpatient wards at Highbury Hospital in Nottingham and Willows ward which was a psychiatric intensive care unit:

- Redwood 1- 16 beds for male patients
- Redwood 2- 16 beds for female patients
- Rowan 1-16 beds for male patients
- Rowan 2- 16 beds for female patients
- Willows ward- 10 beds for male patients.

At the last comprehensive inspection in November 2017, we rated the acute wards for adults of working age and psychiatric intensive care units as requires improvement overall. We rated all domains: safe, effective, caring, responsive and well led as requires improvement.

We found that the trust had breached regulations under the Health and Social Care act (regulated activities) Regulations 2014. We issued the trust with six requirement notices for acute wards for adults of working age and psychiatric intensive care units. These related to the following regulations under the Health and Social Care act (regulated activities) Regulations 2014:

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulation 10 HSCA (RA) Regulations 2014 Dignity and Respect

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulation 17 HSCA (RA) Regulations 2014 Good Governance

Regulation 11 HSCA Regulations 2014 Need for consent

At this inspection we saw that the trust had implemented nine of the twelve actions we told them they must make since the last inspection in March 2017.They had made progress regarding two of the actions outstanding. They had recruited specialist nurses to provide psychological interventions, but these nurses came into post after our

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

inspection, so we did not see increased psychological interventions in place. On six of the eight wards staff carried out checks of emergency resuscitation equipment, but on two this was not consistently happening. The trust had also made improvements in most of the areas we had said they should make changes. However, staff failed to consistently always protect the privacy of patients which was the case at our last inspection.

The current inspection was unannounced. During the inspection we carried out the following activities:

- looked at the quality of each of the ward environments and observed how staff were caring for patients
- interviewed the ward sites manager or senior nurse for each ward, two modern matrons and the service manager
- attended and observed multidisciplinary ward rounds and handovers
- spoke with 43 staff including an environmental coordinator, peer support worker, nurses, healthcare assistants, occupational therapists, a pharmacist, an activity coordinator, a ward clerk a psychologist and psychiatrists
- spoke with 25 patients, Healthwatch carried out 7 patient interviews in partnership with us
- reviewed 36 care records
- reviewed 64 electronic medicine administration records.

Summary of this service

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

- We found that there was inconsistency and lapses in governance across wards. Risk and safety were not always well managed including staffing and clinical activity that kept patients safe. There were issues with bed management and availability of beds. Supervision did not always take place and neither did team meetings, therefore there was inconsistent evidence of learning from complaints and incidents.
- Staff did not always monitor patients' physical health adequately and had sometimes not completed National Early Warning Scores when indicated. Staff did not always undertake physical observations after giving patients rapid tranquilisation
- Staff did not always carry out checks to see if emergency resuscitation equipment worked properly.
- Staff did not always manage risks well. We reviewed 36 care records. Five of these contained no record of a risk assessment and, in a further seven, the risk assessments were not fully developed or did not contain all the risk information required.
- On Lucy Wade Unit, some staff did not know how to open all the anti-barricade doors. There were three doors that had a different opening system. However, the trust was replacing these doors.
- Wards had restrictions in place. All patients had restricted access to outside space and there were various restrictions in relation to the use of crockery and cutlery that were not always individually risk assessed. On B2 ward, staff restricted female patients' access to bathrooms, toilets and bed space and male patients' access to bathrooms.
- There were not always sufficient staff numbers on the wards and the wards relied on bank staff. There were 23% of shifts where staff fill rates fell below 90% between July and September 2018. Staff told us they felt under pressure and that there were not always two nurses on the ward. This meant it was not always possible for a nurse to be available in communal ward areas and made it difficult for staff to offer patients one to one sessions. At the time of inspection staff vacancies had reduced but staffing continued to be reported as an ongoing issue.

- There were some omissions in medication management. We observed that patients did not have care plans for medication that doctors had prescribed patients to take as required. Also, staff did not always record the date that they opened patients' medication that became short dated when opened.
- Care plans were personalised but did not always demonstrate a holistic approach. In 15 of the 33 care plans we saw this was not the case.
- Patients had limited access to psychological therapies and activities. However, the trust had already taken steps to improve this and new staff started work following our inspection to provide this.
- Staff did not always ensure the privacy of patients. On some occasions, staff left the privacy blind on patients' bedroom doors open. We observed a male member of staff carrying out observations without telling female patients he was looking through the blinds. Also, on one ward we could clearly see patient information displayed on the patient information board, staff had not covered this when it was not in use.
- Patient community meetings did not always take place as planned on a weekly basis. Staff did not always record what patients had discussed at meetings or actions from them. There were areas for family visits, but these were not always available as these rooms were used as a place of safety when the 136 suites were unavailable.
- There were dormitories on B2 ward at Bassetlaw Hospital and Orchid ward. The trust was considering how they could eradicate dormitories however there were no firm plans in place at the time of inspection.
- Beds were not always available locally when needed. However, the trust had commissioned 16 male and 16 female acute beds to reduce the number of out of area placements and ensure more people received care and treatment close to their home area. There had been 314 occasions when a patient had been admitted to an out of area bed between October 2017 and September 2018. This had increased since our last inspection. The wards used the health based places of safety at Highbury Hospital and Millbrook Mental Health Unit when they could not find a bed as a short-term measure. Patients' beds were not always available to them when they returned from leave. The trust did not have current data about how often this happened.
- Staff were not familiar with the trust's vision and values.

However:

- Staff undertook regular environmental risk assessments. Wards were clean, and staff followed good practice in infection control, and checked equipment regularly.
- Staff were kind and responsive when interacting with patients. Patients engaged well with staff and spoke positively about how staff treated them. Staff supported patients to access education and work opportunities. Staff were trained to work with families and carers and did this well.
- Staff ensured that patients understood their rights under the Mental Health Act and followed trust policy in relation to patients' leave. Staff ensured patients had access to an independent mental health advocate who visited the wards and worked with patients. Staff supported patients to make decisions about their care for themselves, they assessed and recorded capacity where patients had impaired capacity.
- Staff understood how to protect patients from abuse and exploitation and worked well with other agencies to do so. Staff were comfortable to raise concerns about patient safety without fear of the consequences.
- Staff monitored side effects of medication and audits. They completed blood tests for patients who were being prescribed medication that required additional monitoring. Staff used recognised rating scales to assess and record severity and outcomes. Staff participated in clinical audits and took part in quality improvement activities.

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

Is the service safe?

