Northamptonshire Healthcare NHS Foundation Trust

Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

The trust had 23 locations registered with the CQC (on 5 March 2018).

Battle House	**RP1X2**	**Northamptonshire**
Berrywood Hospital	RP1V4	Northamptonshire
Corby Community Hospital	RP1E1	Northamptonshire
Danetre Hospital	RP1J6 / RP1Y8	Northamptonshire
HMP Bedford	RP1X5	Bedford
HMP Littlehey	RP1Y5	Cambridgeshire
HMP Rye Hill	RP1X4	Northamptonshire
HMP Stocken	RP1Y1	Rutland
HMP Onley	RP1M9	Northamptonshire
HMP Whitemoor	RP1Y4	Cambridgeshire
Isebrook Health Campus	RP1F2 / RP1X3	Northamptonshire
John Greenwood Shipman Centre	RP1JG	Northamptonshire
Kent Close	RP1X7	Northamptonshire
Manfield Campus	RP1A2	Northamptonshire
Rainsbrook Secure Training Centre	RP1Y6	Northamptonshire
Short Breaks Unit	RP1NR	Northamptonshire
St James Community Health Clinic	RP1G9	Northamptonshire
St Mary's Hospital	RP1A1	Northamptonshire

The Sett	RP1V6	Northamptonshire
The Squirrels	RP1D7	Northamptonshire
Trust Headquarters	RP1X1	Northamptonshire
Willow Close	RP1Q9	Northamptonshire
Willowbrook Health Centre	RP1P1	Northamptonshire

The trust had 351 inpatient beds across 27 wards, 20 of which were children's mental health beds. The trust also had 84 outpatient clinics a week and 60 community clinics a week.

Total number of inpatient beds	351
Total number of inpatient wards	27
Total number of day case beds	0
Total number of children's beds (MH setting)	20
Total number of children's beds (CHS setting)	22
Total number of outpatient clinics a week	84
Total number of community clinics a week	60

Is this organisation well-led?

Leadership

The trust had a senior leadership team in place with the appropriate range of skills, knowledge and experience to perform its role. There had been no recent changes to the executive team. Executive board members were inspirational, capable, open and responsive to feedback and striving for improvement throughout the organisation.

The chief executive had been in post since September 2013 and the chair since November 2016. There were six non-executive directors who had a wide range of previous and suitable experience including one post that is currently vacant and being recruited to. There are four voting executive directors and a further three non-voting directors that sit at the board but are not full members.

The trust leadership team had a comprehensive knowledge of current priorities and challenges across all sectors and took action to address them. The board were seen as supportive to the wider health and social care system, with both the chief executive and finance director taking up key roles in the local system including through the Health and Care Partnership Board (also known as the STP). The trust were positioning themselves strongly within the system to influence care for all the people in the county.

The Chief Executive was experienced with over 27 year of leadership experience in NHS Community Services. She was also the STP lead for Northamptonshire. The Director of Finance has held a number of senior roles within the NHS covering all aspects of the provider sector. He was also the STP finance lead for Northamptonshire. The Chief Operating Officer was executive sponsor and Chair of the Mental Health Transformation Committee. The Trust chair had experience in being a non-executive director at other NHS organisations prior to her appointment with the Trust. Several executive members had physical health clinical experience whilst only one had mental health clinical experience.

The trust was shortlisted for the health service journal provider trust of the year award in 2017 and the chief executive was ranked by the health service journal as in the 'top fifteen' of chief executives nationally.

The trust board and senior leadership team displayed integrity and the values of the trust on an ongoing basis. The trust's non-executive members of the board were challenging, holding the executive team to account to improve the performance of the trust. The trust leadership team had a comprehensive knowledge of current priorities and challenges and took action to address them. The leadership team has worked hard to model behaviours and practices that underpin the values of the trust. The board has espoused a distributed leadership style and this was evident throughout the organisation.

The trust is defined by NHS Improvement as a 'segment 1' organisation (providers with maximum autonomy: no potential support needs identified. Lowest level of oversight; segmentation decisions taken quarterly in the absence of any significant deterioration in performance). NHS Improvement defined segmentation as: 'level of support needed across the five themes. The segment in which a provider is placed is determined by the extent and nature of the issues they need to address, and the level of support we have decided is appropriate'

When senior leadership vacancies arose the recruitment team reviewed capacity and capability needs. The trust had a robust appointment process (including focus groups) for all board directors, with strong focus on the changing environment and skill sets required. The trust completed exit interviews on resignation/end of term of office for both executive and non-executive directors.

Fit and proper persons checks were in place. We reviewed the personnel files of senior staff and found that checks were carried out, disclosure and barring checks were completed on appointment and within the last three years. There was an annual declaration of interests and records maintained of professional qualifications and registrations with expiry dates present. Appraisals were completed, with actions identified.

The board of directors and governors completed a programme of board visits to services, with a focus on talking to staff on the ground. The trust also held listening events for staff and BIG conversation webinars. Across all services, staff told us that leaders were approachable, their local managers were supportive and senior leaders were visible within their services. Staff were particularly praising of their chief executive and chair. The non-executives had an "eyes on/hands off" approach.

The trust had a lead for child and adolescent mental health, learning disability and autism.

The trust demonstrated a strong focus on leadership development. As part of the trust's 'maximising potential' framework, the trust offered a 'leadership matters' development programme and leadership conferences, acknowledged by NHS improvement; and demonstrated through presentations to external national companies and the nomination for The Chartered Institute of Personnel and Development best learning and development initiative in the public/third sector. We heard about the positives effects of these schemes from staff throughout all levels of the organisation. The board had undertaken significant board development and this was valued by all board members.

Data provided to February 2018 showed: 386 staff attended the leadership matters programme in the year 2016/2017 and 625 staff in the last twelve months (1 February 2017 to 31 January 2018). 860 staff attended the leadership matters conferences in in the year 2016/2017 and 983 staff in the last twelve months (1 February 2017 – 31 January 2018).

The trust demonstrated succession planning at board level. The trust's framework, 'maximising potential' detailed their approach to talent management and succession planning. This framework contained a structured plan to develop the capabilities required to develop staff with the desire, capabilities and potential for progression within the organisation. Maximising potential conversations were being rolled out with all leaders during 2018.

The executive board members comprised 0% black and minority ethnic (BME) members and 43% women.

The non-executive board members comprised 14% BME members and 57% women.

	BME %	Women %
Executive	0%	43%
Non-executive	14%	57%
Total	7%	64%

Vision and strategy

The trust had a clear vision and set of values with quality and sustainability as the top priorities. The trust values were people first, respect and compassion, improving lives, dedication and equality known by the acronym PRIDE. Values were embedded within trust processes for example, staff appraisals, recruitment and staff awards which were aligned to values. Staff we spoke with during the inspection of services and the leadership team was able to discuss the values and what they meant to the service they provided. At board meetings discussions consistently linked to the values. The values were visible on the trust website. Posters publicising these values were on display throughout the trust.

The trust celebrated staff that championed their values through their quality awards. Visions and values were embedded in both recruitment and appraisal processes. We were impressed by how well the vision and values were considered in all aspects of care provided to patients, including service re-design. The trust benchmarked their ‘business as usual’ against the vision and values and kept the message at the heart of all aspects of the running of the organisation.

We noted that the trust’s vision and values were embedded at board level and informed how the senior leadership team operated. This was also evident throughout the services we inspected. The board culture was open and honest.

The trust’s vision was to be a leading provider of outstanding, compassionate care. The trust’s mission statement "making a difference for you, with you" was coproduced with staff, patients and stakeholders, and designed to focus everyone in the organisation on the importance of engaging with the patient/service user and the family/carers as well as placing value on the benefits of good staff engagement leading to high quality, safe care.

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 sustainability and transformation plans. The trust strategy was known internally as DIGBQ (develop, innovate, grow, build, quality) and set out the principles for the organisation that they would: develop in partnership, innovate, grow staff capability, build a sustainable organisation and quality and safety in everything they do. The overall strategy underpinned the board assurance framework. and had objectives aligned to each of the five themes.

The trust had developed a ‘54321’ roadmap. This related to:

5 – five pride values:

(people first, respect and compassion, improving lives, dedication, equality)

4 – leadership behaviours:

(being authentic, working together, taking responsibility, embracing change)

3 – directorates:

(adult, children's and ambulatory, mental health, learning disability and speciality corporate)

2 – enablers:

(trust strategy and operational plan)

1 – mission

(making a difference for you, with you).

Staff, patients, carers and external partners had the opportunity to contribute to discussions about trust strategy, especially where there were plans to change services. The strategy was developed and published in 2014, refreshed in 2015 and 2016. In February 2018, the trust advised they were reviewing their organisational strategy; following extensive consultation with staff and stakeholders.

The leadership group communicated to staff, patients and external partners in a co-ordinated manner using newsletters, intranet, blogs, social media and personal visits.

Local providers and people who use services had been involved in developing the strategy. Throughout the redevelopment of the strategy the trust consulted staff, council members, key stakeholders, including the clinical commissioning groups, local authorities, governors, the CQC and the voluntary sector; and held dedicated strategy development days, 'shaping our future together', attended by over 600 staff and stakeholders. The trust held events over five days at four locations. The trust incorporated feedback from these events into the new strategy.

Commissioners and other stakeholders confirmed that the trust was responsive to challenge and worked collaboratively with stakeholders, other local NHS trusts and the third sector to deliver services to patients.

The trust created an 'employer value proposition' through staff engagement and analysis of staff survey results to ensure values were embedded across the organisation. We observed that the principals of DGBIQ and the 54321 roadmap were reflected in all staff interviews, contained within notepads for staff use, were colourful, meaningful and directional.

The trust had planned services to take into account the needs of the local population. The trust played a significant leadership role in the county, including through the Health and Care Partnership Board.