Inadequate  

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

- The number of staff on the ward did not always meet the number planned. The ward relied heavily on bank staff. There were 23% of shifts where staff fill rates fell below 90% between July and September 2018. Staff told us that, because of staffing issues, one to one sessions and section 17 leave did not always go ahead. Staff were concerned that this affected the quality of care they were able to offer and told us that low staffing increased pressure on staff. However, the trust had recruited new staff and at the time of our inspection vacancies had reduced.
- Staff did not always carry out physical health checks after rapid tranquilisation. On Lucy Wade Unit, Orchid and Rowan 1 wards, we saw nine records where staff had administered rapid tranquilisation to patients. These records did not contain evidence that staff carried out physical observations or had attempted these.
- On Lucy Wade Unit and Orchid ward staff did not regularly check that the resuscitation equipment was safe to use. On these wards the adrenaline available to staff did not have its tamper proof seal intact and on B2 ward the adrenaline was stored in a locked cupboard which restricted immediacy of access.
- The completion and quality of risk assessments were inconsistent. We looked at 36 care records. There was no risk assessment recorded in five and, in a further seven, the risk management plan was incomplete.
- We found blanket restrictions in place across wards. On B2 ward, female patients could not access their dormitory or female toilets and bathrooms without asking staff for permission to do so. Female patients could use the disabled toilet on the ward. Staff locked male bathrooms and patients could not access these without asking staff. All wards had a variety of restrictions relating to cutlery and these were not always individually risk assessed. At Highbury Hospital, staff locked the doors to hospital gardens and patients had to ask staff to unlock the door if they wished to use the garden. On all these wards there were patients who were not detained there under the Mental Health Act at the time of inspection.
- There was no notice on Lucy Wade Unit explaining to informal patients how they could leave the ward if they wanted to.
- At our inspection we identified that a member of staff had both a bank card and the pin code for the card belonging to a patient. The patient had requested that staff buy items on their behalf. We discussed our concerns about this with staff and the issue was rectified immediately.
- We observed that patients did not have care plans for medication that doctors had prescribed patients to take as required. However, we saw that doctors reviewed as required medication at regular intervals. On B2, Lucy Wade Unit and Orchid ward, staff did not record the date that they had opened patients' medication.
- On Lucy Wade Unit, some staff did not know how to open all the anti-barricade doors. There were three doors that had a different opening system. The trust was replacing these doors.

However:

- Staff undertook regular environmental risk assessments including ligature risk assessments. They kept the wards clean, followed best practice in infection control, and serviced equipment regularly. Staff had access to alarms.
- Staff used restraint and seclusion only after attempts at de-escalation had failed. Staff participated in the trust's restrictive interventions reduction programme.

- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so.
- Staff completed blood tests for patients who were being prescribed medication that required additional monitoring; for example, clozapine or lithium.

Is the service effective?

Requires improvement ➔➔

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

- Although staff assessed patents' physical health on admission, they did not always undertake ongoing monitoring of their physical health throughout their stay. Staff had omitted observations that had been identified as required in physical health care planning. These included National Early Warning Scores, Malnutrition Universal Screening Tool and blood monitoring.
- The quality of patient care plans varied. Care plans were present in nearly all care records we reviewed and the majority of these were up to date. However, the quality of care plans was mixed. Care plans were personalised but not always fully holistic or focused on patients' strengths and recovery. In 15 of the care plans we reviewed, these areas were not developed sufficiently.
- There was limited access to psychological therapies, due to a low number of clinical psychologists. The trust had employed five specialist nurses who were trained in psychological interventions to facilitate this. These staff started in their new roles after our inspection.
- Staff, except for staff on B2 ward, reported that there were insufficient activities for patients. The trust had recruited a further six activity coordinators who started work after our inspection.

However:

- Staff discussed their rights under the Mental Health Act with patients in a way that they could understand, repeated it as required and recorded that they had done so.
- Staff recorded section 17 leave correctly and offered copies of leave forms to families and patients. Staff discussed patients' leave at handovers, ward rounds and clinical meetings.
- Ward staff worked well together as a team and had effective working relationships with other relevant teams within the organisation and relevant services outside the organisation.
- Staff supported patients to make decisions on their care for themselves. They assessed and recorded mental capacity clearly for patients who may have impaired mental capacity.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives

Is the service caring?

Requires improvement ➔➔

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

- Staff did not always ensure the privacy of patients. On Lucy Wade Unit, we saw male staff looking through the blinds of female patients' bedrooms to carry out observations without informing female patients. On Rowan 1 ward staff had left the privacy blinds of patients' doors open throughout the ward; including when patients were asleep. On one ward, a member of staff told us that there were insufficient keys for staff to open and close the blinds and therefore they left them open.
- On three wards, patient information boards were visible from the ward. The staff used a blind to keep these confidential but on Rowan 1 ward the blind was not pulled down when it was not in use and patient information could be viewed from the ward.
- Patient community meetings did not always go ahead as planned on a weekly basis. Staff did not always record what had been discussed at meetings or actions from them.
- Staff did not always record that they had offered patients a copy of their care plan Staff had made improvements since our last inspection in recording when they had given patients a care plan. However, staff had not done this for eight of the 36 care plans we looked at.

However:

- Staff were discreet, respectful and responsive when interacting with patients. Patients engaged well with staff and patients spoke positively about how staff treated them.
- Staff were comfortable to raise concerns about patient safety without fear of the consequences. Staff provided examples of when this had happened and worked with the trust's safeguarding team.
- There were carers leads on each ward, trained in behavioural family therapy. Staff informed and involved families and carers appropriately.
- Patients had access to an independent mental health advocate who visited the wards and worked with advocates on a regular basis.

Is the service responsive?

Requires improvement

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

- At Highbury Hospital the doors to gardens were kept locked at all times were always kept locked. This meant that patients could not freely access outside space including patients who were not detained under the Mental Health Act.
- There were areas for family visits but staff at Highbury Hospital and Millbrook Mental Health Unit told us that families and patients could not always access the family room as this was used as a place of safety when the 136 suite was in use.
- Bed occupancy was at 104% across the service. This meant that beds were not always available locally when needed. However, the trust had commissioned 16 male and 16 female acute beds to reduce the number of out of area placements and ensure more people received care and treatment close to their home area. There had been 314 instances of patients admitted to a bed out of area between October 2017 and September 2018. This had increased by 108 occasions since our last inspection. Also, patients' beds were not available to them when they returned from leave. The trust did not have current data about how often this happened

- There were dormitories on B2 ward at Bassetlaw Hospital and at Millbrook Mental Health Unit on Orchid ward. The trust was considering how they could eliminate dormitories but had no firm plans or dates set at the time of inspection.
- The wards used the health-based places of safety at Highbury Hospital and Millbrook Mental Health Unit when they could not find a bed. Staff called these 'step up beds.' This was a short-term measure. In the six months prior to our inspection these had been used on 26 occasions for step up and on 13 occasions for seclusion.

However:

- Staff supported patients to access education and work opportunities. They encouraged patients to have contact with friends and family.
- The wards met the needs of all people who use the service – including those with a protected characteristic.
- Staff listened to patients who made a complaint, knew how to handle complaints and gave feedback to patients.

Is the service well-led?

Inadequate 

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

- We found that there was inconsistency and lapses in governance across wards. Risk and safety were not always well managed including staffing and staff did not always carry out clinical activity required to keep patients safe. Risk assessments and records of observations of patients following rapid tranquilisation were not always in place and on two wards resuscitation equipment was not checked in line with policy. There were issues with bed management and availability of beds, both for newly admitted patients and patients who returned from leave. Supervision did not always take place and neither did team meetings, therefore there was inconsistent evidence of learning from complaints and incidents.
- Staff across the wards did not always work in a consistent way and share good ideas or best practice, this meant that staff missed opportunities to share best practice and achieve consistency.
- Staff were not familiar with the trust's vision and values, they were not able to talk about them and managers could not describe how they applied them to the work of their team.

However:

- Staff were positive about working with the patients and their team. They felt valued by managers who were visible and supportive.
- Staff engaged actively in quality improvement activities. The trust had an established programme of quality improvement and a team who supported staff.
- Staff were involved in audits and the trust had an internal audit programme to drive improvement.
- Managers had access to range of information and data to support them in their roles and the ward's performance.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Community-based mental health services of adults of working age

Good ↑

Key facts and figures

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

The last inspection of the service was undertaken in in October 2017. At that inspection the service was rated as requires improvement overall. We found:

At Rushcliffe local mental health team, we witnessed staff did not follow the trust's controlled drugs protocol. Interview rooms at some locations we inspected were not fitted with alarms. Not all staff had access to personal pinpoint alarms and lone worker devices although staff had requested them. Staff did not have rapid access to a psychiatrist when required. Patient information was stored in three separate areas, computerised patient record system, paper files and computerised shared drive.

Care plans were not personalised, holistic and recovery orientated and 14 patient care plans were not updated in line with patient need or change of circumstances. Staff said they did not have the skills and knowledge to meet the needs of the patient group. Training on the Mental Health Act and Mental Capacity Act at some local mental health team locations were below the trust's key performance indicators. At Rushcliffe, staff did not document whether they had reminded patients from time to time, of their rights. Staff were unsure where to obtain advice about applying the Mental Capacity Act to their practice.

Not all staff felt respected supported and valued. Staff did not feel positive and proud about working for the trust. Staff did not know the trust's vision and values and how they applied following the restructure of adult mental health services. Patients and carers were not involved in the decision-making process about the restructure of services and unaware they could meet members of the trust's senior leadership team and governors to give feedback. Social care staff said they were not consulted in the decision-making process regarding the restructure of adult mental health services. Senior leaders were not visible.

During this inspection we:

- visited local mental health teams at Bassetlaw, City North, City East, Broxtowe and Hucknall and Mansfield and Ashfield.
- undertook five tours of the service to look at the environment in which services are provided
- interviewed six patients and eight carers
- interviewed five managers or team leaders, 13 community psychiatric nurses, three health care support workers, two psychiatrists, three occupational therapists, two psychologists and one administrator
- reviewed 22 sets of patients records and 34 medication cards
- we looked at a range of risk assessments and other documentation including lone working policies, documentation relating to the safe use of equipment around the services, ligature risk assessments and fire risk assessments
- attended two multi-disciplinary team meetings, three patient appointments and two planning meetings

Community-based mental health services of adults of working age

- undertook a specific review into the safe storage, transportation and administration of controlled medication across all five of the services we visited.

Summary of this service

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

- The service provided safe care. Clinical premises where patients were seen were safe and clean. The number of patients on the caseload of the teams, and of individual members of staff, was not too high and staff managed waiting lists well to ensure that people who required urgent care were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multi-disciplinary team and with relevant services outside the organisation.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients and families and carers in care decisions. Staff ensured all carers felt listened to and empowered patients to be actively involved in their recovery.
- The service was easy to access. Staff assessed and treated people who required urgent care promptly and those who did not require urgent care did not wait too long to start treatment. The service did not exclude people who would have benefitted from care.
- The service was well led and the governance processes ensured that procedures relating to the work of the service ran smoothly.

However:

- The team at City North had medication that had not been stored properly prior to be disposed of and a problem with the temperature gauges for recording fridge temperatures. They did not transport medication safely when completing visits in the community.
- There was a lack of evidence of the involvement of patients and carers in decision making about the service.

Is the service safe?

Good ↑↑

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

- The service had enough staff, who knew the patients and received training to keep people safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high.

Community-based mental health services of adults of working age

- Staff assessed and managed risks to patients and themselves. They developed crisis plans when this was necessary, responded promptly to sudden deterioration in a patient's health and monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However

- The City North team had some issues with medication management. This included the incorrect storage of medication, problems with the temperature gauge for routinely recording fridge temperatures and the safe storage of medication when taken out into the community.

Is the service effective?

Good ↑

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

- Staff assessed the mental health needs of all patients. They developed individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented and staff updated them when appropriate.
- Staff provided a range of care and treatment interventions suitable for the patient group. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff with appraisals, supervision, opportunities to update and further develop their skill. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure that patients had no gaps in their care. The team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Is the service caring?

Good →←

Community-based mental health services of adults of working age

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

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and empowered patients to understand and manage their care, treatment or condition. Staff provided care that was extremely patient focussed and holistic. Patients and carers felt listened to and cared for by staff who often went above and beyond their role to ensure patients were safe.
- Staff involved patients in care planning and risk assessment. Patients stated that receiving continuity from the same staff during their treatment had a very positive impact on their ability to engage with treatment and their recovery. We also saw that Patients and carers were involved in making decisions about the service.
- Staff actively sought feedback from patients and carers on the quality of care provided. Staff ensured that patients had easy access to advocates when needed and understood the need for patients to have independent support.
- Staff informed and involved families and carers appropriately. Carers stated that staff ensured that they were supported and had good access to carers support and assessments when they needed them.

Is the service responsive?

Good 

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

- The service was easy to access. Its referral criteria did not exclude people who would have benefitted from care. Staff assessed and treated people who required urgent care promptly and people who did not require urgent care did not wait too long to start treatment. Staff followed up people who missed appointments.
- The teams met the needs of all people who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Good 

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

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- Staff knew and understood the trust's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the trust promoted equality and diversity in its day to day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. We looked at all managers dashboard information for this service which showed us that training, appraisal and supervision levels were above trust set targets.

Community-based mental health services of adults of working age

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

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Child and adolescent mental health wards

Good

Key facts and figures

The Hopewood Unit inpatient child and adolescent mental health services are based in The Lookout Adolescent Unit, with educational support provided at The Lookout Education Centre. The Hopewood Unit includes the first dedicated specialist eating disorders inpatient service (Pegasus Ward) and first psychiatric intensive care unit (Hercules Ward) for young people in the East Midlands. The unit provides care and treatment for 12 to18 year olds. Pegasus and Phoenix Wards opened in June 2018 with Phoenix Ward replacing Thorneywood Adolescent Unit. Hercules Ward opened in September 2018. The service is for the local and regional population but can serve the national population if needed.