The trust had a strategy for meeting the physical healthcare needs of inpatients with mental health needs. This was confirmed by our findings during the inspection of the core services where patients' physical health care needs were assessed and responded to appropriately.

The trust had a capital improvement programme which was subject to a prioritisation process.

Culture

The trust's strategy, vision and values underpinned a culture which was patient centred. We were particularly impressed with the caring and compassionate attitudes of staff across all services we visited. Staff consistently demonstrated their desire to put patients first, and to work collaboratively with families, carers and outside agencies towards providing first class patient care.

Leaders showed an inspiring positive culture with a shared purpose towards the vision, values and strategy. Leaders modelled and encouraged compassionate, inclusive and supportive relationships between all grades of staff. For example, staff could leave 'thank you' posts to

colleagues on the trust intranet. By July 2018, over 500 ‘thank you’ posts had been recorded. The trust had an ‘innovation space’ on the intranet. This was available for staff to leave ideas for improvement to services for review and consideration. We heard many examples where staff had made suggestions for improvements that had been taken forward. On one occasion a student nurse had suggested for a video to be shown to students detailing the opportunities for newly qualified staff when joining the trust. This had been taken forward by the chair and was ongoing. Leaders at every level lived the vision and prioritised high quality sustainable and compassionate care.

Staff felt respected, supported and valued. Across all services, staff reported exceptionally supportive relationships with colleagues and local managers. We were told of many examples where staff had gone the extra mile to support their colleagues, such as ensuring staff had safely returned to team bases following community visits. Staff showed pride and talked passionately about their roles, their personal progression opportunities, opportunities to access specialist training and open and transparent relationships with senior colleagues. We were impressed at the culture promoted within the trust for shared learning and encouragement of staff to offer ideas to improve service delivery and patient experience. Staff received appraisals and supervision within all services.

The trust had a number of staff networks established with Executive Director lead, for example a disability network lead by the finance director, a carers network, led by the director of nursing, the BME network, led by the chief executive and the LBGTQ network led by the director of HR and organisational development. The trust promoted an inclusion-themed leadership matters conference during 2017. However, some BME staff we spoke to told us it was not always possible to be released from duties to attend forums and not all middle managers were supportive. Some staff raised concerns that they did not always receive feedback following unsuccessful job applications. However, staff acknowledged that senior managers and the executive team were working hard to embed improvements for all staff with protected characteristics. The executive team were taking part in a reverse mentoring programme. They spoke emotively and powerfully about this and it informed their planning and practice.

The WRES action plan was co-produced with BME staff and as a result of this plan, the reverse mentoring initiative and staff led focus groups were implemented. The National Director for WRES had recently visited the trust and praised the culture and approach.

The trust was ‘highly commended’ in the global equality and diversity awards research category for work on the ‘moving ahead’ project; which addressed inequalities in mental health for black minority and ethnic communities. Along with six other trusts, the trust was praised for the work undertaken to promote racial equality and eliminate discrimination. The trust’s equality and inclusion manager was on the workforce race equality standards national experts programme.

The trust worked appropriately with trade unions. Staff side representatives held monthly meetings with the human resources department, attended by the deputy directors and were involved in consultations when the trust planed changes to services or provision.

Managers addressed poor performance of staff where needed.

The trust was awarded ‘workplace wellbeing charter’ accreditation in November 2017 by Health@Work (an independent national charity). The trust received the highest level of accreditation, excellence for leadership on health and wellbeing, attendance management and action on smoking. The trust was one of only six NHS trusts accredited, reflecting best practice and endorsed nationally by Public Health England.

The trust had clear oversight of the importance of promoting wellbeing amongst the workforce. The trust had arranged a wellbeing conference for all staff in July 2018. At the time of inspection, over 400 staff had booked to attend. A new 'wellbeing wheel' was being introduced, which addressed the ongoing management and support of staff absent through sickness. We were shown how this new tool had been developed in consultation with staff who had experienced long term sickness and noted it was aligned to the 54321 road map 'making a difference for you, with you'.

The trust chief executive had appointed a freedom to speak up guardian in December 2016, and provided them with sufficient resources and support to help staff raise concerns. This was consistent with the contractual obligation placed on all NHS Trusts. This requirement followed the publication of the independent 'Freedom to Speak Up' review authored by Sir Robert Francis in February 2015. The review was a response to evidence that NHS trusts were not always responding appropriately to patient safety concerns raised by staff. Freedom to speak up guardians are intended to provide impartial and independent advice to NHS workers, and to foster a culture of safety and learning. The trust had a raising concerns and whistleblowing policy. The policy met the standards set out in the national 'Freedom to speak up: raising concerns (whistleblowing) policy for the NHS (NHS Improvement April 2016).

The freedom to speak up guardian worked 2 days per week and worked with the chief executive and union representatives to develop the role. The guardian had received appropriate training for their role; including 'train the trainer' to support implementation of the freedom to speak up champions.

The trust had one freedom to speak up champion and another ten had been selected for training in July 2018. The freedom to speak up champions had been selected from staff considered more vulnerable, such as those with protected characteristics, in a considered attempt to make them more diversely approachable. Staff could make contact via a number of methods. The handling of concerns raised by staff met with best practice. The trust reported 112 freedom to speak up contacts since 2016. Across all services we visited, staff told us they felt able to raise concerns without fear of retribution. Staff knew how to raise concerns and about the role of the speak up guardian.

The trust encouraged staff to feel confident to raise concerns openly. We reviewed the trend over the past two years and found evidence to support this was happening. The trust data showed in the year to December 2016 staff raised 17 concerns, 6 (35%) of which were anonymous. To December 2017, 57 concerns were raised, 11 (19%) of which were anonymous and between January – May 2018, 30 concerns had been raised. None of these were anonymous.

The freedom to speak up guardian produced a report to board every six months. Quarterly reports were produced for the executive team which included a 'report on a page' showing which directorates had received concerns, and trends over time. An escalation protocol was in place which followed the trust's risk management strategy. The protocol had been approved by the executive board but had not yet been included in the trust policy.

The trust applied Duty of Candour appropriately and we saw good examples of this in practice.

The trust had effective systems in place for learning from incidents. Action plans arising from when things went wrong, raised through incidents or complaints, were monitored and reported on. Investigations into deaths were thorough and involved family and carers where they wished to be. The trust had a mortality lead. Examples were seen where learning was identified and used to implement change; for example, the introduction of self-assessment forms for informal patients prior to utilising leave from adult acute inpatient wards.

Pharmacy incidents and errors were reported and investigated through the trust's electronic incident recording system. We found the trust was extremely consistent at reporting near misses and had a high reporting rate when benchmarked against other trusts. Monthly learning outcomes were shared by the medicines safety group via emails. However, within the acute wards for adults of working age, we found staff were not consistently documenting the actual time of administration of medications. For example, we saw occasions where medications prescribed for administration at 08.00 were administered at 11.00. There was a risk that staff might administer medication doses too closely together. This chief pharmacist was unaware of this practice.

The trust had an appraisal system in place and used an electronic staff record system (ESR) which captured compliance in appraisal and many other trust performance indicators. The trust had trained 'super users' within teams to support staff with the system. The trust was using this system for staff to access and record mandatory training. Managers told us they had greater oversight of staff compliance since transferring to this system. Managers discussed learning and development opportunities available to staff. A robust induction programme was in place to all staff, which was repeated when they moved between teams.

In the 2017, NHS Staff Survey the trust had better results than other similar trusts in 21 key areas:

Key finding	Trust score	Similar trusts average
KF21. Percentage believing the organisation provides equal opportunities for career progression/promotion	86%	91%
KF28. Percentage witnessing potentially harmful errors, near misses or incidents in last month	23%	17%
KF29. Percentage reporting errors, near misses or incidents witnessed in last month	92%	95%
KF18. Percentage attending work in last three months despite feeling unwell because they felt pressure	53%	48%
KF15. Percentage satisfied with the opportunities for flexible working patterns	58%	64%
KF7. Percentage able to contribute towards improvements at work	73%	76%
KF6. Percentage reporting good communication between senior management and staff	34%	47%
KF3. Percentage agreeing that their role makes a difference to patients/service users	89%	92%
KF25. Percentage experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	26%	22%
KF12. Quality of appraisals	3.10	3.39
KF13. Quality of non-mandatory training, learning or development	4.06	1.15
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.76	3.92
KF31. Staff confidence and security in reporting unsafe clinical practice	3.72	3.90
KF19. Org and mgmt. interest in and action on health and wellbeing	3.70	3.87
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.68	3.90
KF4. Staff motivation at work	3.93	4.04
KF8. Staff satisfaction with level of responsibility and involvement	3.90	3.98
KF14. Staff satisfaction with resourcing and support	3.33	3.50
KF5. Recognition and value of staff by managers and the organisation	3.54	3.66
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.85	4.00
KF32. Effective use of patient/service user feedback	3.69	3.99

In the 2017 NHS Staff Survey: the trust had worse results than other similar trusts in four key areas.

Key finding	Trust score	Similar trusts average
KF11. Percentage appraised in last 12 months	92%	97%
KF16. Percentage working extra hours	71%	65%
KF23. Percentage experiencing violence from staff in the last 12 months	2%	1%
KF27. Percentage most recent experience of harassment, bullying or abuse	57%	66%

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

The trust scored between 1% and 4% better than/ the England average for patients recommending it as a place to receive care for five of the six months in the period (October 2017 to February 2018). Both December 2017 saw the highest percentage of patients who would recommend the trust as a place to receive care with 92%.

The trust was better than the England average in terms of the percentage of patients who would not recommend the trust as a place to receive care in all six months.