This core service provides the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

The Hopewood Unit has three wards:

- Pegasus Ward – mixed gender, 12 beds – eating disorder service
- Phoenix Ward – mixed gender, 12 beds – general mental health
- Hercules Ward– mixed gender, eight beds – psychiatric intensive care unit.

The Lookout Adolescent Unit also has a mother and baby called Margaret Oates Ward with eight beds. This is not part of the child and adolescent mental health services inpatient core service, so we did not inspect it at this inspection.

We inspected all three wards and looked at all five key questions. Our inspection was unannounced (staff did not know we were coming on the first day) to enable us to observe routine activity.

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

Three Care Quality Commission inspectors, a specialist advisor who was a doctor specialised in child and adolescent mental health services eating disorders and a specialist advisor who was a nurse experienced in working in child and adolescent mental health services inspected The Hopewood Unit.

During the inspection, the inspection team:

- visited all three wards, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with nine patients and six relatives spoke with the ward managers or acting ward managers of each ward
- spoke with 40 staff including nurses, doctors, healthcare assistants, psychologists, occupational therapists, teachers, occupational therapy assistants, pharmacists, senior managers, administrative and domestic staff
- attended and observed one multidisciplinary team handover
- observed and attended patients' activities such as groups and community meetings

Child and adolescent mental health wards

- looked at the care records of 12 patients including Mental Health Act paperwork
- reviewed 18 medication charts
- spoke with visitors to the wards including an advocate, NHS England case manager and approved mental health professional
- Healthwatch carried out four interviews with patients in partnership with us.

Summary of this service

We have not rated this service before. We rated it as good because:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the wards who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They followed good practice with respect to young people's competency and capacity to consent to or refuse treatment.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The service was well led, and the governance processes ensured that ward procedures ran smoothly.

However:

- Staff did not always use the systems in place to keep information about patients confidential.
- Staff did not all have access to specialised training in eating disorders, taking blood tests and how to care for patients on the psychiatric intensive care unit.
- There were some issues relating to a new build including heating, security and parental controls for the new Wi-Fi system and inconsistent alarms, that required action to fully resolve for which the trust had actions in place to remedy. Staff were not always aware of who to contact to resolve these issues.
- Staff did not update the personal emergency evacuation plans of patients who needed them when the patient moved between wards or was cared for in the seclusion room.
- Staff did not ensure that medicine fridge temperatures were always within the range for safe storage of medicines.

- Staff did not have access to all of patients' paper records in the electronic patient records system, so they could use it effectively.
- Patients and their carers did not have all the appropriate information available to them in an accessible format at the time of admission and throughout admission. However, the trust confirmed it was in the process of printing leaflets in different languages and formats to be made available for patients and carers using the service.

Is the service safe?

Good

We have not rated this service before. We rated it as good because:

- All wards were clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the trust's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply it. There was an identified named nurse and doctor for child protection.
- Staff followed best practice when, dispensing, and recording the use of medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- On Hercules Ward there was a low wall between the communal areas that could be a risk to patients and staff safety if a patient climbed onto it. The trust had assessed this risk and were taking action to reduce it.
- There were problems with the alarm system which sometimes sent staff to the wrong ward or sounded for no reason. There was also a problem with the heating which could be too cold or too hot. The trust had identified these issues and were working with the contractors who had built the unit to resolve them.
- Staff had recorded the medicines fridge temperatures on Pegasus ward as higher than the recommended for safe storage on several occasions but had not reported this to the pharmacy team to resolve. This was done at the time of our inspection.
- Staff did not have access to all of patients' paper records in the electronic patient records system, so they could use it effectively.

Child and adolescent mental health wards

Is the service effective?

Requires improvement

We have not rated this service before. We rated it as requires improvement because:

- Staff did not all have access to specialised training in eating disorders and how to care for patients on the psychiatric intensive care unit.
- Staff did not always keep information about patients securely and ensure that patient images recorded on closed circuit television cameras were kept private.
- Only doctors were trained to take bloods which were often needed, so this was not an effective use of doctors' time.

However:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. They supported staff with appraisals, supervision and some opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under the age of 16. Staff assessed and recorded capacity or competence clearly for patients who might have impaired mental capacity or competence.

Is the service caring?

Good

We have not rated this service before. We rated it as good because:

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

- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- We found that staff informed and involved some families and carers in their child's care however some parents did not feel involved. The information provided was not in an accessible format at the time of our inspection but was being printed. Some parents we spoke with had not received general information before their child's admission including visiting times and how to make a complaint.

Is the service responsive?

Good

We have not rated this service before. We rated it as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- Staff facilitated young people's access to high quality education throughout their time on the wards.
- The food was of a good quality and patients had access to hot drinks and snacks at any time dependent on their individual meal plans.
- The wards met the needs of all people who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- Patients did not have access to Wi-Fi as this had been switched off as parental controls had not been fixed. This meant that patients did not have the same access to the Internet as they would have if not in hospital.
- Staff told us that the ward kitchens were used by staff for breaks which reduced some patients' opportunities to develop their skills in independent cooking.
- Some parents and patients did not know how to make a complaint.

Is the service well-led?

Good

We have not rated this service before. We rated it as good because:

- Ward managers had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

- Staff knew and understood the trust's vision and values and how they were applied in the work of their team.

- Staff felt respected, supported and valued. They reported that the trust promoted equality and diversity in its day to day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

However:

- Patients were unsure of how staff resolved issues raised at community meetings.
- The newly created role of the site manager was not embedded, and staff were unsure of who to go to so that issues with the building could be resolved.
- Staff were not clear of how all the governance processes operated and how their work was communicated to senior managers and the board.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Community mental health services for people with a learning disability or autism

Good ➔➔

Key facts and figures

Nottinghamshire Healthcare NHS Foundation Trust provides community-based mental health services for people with a learning disability or autism. The trust's intellectual and developmental disabilities directorate consist of two services: one for adults with an intellectual disability and one for adults with neurodevelopmental conditions. This inspection focussed on community services provided to adults with an intellectual disability.

Community learning disability teams are based at nine locations across the county, divided into four geographical teams. The city community learning disability team consisted of Nottingham City north and Nottingham City south teams. The county community learning disability north team consisted of Worksop and Newark team locations. The county community learning disability south team consisted of Gedling, Broxtowe, and Rushcliffe team locations. The county community learning disability west team consisted of Ashfield and Mansfield team locations. Trust community staff work in partnership with adult social care staff, with many being co-located within community learning disability teams. During the inspection we visited team locations for Nottingham City north and Ashfield.

The trust has several other teams as part of community services for adults with an intellectual disability. Two intensive community assessment and treatment teams work to provide rapid-response, short-term advice and intervention, and prevent placement breakdown where possible. One team is based in the north and one in the south of the county. The epilepsy specialist nursing team provides a service to adults with epilepsy and an intellectual disability. The team provides an integrated service with neurology teams at local acute hospital. We visited the south intensive community assessment and treatment team, and the epilepsy specialist nursing team.

The trust also provides acute liaison nurses and primary care liaison nurses as part of community services for adults with an intellectual disability.