	Trust wide responses				England averages	
	Total eligible	Total responses	% that would recommend	% that would not recommend	England average recommend	England average not recommend
Mar 2018	558	6651	88%	2%	89%	4%
Feb 2018	792	7021	90%	3%	89%	4%
Jan 2018	825	7021	91%	2%	88%	4%
Dec 2017	473	5975	92%	1%	88%	4%
Nov 2017	673	6850	89%	2%	87%	5%
Oct 2017	694	6229	90%	1%	86%	4%

The Staff Friends and Family Test asks staff members whether they would recommend the trust as a place to receive care and also as a place to work.

The trust showed an improving trend over the last six quarters. Quarter two had the highest scores for staff recommending the trust as a place to receive care and work for both 2015/16 and 2016/17. Response rates were the lowest in these quarters and are therefore less likely represent the staff views overall.

There is no reliable data to enable comparison with other individual trusts or all trusts in England.

Please note: Data is not collected during Q3 each year because the Staff Survey is conducted during this time

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			Trust target
Total number of substantive staff	At 31 January 2018	3011.4	N/A
Total number of substantive staff leavers	1 February 2017 – 31 January 2018	288.2	N/A
Average WTE* leavers over 12 months (%)	1 February 2017 – 31 January 2018	8.9%	8-12%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 31 January 2018	279	N/A
Total vacancies overall (%)	At 31 January 2018	11%	10%
Total permanent staff sickness overall (%)	At 31 January 2018	6%	4.2%
	1 February 2017 – 31 January 2018	6%	4.2%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 31 January 2018	1260.4	N/A
Establishment levels nursing assistants (WTE*)	At 31 January 2018	990.5	N/A
Number of vacancies, qualified nurses (WTE*)	At 31 January 2018	141.2	N/A
Number of vacancies nursing assistants (WTE*)	At 31 January 2018	123.7	N/A
Qualified nurse vacancy rate	At 31 January 2018	11%	10%
Nursing assistant vacancy rate	At 31 January 2018	12%	10%
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 February 2017 – 31 January 2018	14171 (55%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 February 2017 – 31 January 2018	10118 (39%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 February 2017 – 31 January 2018	1440 (6%)	N/A
Substantive staff figures			**Trust target**
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 February 2017 – 31 January 2018	16465 (87%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 February 2017 – 31 January 2018	1034 (5%)	N/A
Shifts NOT filled by bank or Agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 February 2017 – 31 January 2018	1456 (8%)	N/A

The trust ensured safe staffing levels were maintained within services. The trust had a favourable staffing position and had worked hard to recruit and retain staff. While bank and agency staff were used, they were often regular staff who knew the wards and patients well.

The trust had a recruitment and retention strategy which had delivered innovative ways to recruit staff, such as career events, links with universities, bank work for those who had retired, social media campaigns and wellbeing packages for staff.

The trust worked in partnership with other providers to address their joint recruitment difficulties. They participated in a 'best of both worlds' campaign; a recruitment campaign launched between four leading NHS healthcare providers and one local leading charity providing specialist mental healthcare in Northamptonshire. Undertaken in partnership with the University of Northampton, the aim was to attract doctors and nurses to relocate to live and work in Northamptonshire. The trust reported approximately 25 experienced staff were recruited because of this campaign.

Staff in all services we inspected reported staffing levels were good and duty rotas confirmed this. Safer staffing levels were adhered to.

The trust employed apprentices across all directorates. Apprenticeships are designed to provide staff with the opportunity to gain the knowledge, skills and behaviours needed to achieve their desired positions within the organisation. Data provided showed as of May 2018 the trust had 70 current apprentices (in post or in recruitment). Adult and children's services had 29, Adult mental health 25 and 16 were employed in support services.

The trust held a number of open days to recruit new staff to services. For example, on Shearwater ward (psychiatric intensive care unit) the trust invited candidates to attend the ward. Interviews and pre-employment checks were completed the same day and conditional offers of appointments made. A similar process was being undertaken within the intermediate care team.

The trust used a trust wide recruitment performance dashboard which used a RAG rating system to track recruitment processes for new staff. We reviewed the dashboards across directorates for May 2018 and saw the trust was meeting its target from advertisement to start date for new employees. There had been a significant improvement from 126 days in May 2017 to 87 days in May 2018.

The trust gathered information when staff left the service. Staff were invited to complete a survey monkey, audited by a retention workstream. The trust had reduced the numbers of questions asked from 50 to 12. This had improved uptake and allowed for greater analysis of themes.

The trust had developed a human resources and organisational development model that aimed at maximising staff potential. Several executives had been recruited from within the trust and had received development in order for them to be successful at recruitment.

As at 31 January 2018, the training compliance for trust wide services was 47% against the trust target of 90%. Of the training courses listed 28 failed to achieve the trust target and of those, 27 failed to score above 75%.

The training compliance reported for the trust during this inspection was higher than the 28% reported in the previous year.

Training Course	Compliance %
Falls Prevention Training - Level 2	93%
Falls Prevention Training - Level 1	81%
Infection Prevention (Level 2)	74%
Mental Health Act	72%
Fire Safety	72%
Information Governance	67%
Resuscitation Level 2 - Adult & Paediatric	62%
Resuscitation Level 3 - Immediate Life Support	62%
Duty of Candour	54%
Safeguarding Adults Level 1	43%
Safeguarding Children (Level 1	43%
Mental Capacity Act DoLS	43%

Safeguarding Adults (Level 2)	41%
Safeguarding Children (Level 3)	40%
Conflict Resolution	39%
Staff and Pt. Safety (Quality & Safety)	39%
Infection Prevention (Level 1)	37%
Safeguarding Children (Level 2)	32%
Safeguarding Prevent Health WRAP	32%
Venous Thromboembolism	31%
Learning Disability Awareness	31%
Moving and Handling	29%
Dementia Awareness (inc Privacy and Dignity Standards)	28%
Breastfeeding Annual Update	26%
Making Every Contact Count	26%
Raising concerns and whistleblowing	24%
Equality and Diversity	23%
Health, Safety and Welfare	19%
Resuscitation Level 1	16%
Total (%)	47%

The trust had changed the method by which it recorded compliance with mandatory training. All training data had transferred to the electronic staff record. Therefore, data provided as at January 2018 was not reliable. The trust provided updated figures for compliance with mandatory training for all staff across all teams prior to the inspection. This data showed an overall trust compliance figure in May 2018 of 92%. The lowest overall compliance for the 12-month period to May 2018 was 81% in June 2017. The lowest compliance for a training course in May 2018 was 50% for resuscitation - Level 3 - Adult Immediate Life Support - 1 Year for the forensic inpatient secure wards. Overall, as at the end of May 2018, only 2% of 21 training courses, delivered to 16 teams had failed to achieve over 75% compliance; with the clear majority achieving over 80%. Therefore, we were satisfied that staff received appropriate training for their roles.

The trust's target rate for appraisal compliance is 90%. As at 31 December 2018, the overall appraisal rates for non-medical staff was 91%.

Fourteen of the 19 teams (74%) achieved the trust's appraisal rate. The core services failing to achieve the trust's appraisal target were 'CHS – Community dental' with 88%, 'MH – Specialist mental health services for children and young people' with 82%, 'MH – Community mental health services for people with a learning disabilities or autism' with 80%, 'Other' with 75% and 'MH – Wards for people with learning disabilities or autism' with 61%.

Core Service	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% of non-medical staff who have had an appraisal
MH - Child and adolescent mental health wards.	53	53	100%
Other - PMS service	2	2	100%
MH - Wards for older people with mental health problems.	91	88	97%
CHS - Community inpatient services	175	168	96%

Core Service	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% of non-medical staff who have had an appraisal
MH - Forensic inpatient/secure wards.	27	26	96%
MH - Community-based mental health services for older people.	70	66	94%
MH - Long stay/rehabilitation mental health wards for working age adults	18	17	94%
CHS - End of Life Care	108	100	93%
MH - Acute wards for adults of working age and psychiatric intensive care units.	216	201	93%
MH - Mental health crisis services and health-based places of safety.	98	91	93%
CHS - Community health services for adults	711	651	92%
CHS - Community health services for children, young people and families	537	494	92%
Support service	529	484	91%
MH - Community-based mental health services for adults of working age.	215	193	90%
CHS - Community Dental	25	22	88%
MH - Specialist community mental health services for children and young people	57	47	82%
MH - Community mental health services for people with a learning disability or autism	115	92	80%
Other	171	128	75%
MH - Wards for people with learning disabilities or autism.	18	11	61%
Total	3236	2934	91%

The trust's target rate for appraisal compliance is 90%. As at 31 December 2017, the overall appraisal rates for medical staff was 84%.

Seven of the 10 teams (70%) achieved the trust's appraisal rate. The core services failing to achieve the trust's appraisal target were 'All inpatient and community mental health services for children and young people' with 25%, 'CHS – End of life care' with 75% and 'All mental health inpatient and community services for people of a working age' with 82%.

Core Service	Total number of permanent medical staff who have had an appraisal within the last 12 months	Total number of permanent medical staff required for an appraisal in the last 12 months	% appraisals
All community inpatient services	2	2	100%

Core Service	Total number of permanent medical staff who have had an appraisal within the last 12 months	Total number of permanent medical staff required for an appraisal in the last 12 months	% appraisals
All inpatient and community services for adults and children with a learning disability or autism	1	1	100%
All mental health inpatient and community services for older people	2	2	100%
CHS - Adults Community	1	1	100%
CHS - Children, Young People and Families	1	1	100%
CHS - Dental Services	7	7	100%
Other	5	5	100%
All mental health inpatient and community services for people of a working age	9	11	82%
CHS - End of Life Care	3	4	75%
All inpatient and community mental health services for children and young people	1	4	25%
Total	32	38	84%

The trust's target rate for appraisal compliance is 90%. As at 31 December 2017, the overall appraisal rates for non-medical staff was 91%.

Fourteen of the 19 teams (74%) achieved the trust's appraisal rate. The core services failing to achieve the trust's appraisal target were 'MH – Wards for people with a learning disability or autism' with 61%%, 'Other' with 75%, 'MH – Community mental health services for people with a learning disability or autism' with 80%, MH – specialist community mental health services for children and young people with 82% and 'CHS – Community dental' with 88%.