We last made a comprehensive inspection of the community mental health services for people with a learning disability or autism in 2014. The inspection approach at that time looked at community and inpatients services together as services for people with learning disabilities or autism. We applied an overall rating of 'Requires Improvement' to the services. We carried out a follow-up inspection in 2015 to assess if compliance actions from the 2014 inspection had been met. We applied an overall rating of 'Good' for community mental health services for people with a learning disability or autism as a result of the follow-up inspection.

Our inspection between 11 and 13 February 2019 was unannounced (staff did not know we were coming) to enable us to observe routine activity.

During the inspection we:

- visited the team locations for Nottingham City north and Ashfield. We spoke with staff based there
- visited the south intensive community assessment and treatment team, and the epilepsy specialist nursing team
- spoke with 17 members of staff from different teams including mangers, nurses, doctors, and physiotherapists
- accompanied staff on three community visits to observe how staff cared for patients
- spoke with three patients currently using the service
- spoke with seven carers of patients that were currently using, or had recently used the service
- reviewed the care and treatment records of 16 patients

Community mental health services for people with a learning disability or autism

- observed one referral meeting and one positive behavioural support meeting
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

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

- The service provided safe care. The number of patients on the caseload of the teams, and of individual members of staff, was not too high. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Teams included, or had access to, the full range of specialists required to meet the needs of patients in the community. Managers ensured that staff received training and supervision. Staff worked well together as a multi-disciplinary team and with relevant services outside the organisation.
- Staff understood and performed their roles and responsibilities under the Mental Health Act and the Mental Capacity Act.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. Staff involved patients and families and carers in care decisions.
- The service was easy to access and staff and managers managed access and caseloads well. The service did not exclude people who would have benefitted from care. Staff assessed and initiated care for people who required urgent care promptly and those who did not require urgent care did not wait too long to receive help and start treatment.

However:

- The trust reported that it had received no complaints from patients under the care of the intellectual and developmental disabilities services. However, staff working in this service did not routinely provide patients and carers with information about how to raise a concern or complaint. Staff were aware of the availability of complaints leaflets, but they were not clear about how patients and carers would access them without asking.
- Some teams within the service had appraisal rates for non-medical staff that were significantly below the trust's target.
- Omissions were present in care planning practices. Records did not always demonstrate that staff always developed care plans to address the identified needs of patients. Additionally, records did not clearly demonstrate when staff had offered or shared care plans with patients.
- Clinical audit practices were not always robust. Outcomes of audits were not always consistent with practices seen during the inspection and staff were not clear how the trust audited the application of the Mental Capacity Act.

Is the service safe?

Good 

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

- Staff did not routinely see patients at team bases. The bases from which staff worked were safe, clean, well maintained and fit for purpose.

Community mental health services for people with a learning disability or autism

- The service had enough staff, who knew the patients and received basic training to keep people safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high.
- Staff assessed and managed risks to patients and themselves. They developed crisis plans when this was necessary and responded promptly to sudden deterioration in a patient's health. The trust did not have waiting lists to access the service. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply it.
- The trust provided staff with policies to guide practice in medicines management. Staff in this service were not required to store or dispense medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The teams had a good track record on safety.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Good ➔➔

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

- Staff made a comprehensive assessment of patients' needs that included mental health, physical health and the circumstances prompting referral. Staff took a function-based approach to assessing the mental health needs of all patients. Staff provided a range of care and treatment interventions suitable for the patient group. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, research and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff with supervision and training opportunities to update and further develop their skill. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure that patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Records did not demonstrate that staff always completed care plans to address the identified needs of patients.

- Some teams within the service had appraisal rates for non-medical staff that were significantly below the trust's target.

Is the service caring?

Good

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

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients and carers when planning care and actively sought their feedback on the quality of care provided. Staff ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers fully appropriately in assessments and in the design of care and treatment interventions.

However:

- Records did not clearly demonstrate when staff had offered or shared care plans with patients.
- Staff reported that it was not routine practice to involve patients in decisions about the future development of the trust's intellectual and developmental disabilities services.

Is the service responsive?

Requires improvement 

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

- The trust reported that it had received no complaints from patients under the care of the intellectual and developmental disabilities services. However, staff working in this service did not routinely provide patients and carers with information about how to raise a concern or complaint. Staff were aware of the availability of complaints leaflets, but they were not clear about how patients and carers would access them without asking. Many of the patients receiving care were potentially vulnerable to abuse or mistreatment.

However:

- The service was easy to access. Its referral criteria did not exclude people who would have benefitted from care. Staff assessed and initiated care for people who required urgent care promptly and people who did not require urgent care did not wait too long to start receiving care. Staff followed up people who missed appointments.
- The teams met the needs of all people who use the service – including those with a protected characteristic. Staff helped patients to remain in their own homes or residential placements rather than being admitted to hospital.
- Staff had the skills, or access to people with the skills, to communicate in the way that suited the patient.

Is the service well-led?

Good 

Community mental health services for people with a learning disability or autism

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

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- Staff knew and understood the trust's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution. The trust promoted equality and diversity in its day to day work.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities. We saw examples of innovations taking place within the service.
- Managers engaged actively other local health and social care providers to ensure that there was an integrated health and care system that met the needs of the local population.

However:

- Staff of the same profession met regularly at uni-discipilinary meetings. The way these meetings were organised did not ensure that staff always discussed essential information from across all disciplines, such as learning from incidents and complaints.
- The outcomes of staff audits were not always consistent with the practices seen during the inspection. For example; staff audits of patient records indicated better care planning practices than those we saw during the inspection.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Forensic inpatient or secure wards

Requires improvement 

Key facts and figures

The Forensic Service Division of Nottinghamshire Healthcare NHS Trust provides the following high, medium and low secure mental health services. We inspect the high secure services as a separate core service and did not inspect this core service during this inspection.

The trust's medium secure services are based at two sites: Wathwood Hospital and Arnold Lodge. These are purpose built facilities and provide inpatient mental health services for adults aged 18 upwards. Wathwood Hospital is a 76-bedded hospital based in Rotherham. Its services include acute admission wards, continuing care ward, rehabilitation ward and the lodges. These are units that encourage people to become more independent. Arnold Lodge is a 110-bedded hospital based in Leicester. Its services include an admissions and assessment ward including psychiatric intensive care unit for men with mental illness, two male rehabilitation units, and two male personality disorder units. The service also provides women's standard and enhanced medium secure units.

The trust's low secure service is based at The Wells Road Centre. The Wells Road Centre is an 82-bedded low secure inpatient service that provides care and treatment for men and women who are detained under the Mental Health Act, and who have a mental illness or learning disability.

Prospect House is a 7-bedded pre-discharge unit which provides 'step-down' care from low secure hospitals. Its purpose is to help people to return to the community.

This core service provides the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

At our last inspection of this core service in April 2014, we rated the forensic core service as good in all domains. At the time of our last inspection, this included the trust's high secure hospital. We rated all domains: safe, effective, caring, responsive and well led domains as good.

We found the trust had breached regulations under the Health and Social Care act (regulated Activities) Regulations 2014. We issued the trust with a requirement notice for forensic services. This related to the following regulations under the Health and Social Care act (regulated Activities) Regulations 2014:

- Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

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

We inspected this service as part of our ongoing inspection schedule of the trust. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Our inspection team comprised two CQC inspection managers, three CQC inspectors, two pharmacy specialists and three specialist advisors who were nurses experienced in working in forensic mental health services.

During our inspection, we:

Forensic inpatient or secure wards

- Spoke with 75 staff members across the three hospital sites including general managers, ward managers, modern matrons, nurses, doctors, healthcare assistants, psychologists, occupational therapists, a violence reduction manager, a social worker, a physical healthcare staff and pharmacists
- Spoke with 41 people who were using the service at the time of our inspection
- Spoke with four carers or family members of people using the service
- Looked at 46 care and treatment records of people using the service across the three hospital sites
- Looked at the quality of each of the ward environments and observed how staff were caring for patients
- Attended and observed one multidisciplinary team review meeting, one staff meeting and a community meeting
- Reviewed 47 medication charts.

Summary of this service

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

- The service did not consistently provide safe care across the three hospital sites. Not all of the ward environments were safe or clean and staff did not always know how to use emergency equipment. The wards did not have enough qualified nursing staff to support patient care and treatment. The service did not effectively minimise the use of restrictive practice or follow good practice with regards to medicines management.
- Staff did not use clinical audit and complaints effectively to evaluate and improve on the quality of care they provided.
- Staff did not follow the trust's policy around the use of observation and did not follow national guidance to monitor deterioration in patients' physical health.
- The governance processes did not ensure that wards were safe or that staff used every opportunity to improve on their practice.
- The service did not consistently protect and promote patients' privacy and dignity.
- Vacancies in the psychology department at The Wells Road Centre had resulted in some patients having poor access to psychological therapies.

However:

- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
- Managers ensured that staff received training, supervision and appraisal. The ward staff worked well together as a multi-disciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

Forensic inpatient or secure wards

Is the service safe?

Inadequate

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

- Wards were not always safe, clean and well maintained. Staff did not keep accurate records of the cleaning schedules. Staff did not always assess and manage risks presented by the environment or undertake routine maintenance of equipment. Safety checks did not consistently identify or record areas of risk and actions were not taken consistently to address these issues. Emergency equipment differed across wards and staff were not aware of the rationale for this. Staff did not complete accurate checks of emergency equipment to ensure it was safe to use and not all staff were trained in the proper use of emergency equipment.
- The service did not always have enough qualified nursing staff to support the needs of the patients and maintain safe staffing levels. This impacted negatively on patients' access to activities, visits from family and escorted leave.
- Staff did not consistently record or respond to a deterioration in patients' physical health in line with national early warning scores guidance. Staff did not always follow the trust's policy around monitoring patients' physical health after administering rapid tranquilisation medication.
- Staff did not consistently follow policies and procedures for the use of observation, including to minimise risk from potential ligature points.
- Staff did not always achieve the right balance between maintaining safety and providing the least restrictive environment possible to facilitate patients' recovery. For example at Arnold Lodge there were several blanket restrictions such as timings to access drinks and snacks, bedtime and rules about wearing hats or caps.
- Staff did not always follow best practice when storing, dispensing, and recording the use of medicines.
- Staff did not always keep records for seclusion in an accessible, consistent manner. This made it difficult to ascertain whether and when staff had reviewed patients being nursed in seclusion in line with the Code of Practice.

However:

- Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the trust's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Forensic inpatient or secure wards

Is the service effective?

Good ➔➔

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

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. The care plans included specific safety and security arrangements and a positive behavioural support plan.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They supported patients to live healthier lives and used technology effectively to improve how they supported patients.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation and engaged with them early on in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Staff did not record staff supervision in line with the trust's policy.
- Some staff said they needed more time to complete effective handovers between shifts.
- Vacancies in the psychology department at The Wells Road Centre had resulted in some patients having poor access to psychological therapies.

Is the service caring?

Good ➔➔

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

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

Forensic inpatient or secure wards

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

However:

- Privacy and dignity was compromised which impacted on the care and treatment of patients (see below).

Is the service responsive?

Requires improvement

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

- The trust did not always protect patients' privacy and dignity in their delivery of care and treatment. There was inadequate sound-proofing between two seclusion rooms at Arnold Lodge. At The Wells Road Centre, the hatch on the seclusion room door led to the patient toilet. The trust told us they did not use the hatch to provide drinks to patients in seclusion. Also, at The Wells Road Centre, a whiteboard with patient information on it, could be seen through the window of the nursing office. Patients were not always able to make a phone call in private and on one ward the patient phone had been out of use for 18 months. Although this was in the process of being addressed at the time of our inspection and staff had implemented temporary mitigations, this demonstrated a poor response to maintenance requests.
- Some patients' personal belongings were stored in a disorganised manner.
- Staff did not always use complaints as an opportunity to learn or make improvements to the quality of care they delivered. We found the tone of the written feedback to complainants was not always compassionate and respectful.

However:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.
- The design, layout, and furnishings of the ward/service supported patients' treatment. Each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. There were quiet areas for privacy on all of the wards.
- Staff supported patients to engage with activities and work opportunities within the wider community and encouraged patients to maintain relationships with people that mattered to them.
- The wards met the needs of all people who use the service – including those with a protected characteristic. This included access to information in a format that was suitable for the patient population. Staff helped patients with communication, advocacy and cultural and spiritual support.

Is the service well-led?

Requires improvement 

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

Forensic inpatient or secure wards

- Our findings from the other key questions did not demonstrate that governance processes consistently operated effectively. This included a lack of effective systems to ensure wards were safe and clean, that the safety and effectiveness of medicines management was monitored or that staffing levels were consistently adequate to provide safe and effective care and treatment.
- Staff did not always use audits and complaints effectively to make improvements to the care and treatment delivered to patients
- The trust did not provide sufficient support to bank staff who reported feeling undervalued and demoralised.
- The trust did not ensure all staff had easy access to the trust's counselling service.
- The electronic systems were slow and caused delays to staff inputting information. There was a lack of technical support on site which caused delays to fixing issues when they arose.

However:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- Most staff felt respected, supported and valued. They reported that the trust promoted equality and diversity in its day to day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Staff knew and understood the trust's vision and values and how they were applied in the work of their team.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities and the trust encouraged staff to participate in research and innovative practice to improve the services.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Mental health crisis services and health-based places of safety

Good

Key facts and figures

Nottinghamshire Healthcare NHS Foundation Trust provides four crisis resolution and home treatment teams and two health-based places of safety. Two of the crisis teams, City and County are based at Highbury Hospital in Bulwell, Nottingham. The third crisis team is based at Millbrook Hospital, Kings Mill, Sutton in Ashfield and the fourth team are based at Bassetlaw Hospital, Worksop. The focus of the home treatment teams was to provide short term care to meet people's immediate needs in a crisis.