Core Service	Total number of permanent medical staff who have had an appraisal within the last 12 months	Total number of permanent medical staff required for an appraisal in the last 12 months	% appraisals
MH - Child and adolescent mental health wards.	53	53	100%
Other - PMS service	2	2	100%
MH - Wards for older people with mental health problems.	88	91	97%
CHS - Community inpatient services	168	175	96%
MH - Forensic inpatient/secure wards.	26	27	96%
MH - Community-based mental health services for older people.	66	70	94%
MH - Long stay/rehabilitation mental health wards for working age adults	17	18	94%
CHS - End of Life Care	100	108	93%

Core Service	Total number of permanent medical staff who have had an appraisal within the last 12 months	Total number of permanent medical staff required for an appraisal in the last 12 months	% appraisals
MH - Acute wards for adults of working age and psychiatric intensive care units.	201	216	93%
MH - Mental health crisis services and health-based places of safety.	91	98	93%
CHS - Community health services for adults	651	711	92%
CHS - Community health services for children, young people and families	494	537	92%
support service	484	529	91%
MH - Community-based mental health services for adults of working age.	193	215	90%
CHS - Community Dental	22	25	88%
MH - Specialist community mental health services for children and young people	47	57	82%
MH - Community mental health services for people with a learning disability or autism	92	115	80%
Other	128	171	75%
MH - Wards for people with learning disabilities or autism.	11	18	61%
Total	2934	3236	91%

The trust's target rate for clinical supervision is 90%. Between 1 January 2017 and 31 December 2017 the overall clinical supervision compliance was 123%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Fifteen of the 17 teams (88%) achieved the trust's clinical supervision target. The core services failing to achieve the trust's target were 'dental services' *with* 79*%, and '*MH – Wards for people with learning disabilities or autism' *with* 79*%.*

Caveat: There are two totals, which have been listed for clinical supervision. The first total is for the services listed in the table below and the second is for 'all services' in the provider information return. Services were included within the provider information return, which could not be aligned to a core service and have not been included in the table below.

Core Service	Formal supervision sessions each identified member of staff had in the period	Formal supervision sessions should each identified member of staff have received	Clinical supervision rate (%)
MH - Forensic inpatient/secure wards.	95	44	216%

Core Service	Formal supervision sessions each identified member of staff had in the period	Formal supervision sessions should each identified member of staff have received	Clinical supervision rate (%)
MH - Mental health crisis services and health-based places of safety.	442	238	186%
MH - Community-based mental health services for adults of working age.	1121	684	164%
MH - Long stay/rehabilitation mental health wards for working age adults	67	42	160%
MH - Acute wards for adults of working age and psychiatric intensive care units.	673	452	149%
MH - Community-based mental health services for older people.	318	230	138%
CHS - Community health services for children, young people and families	2221	1722	129%
CHS - Community inpatient services	384	358	107%
MH - Specialist community mental health services for children and young people	85	80	106%
CHS - Community health services for adults	1568	1498	105%
CHS - Adults Community	100	96	104%
CHS - End of life care	271	268	101%
MH - Child and adolescent mental health wards.	110	110	100%
MH - Community mental health services for people with a learning disability or autism	313	314	100%
MH - Wards for older people with mental health problems.	186	202	92%
Dental Services	63	80	79%
MH - Wards for people with learning disabilities or autism.	38	48	79%
(Total – for services listed above)	*8055*	*6466*	80%
TOTAL (Overall)	9378	7604	123%

Staff received regular supervision across all services. The trust monitored staff compliance via the electronic staff record. Staff interviewed within core services confirmed they received support from peers and managers on an ongoing basis.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

	In Days	Target Performance
What is your internal target for responding to* complaints?	3	3
What is your target for completing a complaint?	25	25

If you have a slightly longer target for complex complaints please indicate what that is here	N/A	N/A

* Responding to defined as initial contact made, not necessarily resolving issue but more than a confirmation of receipt

**Completing defined as closing the complaint, having been resolved or decided no further action can be taken

	Total	Date range
Number of complaints resolved without formal process*** in the last 12 months	593	January 2017 – December 2017
Number of complaints referred to the ombudsmen (PHSO) in the last 12 months	7	January 2017 – December 2017

**Without formal process defined as a complaint that has been resolved without a formal complaint being made. For example, PALS resolved or via mediation/meetings/other actions.

The trust had a robust and effective complaints process led by qualified and experienced staff. Staff ensured cross checking for any safeguarding and welfare concerns and took immediate actions. Staff across the trust knew how to support patients and carers to complain, and were not afraid to raise complaints themselves. Staff were encouraged where possible to resolve complaints locally. The trust worked with their Patient Advice and Liaison Service to provide patients, their carers and families with help, information and support to resolve any concerns quickly and efficiently.

Staff who investigated complaints received training and had access to a toolkit to help them investigate. Managers shared learning and action plans from complaints to teams via team meetings, the 'learning lessons zone' on the trust intranet and via a weekly 'e-brief', and governance forums. The chief executive chaired a quarterly complaints review committee, which included service users, governors and non-executive directors. We sampled complaints during our inspection and found the trust were robust in their investigations and met targets for responding to complaints. Duty of candour principals were followed, where indicated.

The trust participated in the 'I want great care' initiative. This service allowed patients and carers to comment on the care they have received via the internet. The trust had a 'I want great care' lead, who reported to the medical director. The lead oversaw the system and could respond directly or forward to the relevant team for action. The trust reported 90,939 pieces of feedback since the initiative started. The initiative was embedded into governance, quality and strategy processes.

This trust received 1,291 compliments during the last 12 months from 1 January 2016 to 31 December 2017. This was similar to the 1,229 reported at the last inspection. 'CHS – End of Life Care' had the highest number of compliments with 29%, followed by 'CHS – Adults Community' with 22% and 'CHS Inpatients' with 15%.

Governance

The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers meetings. Leaders regularly reviewed these structures. Ratification of decisions made were taken by the board and the council of governors working collaboratively. This meant that the board had oversight of local challenges, developments and successes.

Non-executive and executive directors were clear about their areas of responsibility. The trust used the organisational risk register as its board assurance framework to support good governance. The trust revised the organisational risk register following the refresh of the trust's strategic plan 2018 – 2023.

Individual directorates were held to account by the board on financial, performance and quality. Business portfolios were well defined and owned by an executive director. Risk registers were analysed and reviewed at the relevant performance or quality committees, which fed into the board assurance framework. Risks, risk levels and risk owners were identified. Each identified risk had clear detail of controls, assurances and key actions. The Trust used a risk management information system incorporating the use of dashboards for real-time reporting and escalation of identified risks.

The trust have provided their board assurance framework, which details any risk scoring 27 or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. The four strategic ambitions outlined by the trust relating to this core service are as follows:

1 – Develop in partnership

2 – Build a sustainable organisation

3 - Quality

4 – Grow our staff capability

The trust provided a document detailing its highest profile risks at Directorate level. Each of these had a current risk score of 15 or more.

High (15-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

Opened	ID	Description	Risk score (current)	Last review date
16/01/2017	3156	The Children's Response and Resolution Team are currently experiencing a staffing concern. There has been regular staff leave the service and new staff joining the team resulting in a shortage of competent team members to meet the demands of the team	**15**	29/12/2017
19/01/2017	3166	Increased number of patients discharged from local Acute Hospitals without referral to service as well as patients referred via trusted assessor process (DTA) for which clinical information differs from clinical presentation of patients at initial assessment who are often found to be clinically unstable and unfit to be left at home	**16**	09/11/2017
03/08/2017	3477	Insufficient funding for places on District Nursing Specialist Nursing Qualification. Four places funded in 2017/18 but no backfill monies	**15**	03/11/2017
29/01/2018	3644	Considerable feedback from staff regarding lack of suitable clinical room availability in Sudborough House. This	**15**	29/01/2018

Opened	ID	Description	Risk score (current)	Last review date
		impacts clinical quality of service as well as resource management		
21/02/2018	3672	Due to a shortfall of funds, equipment budget is being managed through the Community Equipment Panel. There is a long delay of funding of equipment, therefore children are being placed at risk due to lack of provision	**16**	21/02/2018
09/10/2014	2107	Ongoing pressures on staffing levels due to sickness, vacancies and maternity leave	**15**	07/02/2018
03/12/2014	2139	Ongoing difficulty recruiting nursing staff at band 7 advanced nurse practitioner level for district nursing services	**15**	09/11/2017
24/05/2016	2810	The Trust does not have an EPMA system to record medication electronically	**16**	19/09/2017
21/06/2016	2859	High parking demand at sites creating safety risks	**15**	16/02/2018
13/09/2017	3501	Switchboard solution within NHFT is either old and failing (Berrywood) or going out of support (Bevan House and SMH)	**16**	21/09/2017
27/10/2013	1819	Transportation of health records may not be secure and could result in the unauthorised disclosure of sensitive and confidential data	**16**	19/09/2017

Northamptonshire Healthcare NHS Foundation Trust has submitted details of one external review commenced or published in the last 12 months (1 February 2017 to 31 January 2018).

The board assurance framework provided a balance of internal and external sources of assurance. The latest 'head of internal audit opinion', dated May 2018 stated they could provide reasonable assurance that there were no major weaknesses in the system of internal control. The opinion recorded was 'generally satisfactory with some improvements required'.

The Trust was visited by an NHS Improvement Control and Prevention Lead to undertake a quality review. The outcome of the visit was a 'Green' rating for infection control.

Papers for board meetings and other committees were of a good standard and contained appropriate information. All reports were presented on a standard template, which included a governance table stating the alignment to the DIGBQ, any organisational risk considerations, false and misleading information considerations and equality considerations. Meeting minutes showed that the board received the correct level of information from trust committees to enable them to make informed decisions.