The two health-based places of safety, also known as section 136 suites, are located at Highbury Hospital and the second one at Millbrook Mental Health Unit. A health-based place of safety is where police officers can take someone who may be suffering from a mental health problem, using section 135 or 136 of the Mental Health Act 1983, where a team of mental health professionals can assess them.

This core service provides the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury.

This was the second CQC inspection of mental health crisis services. We have not inspected health-based places of safety before. At the previous inspection in April 2014 the service was called crisis resolution and community based crisis services and we rated them as Good.

Our inspection was short-notice announced (staff knew we were coming a few days before) to ensure that everyone we needed to talk to was available.

We inspected three of the crisis and home treatment teams City, Bassetlaw and Mid-Nottinghamshire, and both section 136 suites (Cassidy Suite and Jasmine Suite).

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

During the inspection, the inspection team:

- spoke with 15 staff including non-medical nurse prescribers, clinical leads, nurses, healthcare assistants, an occupational therapist, a psychologist, and consultant psychiatrists
- spoke with two service managers and five team managers
- spoke with three patients and two relatives/carers
- visited three of the crisis and home treatment teams and both section 136 suites
- attended and observed two multidisciplinary meetings
- observed staff on duty answering the phone and talking to people in crisis
- visited the crisis home in Nottingham
- looked at the care records of 19 patients.

Mental health crisis services and health-based places of safety

Summary of this service

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

- Clinical premises where staff saw patients were safe and clean. The number of patients on the caseload of the mental health crisis teams and of individual members of staff, was not too high. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff had provided a range of treatments suitable to the needs of the patients and staff engaged in clinical audit to evaluate the quality of care they provided.
- The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients. Managers ensured staff received training. Staff worked well together as a multi-disciplinary team and with relevant services outside the organisation.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients, families and carers in care decisions.
- The mental health crisis service and the health-based places of safety were easy to access. Staff assessed people promptly. Those who required urgent care were taken onto the caseload of the crisis teams immediately. Staff and managers managed the caseloads of the mental health crisis teams well. The services did not exclude people who would have benefitted from care.

However:

- Staff working for the mental health crisis team at Millbrook Mental Health Unit had not always developed holistic, recovery-oriented care plans and staff at Millbrook Mental Health Unit and Bassetlaw Hospital had not offered all patients a copy of their care plan.
- Managers had not ensured that staff received supervision and appraisal in line with their policy.
- Staff did not always follow trust guidelines in relation to medicines management. Highbury Hospital staff did not safely deliver medication to patients as they did not secure the medicine in a safe way to transport it to a patient's home or get patients to sign they had received it.
- In the section 136 Cassidy suite the locks and bolts on the suite doors were not suitable and therefore did not provide a safe environment for patients or staff.
- Although the environment at the Cassidy suite met the requirements of the Mental Health Act Code of Practice the Jasmine suite did not because there was no clock visible to patients when they were detained in the suite.
- Staffing levels in the section 136 suites did not meet safe staffing levels when there were emergencies.

Is the service safe?

Requires improvement 

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

- Staff did not always follow trust guidelines in relation to medicines management. Staff in the City team did not deliver medication to patients safely because they did not secure the medicine in a safe way to transport it to a patient's home or get patients to sign they had received it. Although staff kept medication in a locked cupboard in the crisis team suite, the door to the room where the cupboard was kept was left open. The key to the safe that held the prescriptions was at times left unsupervised in an unlocked drawer.
- Staffing levels in the section 136 suites did not meet safe staffing levels when there were emergencies. The hospital policy stated three staff were needed when using restraint procedures. Records indicated there had been delays arranging three staff and this could compromise both staff and patient safety.

However:

- All clinical premises where patients received care were safe, clean, well equipped, well-furnished and well maintained.
- The crisis resolution and home treatment teams had enough staff, who received basic training to keep people safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams, was not too high.
- Staff assessed and managed risks to patients and themselves. Staff working for the mental health crisis teams developed crisis plans when this was necessary and responded promptly to sudden deterioration in a patient's health. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Is the service effective?

Good 

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

- Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams developed individual care plans and updated them when needed. Care plans reflected the assessed needs.
- Staff working for the mental health crisis teams provided a range of care and treatment interventions suitable for the patient group.
- Staff working for the mental health crisis teams used recognised rating scales to assess and record severity and outcomes. Staff working for the crisis teams and in the health-based places of safety participated in clinical audit, benchmarking and quality improvement initiatives.
- The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff by offering them opportunities to update and further develop their skill. Managers provided an induction programme for new staff.
- The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Mental health crisis services and health-based places of safety

- Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.
- The service had a good track record on safety and there had been no serious case reviews relating to this service between 1 October 2017 and 30 September 2018.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- At Millbrook Mental Health Unit care plans were not always personalised, holistic and recovery-oriented. At Bassetlaw Hospital and Millbrook Mental Health Unit staff did not either give or record when they gave patients copies of their care plans.
- There was inconsistent recording and completion of physical health checks across the three crisis and home treatment teams.
- Staff did not know where to find medicine alerts, recalls or safety news.
- The rates of supervision and appraisal were low according to records kept by the trust. However, when we asked staff and local managers, we concluded that most staff were receiving supervision and appraisal.

Is the service caring?

Good 

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

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Although not all patients received a copy of their care plan, staff in the mental health crisis teams involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had access to advocates when needed.
- Staff informed and involved families and carers appropriately. The crisis and home treatment teams had received compliments from patients and families thanking staff for the work the teams had done with them.

Is the service responsive?

Good 

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

- The mental health crisis service was available 24 hours a day and was easy to access, including through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude people who would have benefitted from care. Staff assessed and treated people promptly. Staff followed up people who missed appointments.

Mental health crisis services and health-based places of safety

- The health-based places of safety were available when needed and there was an effective local arrangement in place for young people who were detained under Section 136 of the Mental Health Act. Section 12 approved doctors and approved mental health professionals attended promptly when required.
- The services met the needs of all patients who use the service – including those with a protected characteristic under the Equality Act (2010). Staff helped patients with communication, advocacy and cultural support.
- The services treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Good 

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

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- Staff knew and understood the trust's vision and values and how they applied to the work of their team.
- Staff felt respected, supported and valued by local managers. They reported that the trust promoted equality and diversity in its day to day work and in providing opportunities for career progression. Most staff felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities. The trust was currently working with the Core Fidelity scale which measures how well teams are objectively demonstrating their effectiveness in meeting current best practice standards, as well as a tool to measure service improvement outcomes.
- There were effective, multi-agency arrangements in place to agree and monitor the governance of the mental health crisis service and the health-based places of safety.