The trust leadership team monitored and the delivery of the financial efficiency programme (CIPs) weekly, and tracked monthly, through the performance review meeting. The tracking of CIPs then fed into the monthly board performance committee meetings. The trust provided regular updates regarding CIPs to NHS Improvement.

A clear framework set out the structure of ward/service team, division and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and took action as needed.

Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person.

Appropriate governance arrangements were in place in relation to Mental Health Act administration and compliance. The trust had identified executive and non-executive leads at board level. The trust had a scheme of delegation and robust governance arrangements in place. The Mental Health Act and Mental Capacity Act Scrutiny Committee met bi-monthly to review all MHA, MCA & DoLS related activity, a detailed report was discussed. Issues of concern were escalated via Directorate Management Team & Executive Board with necessary actions required. A further condensed report was submitted to Quality Forum and then to the Quality and Governance subcommittee of the Trust Board. Non-executive Directors were held to account with regards to the MHA by the Governors' Patient and Staff Sub Group, where issues from the MHA Committee were raised.

The trust did not have a section 75 agreement in place. Section 75 agreements are made between local authorities and NHS bodies and can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partners.

The trust was working with third party providers effectively to promote good patient care. The trust had a service level agreement with the local acute trusts to provide advice and responsible clinician cover for patients detained at Northampton General hospital and Kettering General hospital. There were also arrangements in place to provide nurse escorts when trust patients required physical health treatment at the acute hospitals.

The trust had acute liaison teams based in both the local general hospitals and had operational policies in place. However, we found the improvements required for interview rooms in both Northampton and Kettering general hospitals, identified during the last inspection, had not yet been fully rectified and did not met the Psychiatric Liaison Accreditation Network (PLAN) standards. PLAN was run by the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI). PLAN was open to all liaison psychiatry services in the UK and Ireland. Its aim was to support services to continually improve and develop, at a suitable pace.

At the time of the inspection, both facilities posed a potential risk to both patients and staff. However, the trust was working towards PLAN accreditation, had an action plan in place to make improvements to the environments and was expecting its peer review in July 2018.

The trust had clear health and safety strategies and worked with external agencies to monitor and assess legionella, asbestos and fire risks. Estates staff had extensive knowledge of how to manage and respond to national guidance. The trust had identified issues with car parking across their sites and had ongoing plans to address; details of which were to be shared with staff when finalised.

Management of risk, issues and performance

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts. Safety and governance teams regularly reviewed the systems. Senior management committees and the board reviewed performance reports and board members actively encourage challenge on issues. Leaders regularly reviewed and improved the processes to manage current and future performance.

The trust completed quality impact assessments on all cost improvement schemes, together with equality impact assessments.

The trust reported an increase in the use physical interventions (restraint) including prone restraint and seclusion, since the last inspection. However, the trust had a new psychiatric intensive care unit, not inspected previously, which accounted for much of this increase. Senior managers and staff reported that prone restraint was predominantly used to administer medication, and to exit seclusion safely. Data provided from February 2017 to January 2018 showed, across all acute wards and psychiatric intensive care units, there were 288 incidents of prone restraint and 276 incidents of seclusion or administration of rapid tranquilisation, equating to 96%. However, information provided by the trust did not indicate that staff were encouraged to consider alternate sites for administration of rapid tranquilisation. Prone restraint accounted for 56% of all the restraint incidents across this service. We considered the trust should review its practice around the use of prone restraint, in accordance with the Mental Health Act Code of Practice guidelines.

The trust developed a restraint reduction strategy in 2016. This was developed alongside service users and was widely consulted upon with staff from the in-patient areas. The model was adopted in early 2017. Individual elements of the strategy have been monitored via the monthly PMVA meetings, with any issues being escalated to the Mental Health Act scrutiny group. The use of the prone position was specifically recorded (by reason for use and duration) and the data was presented and scrutinised. In conjunction with this, individual clinical records were examined and lessons learnt were discussed and shared with attendees. The outcome of the monthly PMVA meetings were reported through to the Mental Health Act/Mental Capacity Act scrutiny committee via a document produced by the Mental Health Act manager. This committee was attended by the chief operating officer, trust chair, non-executive lead (to provide board oversight), deputy medical director, deputy director of mental health, head of mental health north and south, CAMHS and the relevant heads of service. The MHA/MCA scrutiny committee reported to the quality forum and the quality and governance committee, a sub group of the trust board. The strategy has just been reviewed following an assessment of new data and national trends (June 2018) and was going to the next Mental Health Act Scrutiny Group for evaluation and ratification.

The trust reported an increase in out of area placements within the acute wards for adults when beds were not available. Data showed between 01 February 2017 and 31 January 2018, 264 patients had been placed out of area due to lack of beds; against 133 patients between October 2015 and September 2016. Between February 2018 and June 2018, a total of 92 patients were placed out of area. Therefore, we observed a small decrease in out of area placements over the five months to June 2018. However, we were aware of serious financial challenges within the wider system; which were outside of trust control. The trust was taking a system lead in an attempt to address these concerns, for example leading the local STP, including local financial negotiations. We also noted from the National Mental Health Benchmarking Report for 2017 the trust were lower bed weighted per population (14 beds per 100,000 against an average of 18 beds per 100,000). We considered, therefore, that the trust was managing extreme local pressures in a considered and appropriate manner to ensure safe care was delivered to patients when needed.

In-patients staff work collaboratively with occupational therapy to provide activities relevant to the needs of the patient population and an open visiting approach is supported. In older people's mental health in-patient units, they use the John's Campaign model to support relative interaction.

The trust had plans in place for emergencies and other unexpected or expected events. For example, adverse weather, a flu outbreak or a disruption to business continuity. The trust achieved full compliance with NHS England emergency preparedness, responsive and resilience core standards. The board participated in externally facilitated 'game of threats' cyber security training.

The trust had no medicines safety officer in post, however, this had been recruited to start in September 2018. The trust had a medicines safety group, which reported to the quality and strategy group, both have standing agenda items for medicines optimisation. The trust had a current business case for expanding their pharmacy service to community hospitals. At the time of inspection, the current service being provided by locum pharmacists was providing the minimum coverage. The trust business case included the request for an education and training pharmacist.

There was a comprehensive trust wide internal audit plan in place, agreed by the executive board and overseen by the audit committee. Quarterly internal audits on data quality reviews were included in the internal audit plan on an annual basis. Examples of audits included seclusion, falls, evaluation of fatigue management, sepsis, physical health and diabetes self-management. Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. Teams acted on results where needed.

Staff had access to the risk register either at a team or division level and could effectively escalate concerns as needed. The Trust has a robust risk assessment and risk register process in place to identify both clinical and non-clinical risks at local, directorate/service and organisational levels. Significant risks were escalated to the organisational risk register.

The Trust's financial and operational performance in 2017/18 evidenced effective processes for managing risks, issues and performance. The current risk management model has been shared with and implemented in neighbouring trusts, due to its success.

The Trust's 2017/18 agency spend was lower by £2.941m than the agency ceiling of £10.425m. This reflected the implementation of new agency initiatives within the year.

Where cost improvements were taking place, there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability. Leaders challenged business development proposals if the impact on the trust was less than positive. Where cost improvements were taking place, the focus was on not compromising patient care.

Providers must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of identifying an incident.

Between 1 January 2017 and 31 December 2017, the trust reported 50 STEIS incidents. The most common type of incident was 'Apparent/actual/suspected self-inflicted harm meeting SI criteria' with 24. Seven of these incidents occurred in 'MH - Community-based mental health services for adults of working age'.

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Northamptonshire Healthcare NHS Foundation Trust reported one never event during this reporting period under the 'Medication incident meeting SI criteria' category.

We asked the trust to provide us with the number of serious incidents from the same period on their incident reporting system. The number of the most severe incidents was not comparable with the number the trust reported to STEIS. (Sixteen reported STEIS incidents were not reflected in the Trust's incident reporting system including nine incidents which occurred in a prison). From the trust's serious incident information, eight of the unexpected deaths were instances of 'Apparent / actual / suspected self-inflicted harm meeting SI criteria' and three of these occurred in 'MH – Acute wards for adults of working age and psychiatric intensive care units'.

We reviewed 15 serious incident investigation reports. We found that reports were comprehensively written to a standardised layout. There was evidence of robust investigation, with involvement of outside agencies as appropriate. Reports contained action plans where needed and involvement of families and carers throughout the process; including involvement in formulation of the terms of reference; where possible. The trust applied the principals of duty of candour when required.

The patient safety manager produced a serious incident learning assurance report on a bi-monthly basis, which was presented to the board to provide assurance of the efficacy of the incident management and duty of candour compliance processes. We reviewed the report for January and February 2018 and found the report demonstrated the systems of control were robust, effective and reliable. It also outlined instances of practice within the Trust that underlined commitment to the continuous improvement of incident and harm minimisation.

Type of incident reported on STEIS	MH - Community-based mental health services for adults of working age.	CHS - Adults Community	MH - Acute wards for adults of working age and psychiatric intensive care units	MH - Mental health crisis services and health-based places of safety	Other - PMS service	MH - Community-based mental health services for older people	Other	CHS - Community Inpatients	MH - Child and adolescent mental health wards	MH - Community mental health services for people with a learning disability or autism	MH - Wards for older people with mental health problems	MH - Wards for people with learning disabilities or autism	Unknown	**Total**
Apparent/actual/suspected self-inflicted harm meeting SI criteria	7		4	4	1	2	1		1		1		3	24
Sub-optimal care of the deteriorating patient meeting SI criteria		2										1		3
Confidential information leak/information governance breach meeting SI criteria					1		1							2
Disruptive/ aggressive/ violent behaviour meeting SI criteria	1									1				2
Medication incident meeting SI criteria		1											1	2
Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria			1											1

Type of incident reported on STEIS	MH - Community-based mental health services for adults of working age.	CHS - Adults Community	MH - Acute wards for adults of working age and psychiatric intensive care units	MH - Mental health crisis services and health-based places of safety	Other - PMS service	MH - Community-based mental health services for older people	Other	CHS - Community Inpatients	MH - Child and adolescent mental health wards	MH - Community mental health services for people with a learning disability or autism	MH - Wards for older people with mental health problems	MH - Wards for people with learning disabilities or autism	Unknown	**Total**
Pressure ulcer meeting SI criteria		1												1
Slips/trips/falls meeting SI criteria								1						1
Treatment delay meeting SI criteria		1												1
Pending review (a category must be selected before incident is closed)					1								12	13
Total	8	5	5	4	3	2	2	1	1	1	1	1	16	50

Providers are encouraged to report patient safety incidents to the National Reporting and Learning System (NRLS) at least once a month. They do not report staff incidents, health and safety incidents or security incidents to NRLS.