However:

- Staff reported a lack of confidence in the trust to support them in raising concerns and two staff did not feel able to raise concerns without fear of retribution.
- Staff reported senior managers were not visible within the service.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

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

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

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

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

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

This section is primarily information for the provider

Requirement notices

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

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

Our inspection team

Kathryn Mason Head of Hospital Inspection led this inspection. We had two executive reviewers, Dawn Slater, Director of People and Professionalism and Lisa Quinn, Executive Director of Commissioning and Quality Assurance.

The team for the well led inspection included one inspection manager, one inspector, one assistant inspector, a Mental Health Act Reviewer, pharmacy inspector and two specialist advisers.

The team for the six core service inspections included two inspection managers, one assistant inspector, ten inspectors and ten specialist advisers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.

Nottinghamshire County Council

Report to Health Scrutiny Committee

23 July 2019

Agenda Item: 7

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

1. To consider the Health Scrutiny Committee's work programme.

Information

2. The Health Scrutiny Committee is responsible for scrutinising substantial variations and developments of service made by NHS organisations, and reviewing other issues impacting on services provided by trusts which are accessed by County residents.

3. The work programme is attached at Appendix 1 for the Committee to consider, amend if necessary, and agree.

4. The work programme of the Committee continues to be developed. Emerging health service changes (such as substantial variations and developments of service) will be included as they arise.

5. Members may also wish to suggest and consider subjects which might be appropriate for scrutiny review by way of a study group or for inclusion on the agenda of the committee.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Considers and agrees the content of the draft work programme.

2) Suggests and considers possible subjects for review.

Councillor Keith Girling
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

HEALTH SCRUTINY COMMITTEE DRAFT WORK PROGRAMME 2019/20

Subject Title	**Brief Summary of agenda item**	Scrutiny/Briefing/Update	Lead Officer	External Contact/Organisation
07 May 2019				
NUH CQC Inspection and Improvement Plan	Initial briefing on outcomes and planning following the CQC inspection	Scrutiny	Martin Gately	NUH
NUH Winter Plans	Briefing on lessons learnt from last winter and future plans	Scrutiny	Martin Gately	NUH
Muscular Dystrophy Pathway	Initial briefing on patient experience in the muscular dystrophy pathway, including the physiotherapy service	Scrutiny	Martin Gately	NUH
Dentistry in Nottinghamshire	An initial briefing on the commissioning of dental services in Nottinghamshire.	Scrutiny	Martin Gately	Laura Burns, NHS England
18 June 2019				
CCG Merger Consultation	Agreement of consultation response to CCG merger.	Scrutiny	Martin Gately	TBC
East Midlands Ambulance Service – Performance and Recruitment Update	An update on the progress by EMAS in filling vacant posts and against key performance indicators.	Scrutiny	Martin Gately	Annette McFarlane, Service Delivery Manager and Keith Underwood, Ambulance Operations Manager for EMAS
Patient Transport Service	The latest performance information on patient transport from the commissioners and Arriva.	Scrutiny	Martin Gately	Neil Moore and Lucy Dadge, Greater Nottingham CCG
23 July 2019				
NHS Property Services	An initial briefing on NHS Property Services and its interaction with tenant/providers.	Scrutiny	Martin Gately	Senior representatives of NHS Property

				Services.
Healthcare Trust CQC Inspection	Briefing on the Trust's improvement plan following recent CQC inspection.	Scrutiny	Martin Gately	Dr John Brewin, Chief Executive, Healthcare Trust
Treatment Centre	An update on the latest position with the procurement of the Treatment Centre.	Scrutiny	Martin Gately	Lucy Dadge, Executive Director Commissioning, Nottinghamshire CCG and Dr Keith Girling, Medical Director, NUH
10 September 2019				
National Rehabilitation Centre	Briefing on the current position.	Scrutiny	Martin Gately	Hazel Buchanan, Nottinghamshire CCG
East Midlands Ambulance Service – CQC Inspection Report/Improvement Plan	A briefing on the recent CQC inspection of EMAS with consideration of the associated improvement plan.	Scrutiny	Martin Gately	Richard Henderson, Chief Executive, EMAS
Healthwatch	Briefing on the recent work of Healthwatch (including reviews).	Scrutiny	Martin Gately	Sarah Collis, Healthwatch
Social Prescribing	An initial briefing on the benefits of social prescribing.	Scrutiny	Martin Gately	Amy Callaway, Programme Manager, Integrated Care System
15 October 2019				
Whyburn Medical Practice Update	Update on contract and service provision.	Scrutiny	Martin Gately	Greater Nottingham CCG
Clinical Services Strategy Update	Further briefing on the strategy.	Scrutiny	Martin Gately	Greater Nottingham CCG
Nottinghamshire Healthcare Trust – Adult Services Update (TBC)	An update on a range of issues in Adult Mental Services, including feedback on additional bed spaces at	Scrutiny	Martin Gately	Kazia Foster/Sandra Crawford, Healthcare Trust

	the Highbury Hospital site.			
NHS Long Term Plan	Update on local engagement and how this will inform local plan.	Scrutiny	Martin Gately	Lewis Etoria, Head of Communications, Integrated Care System.
3 December 2019				
NUH Improvement Plan Update	Further consideration of improvement plan following CQC inspection.	Scrutiny	Martin Gately	Dr Keith Girling, Medical Director NUH (TBC)
Muscular Dystrophy Pathway Update	Update following the previous consideration of the pathway in May.	Scrutiny	Martin Gately	Dr Saam Sedehizadeh, NUH (TBC)
Dentistry Update	Update further to the previous consideration of this issue in May.	Scrutiny	Martin Gately	Laura Burns, NUH
14 January 2020				
25 February 2020				
31 March 2020				
19 May 2020				

NUH Winter Plans	Annual consideration of winter planning issues.	Scrutiny	Martin Gately	Caroline Nolan/Rachel Eddie, NUH (TBC)
To be scheduled				
Public Health Issues				
Integrated Care System – Ten Year Plan (TBC)	An initial briefing on the ICS – ten year plan.	Scrutiny	Martin Gately	TBC
Parity of GP Service Coverage across Nottinghamshire				
Dementia Care in Hospital				
The administration of GP referrals				
Access to School Nurses				
Wheelchair repair				
Allergies in Children				
Operation of the MASH				
Mental Health issues (e.g. suicide) and GP referrals.				
Clinical Commissioning Groups' Merger				
Bassetlaw Hospital Update				
Frail Elderly at Home				
Patient Transport Service Performance Update (To be scheduled for December 2020)				

Potential Topics for Scrutiny:

Recruitment (especially GPs)

Allergies and epi-pens

Diabetes services

Air Quality (NCC Public Health Dept)

Overview Sessions (To be confirmed)

Nottingham University Hospitals (NUH) – July/September 2019

East Midlands Ambulance Service (EMAS) – autumn 2019

VISITS

Urgent Care Pathway (QMC visit) – summer 2019

Medium secure mental hospitals – TBC