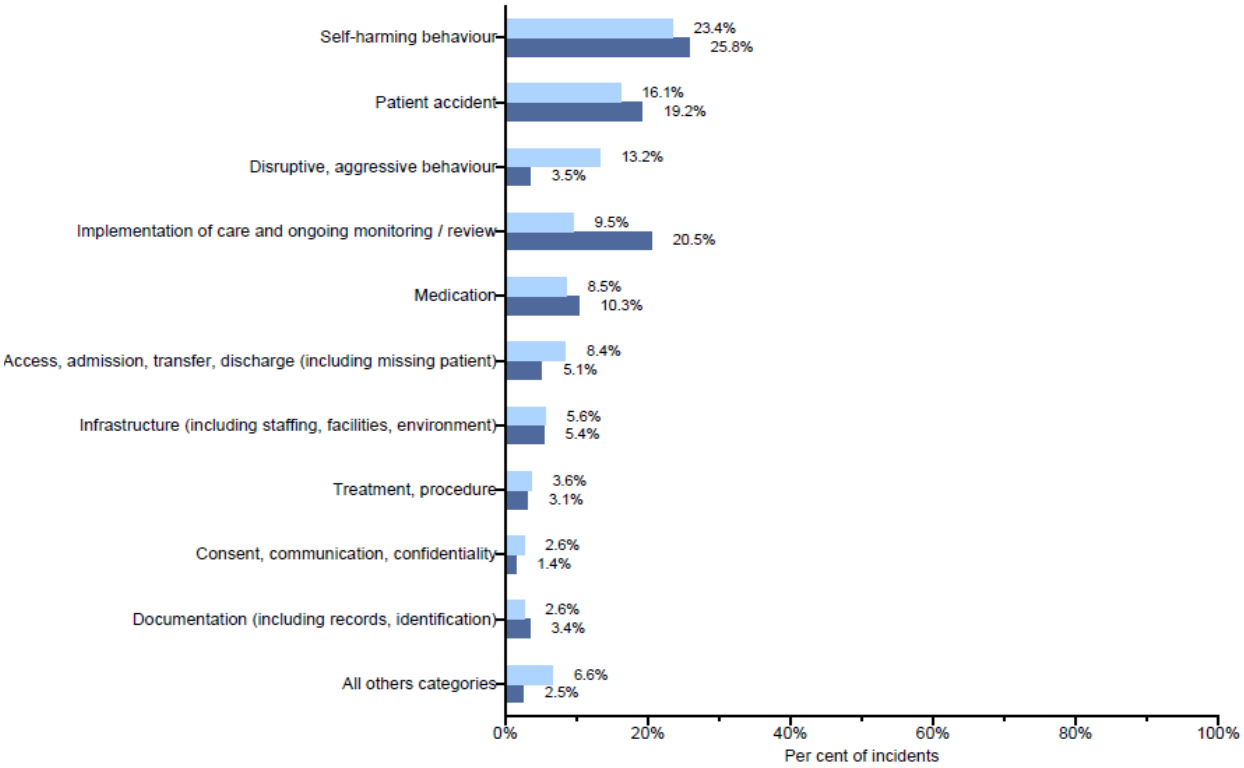
The highest reporting categories of incidents reported to the NRLS for this trust for the period 1 February 2017 to 31 January 2018 were ‘Self-harming behaviour’, ‘Implementation of care and ongoing monitoring/review’ and ‘Patient accident’. These three categories accounted for 3,480 (64%) of the 6,006 incidents reported. ‘Self-harming behaviour’ accounted for 21 of the 24 deaths reported.

Ninety-five percent of the total incidents reported were classed as no harm (63%) or low harm (32%).

Incident type	No harm	Low harm	Moderate	Severe	Death	Total
Self-harming behaviour	774	542	72	2	21	1,411
Implementation of care and ongoing monitoring / review	280	905	90	0	1	1,276
Patient accident	686	398	62	6	1	1,153
Medication	546	13	1	0	0	560
Infrastructure (including staffing, facilities, environment)	360	3	1	0	0	364
Access, admission, transfer, discharge (including missing patient)	287	8	6	0	1	302
Documentation (including electronic & paper records, identification and drug charts)	226	5	0	0	0	231
Treatment, procedure	214	15	2	0	0	231
Disruptive, aggressive behaviour (includes patient-to-patient)	182	44	2	0	0	228
Consent, communication, confidentiality	112	0	1	0	0	113
Other	50	4	4	2	0	60
Medical device / equipment	50	0	0	0	0	50
Clinical assessment (including diagnosis, scans, tests, assessments)	9	1	0	0	0	10
Infection Control Incident	9	1	0	0	0	10
Patient abuse (by staff / third party)	5	1	1	0	0	7
Total	**3,790**	**1,940**	**242**	**10**	**24**	

According to the latest six-monthly National Patient Safety Agency Organisational Report (October 2016 to March 2017), the trust was in the middle 50% of reporters nationally for similar trusts.

‘Implementation of care and ongoing monitoring / review’ and ‘Patient accident’ accounted for a higher proportion of the total number of incidents reported compared to similar trusts.



Organisations that report more incidents usually have a better and more effective safety culture than trusts that report fewer incidents. A trust performing well would report a greater number of incidents over time but fewer of them would be higher severity incidents (those involving moderate or severe harm or death).

Northamptonshire Healthcare NHS Foundation Trust reported more incidents from October 2016 to March 2017 compared with the previous 12 months. The Trust reported more incidents across all categories except for 'Low' harm level which fell (-2%). Reported incidents for the 'No harm' category rose (+55%), 'Severe' (+75%) and 'Deaths' rose from two to 16 deaths (+700%). 'Moderate' incidents saw a slight year on year increase (+8%).

Level of harm	October 2015 – March 2016	October 2016 – March 2017 (most recent)
No harm	1,006	1,557
Low	910	893
Moderate	131	141
Severe	8	14
Death	2	16
Total incidents	**2,057**	**2,621**

Information management

The trust had robust information governance systems in place including the confidentiality of patient records in line with best practice. Front line staff knew the importance of managing patient confidential personal information securely. Access to electronic patient care and treatment records was via smart cards and password protected. Staff had access to the IT equipment and systems needed to do their work.

The trust had a senior information risk owner and a Caldecott guardian. The senior information risk owner was accountable for how the trust managed information and provided a focal point for managing risks and incidents.

The board received holistic information on quality and sustainability. Leaders used meeting agendas to address quality and sustainability at all levels across the trust. Staff said they had access to all necessary information and were encouraged to challenge its reliability. The board and senior staff expressed confidence in the quality of the data and welcomed challenge.

The trust had a robust and effective performance reporting hierarchy which had been developed and reviewed; including integrated performance dashboard, divisional dashboards, workforce dashboard and SMART reporting.

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 team who had oversight of information risk and rights had processes in place to identify and respond to risk in this area. There was an information governance toolkit in place to help staff. We saw a consistent flow of information escalated to board and shared with all staff via the intranet.

The trust had recently introduced a robust system for internal recording of staff appraisal, supervision and mandatory training compliance. The new system provided all staff and senior managers with live and accurate data of performance. The implementation of the electronic staff reporting system had received positive assurance following a robust series of internal audit. All staff spoken to told us that although the system had taken time to embed, they were now finding it a useful tool.

Information was in an accessible format, timely, accurate and identified areas for improvement. Where appropriate, data was produced ‘on a page’ for quick reference, supported by detailed reports.

Systems were in place to collect data from wards/service teams and this was not over burdensome for front line staff.

Staff had access to the IT equipment and systems needed to do their work. IT systems and telephones were working well and they helped to improve the quality of care. However, the trust had identified issues with connectivity for mobile phones in the local area and were actively seeking a resolution.

The trust had completed the information governance toolkit assessment. An independent team had audited it and the trust took action where needed. The information toolkit had achieved compliance of 90%.

Financial information was provided to NHS Improvement regularly and timely to meet with imposed deadlines. The trust communicated with NHS Improvement in an open and prompt manner. There were regular meetings with NHS Improvement through scheduled progress review meetings or by exception.

The trust identified efficiency opportunities highlighted by benchmarking against similar organisations and using the model hospital database to compare performance where available. CIP plans for 2018/19 built on the analysis of model hospital data to deliver financial efficiency savings.

Leaders submitted notifications to external bodies as required.

Engagement

The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives. As of July 2018, the trust reported 50 ongoing patient involvement projects. For example, the trust had a recovery college which supported individuals with experience of mental health difficulties to live the life they want to lead and become experts in their own self-care. All courses were co-produced and co-delivered by people with lived experience of mental health difficulties and mental health professionals, providing a shared learning environment. Courses were open to service users, their carers, friends and family and trust staff.

The Chief Executive had signed up to the principles of County Carer Strategy. This was being redrafted to reflect changes in commissioning and the county council structure. The trust were key participants in this development with a view to ensuring that the strategy covered carers of all ages, including young and working carers.

The trust involvement team promoted the involvement of carers in the development and monitoring of services and carer themes were included in quality forum patient experience reports. Carer Ambassadors were encouraged to raise and discuss carer issues at team meetings. Several carer groups have been established, for example forensic inpatient services, Berrywood Hospital, Welland Centre and NSTEP.

We saw numerous examples of co-production where patients and staff worked together. For example, within the mental health community teams for older adults, some patients were working with the involvement team at the trust. This supported co production in older adult services and included the recruitment and interviewing of new staff. Patients were also invited to participate in the service user reference group.

The trust had significant service user involvement within the management of physical interventions agenda which included; policy writing, strategy development and the formulation of the written assessment used as part of the physical restraint training. The trust captured service user feedback following restraint in a number of ways; formally within the review of the care plan, via iWGC (I Want Great Care), through complaints and PALs. In the 12 months to July 2018, the trust reported no complaints and no PALs concerns relating to restraint.

In community mental health services, patients were invited to participate in service user reference groups. A feedback survey was given to each patient at the end of each appointment. This allowed patients to routinely provide feedback on the service. The survey results were displayed at each location and collated monthly. The results were consistently high.

Prisoners had been invited to draft interview questions for staff applying for roles within the prison service.

Staff were engaged in the strategic ambitions of the Trust through engagement events, such as the recent workshops for the refresh if the Trust's strategy. They were also actively encouraged to participate through their individual directorates.

Staff were engaged in the financial improvement programme through agreement, delivery and accountability for divisional CIP schemes.

Patients and the public are engaged and involved in the Trust strategy through the governors of the Trust in relation to service changes and Trust communications. The Trust has bi-monthly Board meetings which are open to the public. Dates for future Board meetings, together with agendas and approved minutes from previous meetings are available on the Trust's website.

Board members routinely invited patients to board meetings and heard patient stories, and invited patients to trust governance meetings to share views and ideas. Local managers mirrored this in the services and patients told us they were included in decision making about the services.

Patients were actively involved in staff interview panels, forums, advised on business decisions, setting up new services and attended national events and conferences. Service users had been involved in all aspects of the service design of the trust's crisis house; including the grades of staff employed within the service. Service users were involved in a number of trust wide projects and took part in an induction programme and training for roles. We heard examples where previous patients of the trust had now secured employment as healthcare assistants.

The trust restrictive interventions training programme (PMVA) included patients in the training programme and reviews of policy.

Senior staff and team leaders at all levels showed active engagement with local and national stakeholders to improve the delivery of projects and safe care to patients. This included CCG's, local authorities and governing bodies of healthcare. Trust staff attended meetings and volunteered to pilot projects in the trust to ensure they were ahead of innovation in healthcare.

Patients, carers and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs.

The trust sought to actively engage with people and staff in a range of equality groups.

Learning, continuous improvement and innovation

The trust actively sought to participate in national improvement and innovation projects. Staff and patients were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented. For example, the trust involved patients and service users in the production of falls prevention resources. The trust had plans for a falls prevention promotion week in September 2018 linking with acute Trusts.

The trust had implemented a robust strategy around falls prevention. This included the development of "falls prevention in hospital" leaflets for inpatients and relatives, and "falls prevention in the community" leaflets. Staff were encouraged to consider patients' sight when assessing falls risk and the trust utilised an 'vision assessment' as a brief tool for the assessment of risk. The trust had developed and re-launched the falls champions role. Throughout the trust there were over 60 falls champions, in over 30 different clinical settings. The falls champions met regularly to discuss best practice, service development and quality improvement shared ideas and information, as well as having access to additional training in the form of regular study days with a variety of speakers. Falls leads attended regular meetings and service development with falls leads from the acute hospitals, and attended countywide falls meetings as part of the Northamptonshire Falls Strategy. The trust had also produced a leaflet on falls prevention within prison settings.

	Historical data		Projections	
Financial Metrics	Previous financial year (2 years ago)	Last financial year (2016/2017)	This financial year	Next financial year (2018/2019)
Income	£188,037,000	£198,861,000	£197,620,000	£198,873,000
Surplus	-£1,395,000	£3,315,000	£2,000,000	£1,909,000
Full costs	£189,432,000	£195,546,000	£195,620,000	£196,964,000
Budget	£189,991,779	£192,970,955	£194,594,561	£196,964,000

The Board oversaw financial performance at Board meetings, held every other month and through the Performance Committee meetings, which are held in the months where there is no board meeting.

Board responsibilities are clear and understood by the executive team. The Trust had a strong financial position. In 2017/18 the Trust obtained additional STF payment for delivering a higher surplus than planned. Going forward into 2018/19 achievement of the financial position will be more challenging, but the Trust had identified mitigations and had a track record of delivering its financial plan.

The delivery of the financial efficiency programme (cost improvement programmes) was monitored weekly by the Trust leadership team and tracked through the performance review meetings (monthly). The tracking of CIPs then fed into the monthly Board / Performance committee meetings. Regular updates regarding CIPs were provided to NHS Improvement from the Trust. The Trust attended regional network improvement events such as the NHS Improvement Director of Finance meetings and CIP network events.

The Trust was engaged with peers in providing support to the local system (STP) across a variety of areas where improvement is required: financial, operational and quality. The Trust liaises with peers in benchmarking and using best practice. The Trust's risk management model has been shared with neighbouring trusts.

The trust was focused on improving pathways and is continuous in its encouragement of innovations to do so, which are then subsequently reviewed and challenged by the board.

The trust participated in a wide range of audits and accreditation schemes and shared learning. The trust participated in clinical research studies as part of the Collaborations for Leadership in Applied Health Research and Care East of England (CLAHRC). The trust had recruited 2000 participants into research and innovation projects.

We were shown a number of research projects and research publications, underpinning current practices within the trust, including transcranial magnetic stimulation in clinical practice and the feasibility of using body worn cameras in an inpatient mental health setting. The trust had been asked to participate in the first clinical evaluation of magnetic seizure therapy worldwide and was in the process of obtaining ethical approval and advice from the Royal College of Psychiatrists' ECT and related treatments committee for the evaluation.

The trust had recently introduced a bespoke patient gum shield, made by the trusts community dental Department, the intended benefits of the gum shield included reducing post-ECT headache. The trust was in the process of evaluating this outcome. The trust were in the process of producing a research paper for this innovation to encourage other providers to consider this option. The trust included a module for innovation and research within their 'leadership matters' programme.

The trust had set aside funds so that staff could undertake small projects under the QI banner. The trust had not yet identified a QI methodology but had planned a meeting with one of the main organisations to discuss adoption of their methodology.

Effective systems were in place to identify and learn from unexpected deaths. The trust had employed a family liaison officer to provide support for families and carers following serious incidents and unexpected deaths.

The trust had been recognised for its innovation in a number of areas, for example, a staff member from the children and young people's response team who won the 'Our Health Heroes Clinical Support Worker of the Year' award for the East Midlands region; The breathing space service in

Northamptonshire won the Pathway Innovation of the Year Award at the National Primary Care Awards; FAB awards 2017, The referral management centre won the 'penguin' teamwork award for their work in making referrals faster by moving to an online system and the children's mental health service (CAMHS) were shortlisted by young service users for their online chat system, CAMHS live.

NHS trusts can take part in accreditation schemes that recognise services' compliance with standards of best practice. Accreditation usually lasts for a fixed time, after which the service must be reviewed.

The table below shows services across the trust awarded an accreditation (trust-wide only), with the relevant dates and details of those services working towards an accreditation.

Accreditation scheme	Core service	Service accredited	Comments and Date of accreditation / review
Gold Standards Framework Accreditation process, leading to the GSF Hallmark Award in End of Life Care	End of Life Care	Danetre Hospital	Danetre Hospital has achieved accreditation at Care Homes standard and has submitted a portfolio for GSF accreditation for Community Hospitals
AIMS – PICU	Acute Wards for adults of working age and psychiatric intensive care units	Marina ICU	• Accredited November 2017
AIMS – OP (Wards for older people)	Wards for older people with mental health problems	The Forest Centre • Orchard • Spinney Berrywood Hospital • Brookview • Riverside	Orchard and Spinney • Accredited September 2016 Brookview and Riverside • Accredited February 2015.
AIMS – Rehab	Long stay / rehabilitation mental health wards for working age adults	Meadowbank	• Accredited June 2017
Quality Network for Inpatient CAMHS (QNIC)	Child and adolescent mental health wards	The Sett	The Sett • Accredited 7 May 2015 • Three yearly accreditation review booked for 5 April 2018 The Burrows • Had first peer visit in January 2018
Quality Network for Forensic Mental Health Services (QNFMH)		Wheatfield	
AIMS – WA (Working Age Units)	Acute Wards for adults of working age and psychiatric intensive care		Three services have received an AIMS peer review and are waiting for the report • Cove – 11 September 2017

Accreditation scheme	Core service	Service accredited	Comments and Date of accreditation / review
	units		• Bay – 21 September 2017 • Harbour – 20 September 2017
Psychiatric Liaison Accreditation Network (PLAN)			The ALMH team have been working develop the service to meet PLAN and shall be developing an application in the next two months

Community health services

Community health services for adults

Facts and data about this service

Northamptonshire Healthcare NHS Foundation Trust provides health and social care services to the people of Northamptonshire, as well as some specialist services in bordering and nearby counties. The trust offers a comprehensive range of physical, mental health and specialist services, many of which are provided in hospitals, General Practitioner (GP) surgeries and clinics. The community service aims to deliver care to patients in their own homes whenever possible and provides many services outside of the hospitals and in the community. Their comprehensive range of services includes podiatry, physiotherapy and district nursing services. The trust's sites are located in Corby, Daventry, Kettering, Northampton and East Northamptonshire.

Community health services for adults were last inspected in January 2017. We rated the service as good overall with a rating of requires improvement for safe, and good for effective, caring, responsive, and well-led. We told the trust they must take the following actions:

- The trust must ensure there are systems in place to ensure patients were able to access the right care at the right time, and patients' conditions were not deteriorating.
- The trust must ensure there were processes in place to routinely monitor and assess patient outcomes.
- The trust must ensure there were robust systems in place to manage environment, cleanliness and equipment.
- The trust must ensure that staff receive training that is relevant, and at a suitable level for their role.

We carried out an announced inspection from 5 June to 7 June 2018 and found all actions had been completed.

During this inspection we visited community therapy and nursing staff bases, the intermediate care team, and a variety of outpatient clinics. The sites we visited were: Danetre Hospital, Corby Community Hospital, and Isebrook Community Hospital.

We spoke to 56 members of staff including clinical and operational service leads, nursing staff, allied health professionals, and support staff. We spoke with 12 patients and two relatives and reviewed seven patient care records. We also observed patient care, staff handovers and reviewed information including meeting minutes, audit data, action plans and training records.

Information about the sites, which offer services for adults at this trust, is shown below. All the sites have a mixed patient group.

Location site name	Team/ward/satellite name	Address	Postcode	Number of clinics per month	Geographical area served
Battle House	Podiatric Surgery	Battle House, Billing Road, Northampton General Hospital, Northampton,	NN1 5BD	8	Countywide
Battle House	Podiatric Surgery	Danetre Hospital, London Road, Daventry, Northants,	NN11 4DY	40-50 per month	Countywide
Trust Headquarters	Adults Speech & Language Therapy Services	Brackley Health Centre, 68 Halse Road, Brackley, Northants	NN13 6EJ	4/5 per month	South of the county up to Towcester
Trust Headquarters	Adults Speech & Language Therapy Services	Danetre Hospital, London Road, Daventry, Northants	NN11 4DY	8/10 per month	South west of the county
Trust Headquarters	Adults Speech & Language Therapy Services	Highfield Clinical Care Centre, Cliftonville Road, Northampton	NN1 5DN	40-50 per month	Northampton central area
Trust Headquarters	Adults Speech & Language Therapy Services	Irthlingborough Road Wellingborough	NN8 1LP	30-40 per month	North east
Trust Headquarters	Adults Speech & Language Therapy Services	St Mary's Hospital, London Road, Kettering	NN15 7PW	40-50 per month	North & north west of the County.
Trust Headquarters	Community Nursing Team	Willowbrook Health Centre, Cottingham Road, Corby	NN17 2UR	N/A	Corby
Trust Headquarters	Community Nursing Team	Danetre Hospital, London Road, Daventry, Northants	NN11 4DY	N/A	Daventry
Trust Headquarters	Community Nursing Team	Bugbrooke Medical Practice, Levitts Road, Bugbrooke, Northampton	NN7 3QN	N/A	Daventry and South Northants
Trust Headquarters	Community Nursing Team	Crick Medical Practice, 16 Watford Road, Crick, Northants	NN6 7TT	N/A	Daventry
Trust Headquarters	Community Nursing Team	Guilsborough Surgery, Weston Haddon Road, Guilsborough, Northants	NN6 8QE	N/A	Daventry
Trust Headquarters	Community Nursing Team	Long Buckby Practice, 24 Station Road, Long Buckby, Northants	NN6 7QB	N/A	Daventry
Trust Headquarters	Community Nursing Team	Rectory Road Clinic, Rectory Road, Rushden	NN10 0AE	N/A	East Northants
Trust Headquarters	Community Nursing Team	Romic House, Garrard Way, Telford Way Industrial Estate, Kettering	NN16 8TD	N/A	Kettering

Location site name	Team/ward/satellite name	Address	Postcode	Number of clinics per month	Geographical area served
Trust Headquarters	Community Nursing Team	Abington Medical Centre, 51a Beech Avenue, Northampton,	NN3 2JG	N/A	Northampton Central
Trust Headquarters	Community Nursing Team	Abington Park Surgery, Christchurch Medical Centre, Ardington Road, Northampton	NN1 5LT	N/A	Northampton Central
Trust Headquarters	Community Nursing Team	County Surgery, 202-204 Abington Avenue, Northampton	NN1 4AQ	N/A	Northampton Central
Trust Headquarters	Community Nursing Team	Crescent Surgery, 2 The Crescent, Kingsley, Northampton	NN1 4SB	N/A	Northampton Central
Trust Headquarters	Community Nursing Team	Greenview Surgery, 129 Hazeldene Road, Northampton	NN2 7PB	N/A	Northampton Central
Trust Headquarters	Community Nursing Team	King Edward Road Surgery, Christchurch Medical Centre, King Edward Road, Northampton	NN1 5LY	N/A	Northampton Central
Trust Headquarters	Community Nursing Team	Maple Access Partnership, Maple House, 17 - 19 Hazelwood Road, Northampton	NN1 1LG	N/A	Northampton Central
Trust Headquarters	Community Nursing Team	Park Avenue Medical Centre, Park Avenue North, Northampton	NN3 2HZ	N/A	Northampton Central
Trust Headquarters	Community Nursing Team	The Mounts Medical Centre, Campbell Street, Northampton	NN1 3DS	N/A	Northampton Central
Trust Headquarters	Community Nursing Team	Danes Camp Surgery, Rowtree Road, East Hunsbury, Northampton	NN4 0NY	N/A	Northampton East & South
Trust Headquarters	Community Nursing Team	Denton Village Surgery, Orchard Lane, Denton, Northampton	NN7 1HT	N/A	Northampton East & South
Trust Headquarters	Community Nursing Team	Ecton Brook Medical Centre, Ecton Brook Road, Northampton	NN3 5EN	N/A	Northampton East & South
Trust Headquarters	Community Nursing Team	Moulton Surgery, 120 Northampton Lane North, Northampton	NN3 7QP	N/A	Northampton East & South
Trust Headquarters	Community Nursing Team	Penvale Park Medical Centre, Hardwick Road, East Hunsbury, Northampton	NN4 0GP	N/A	Northampton East & South
Trust Headquarters	Community Nursing Team	Rillwood Medical Centre, Tonmead Road, Lumbertubs, Northampton	NN3 4HZ	N/A	Northampton East & South
Trust Headquarters	Community Nursing Team	Weston Favell Health Centre, Billing Brook Road, Weston Favell, Northampton	NN3 8DW	N/A	Northampton East & South

Location site name	Team/ward/satellite name	Address	Postcode	Number of clinics per month	Geographical area served
Trust Headquarters	Community Nursing Team	Woodview Medical Centre, Holmecross Road Thorplands, Northampton	NN3 8AW	N/A	Northampton East & South
Trust Headquarters	Community Nursing Team	Wootton Medical Centre, 36-38 High Street, Wootton, Northampton	NN4 6LW	N/A	Northampton East & South
Trust Headquarters	Community Nursing Team	Camp Hill Health Clinic, Hunsbury Hill Road, Camp Hill, Northampton	NN4 9UW	N/A	Northampton East & South
Trust Headquarters	Community Nursing Team	Clarence Avenue Surgery, 14 Clarence Avenue, Northampton	NN2 6NZ	N/A	Northampton West
Trust Headquarters	Community Nursing Team	Delapre Medical Centre, Gloucester Avenue, Northampton	NN4 8QF	N/A	Northampton West
Trust Headquarters	Community Nursing Team	Kings Heath Surgery, North Oval, Kings Heath, Northampton	NN5 7LN	N/A	Northampton West
Trust Headquarters	Community Nursing Team	Langham Place Surgery, 11 Langham Place, Northampton	NN2 6AA	N/A	Northampton West
Trust Headquarters	Community Nursing Team	Leicester Terrace Surgery, 7 - 8 Leicester Terrace, Northampton	NN2 6AL	N/A	Northampton West
Trust Headquarters	Community Nursing Team	Queensview Medical Centre, Thornton Road, Northampton	NN2 6LS	N/A	Northampton West
Trust Headquarters	Community Nursing Team	St Luke's Primary Care Centre, Timken Way South, Northampton,	NN5 6FR	N/A	Northampton West
Trust Headquarters	Community Nursing Team	The Pines Surgery, Harborough Road, Kingsthorpe, Northampton	NN2 8LL	N/A	Northampton West
Trust Headquarters	Community Nursing Team	Whitefields Surgery, Hunsbury Hill Road, Camp Hill, Northampton	NN4 9UW	N/A	Northampton West
Trust Headquarters	Community Nursing Team	Brackley Health Centre, 68 Halse Road, Brackley, Northants	NN13 6EJ	N/A	South Northants
Trust Headquarters	Community Nursing Team	Brook Health Centre, Swinneyford Road, Towcester	NN12 6HD	N/A	South Northants
Trust Headquarters	Community Nursing Team	Grange Park Primary Care Centre, Wilks Walk, Grange Park, Northampton	NN4 5DW	N/A	South Northants
Trust Headquarters	Community Nursing Team	Weedon Medical Practice, 57 New Croft, Weedon	NN7 4RX	N/A	South Northants
Trust Headquarters	Community Nursing Team	Isebrook Hospital, Abbey Block, Irthlingborough Road, Wellingborough, Northants	NN8 1LP	N/A	Wellingborough
Trust Headquarters	Diabetes and High Risk Foot Service	Isebrook Hospital, Castle Unit	NN8 1LP	12-15 per month weds half (sic)	Countywide

Location site name	Team/ward/satellite name	Address	Postcode	Number of clinics per month	Geographical area served
		Irthlingborough Road, Wellingborough, Northants			
Trust Headquarters	Diabetes and High-Risk Foot Service	Diabetes Centre, Kettering General Hospital, Rothwell Road, Kettering	NN16 8UZ	40-50 per month	Countywide
Trust Headquarters	Diabetes and High-Risk Foot Service	Oakwood Centre, St Mary's Hospital, London Road, Kettering	NN15 7PW	40-50 per month	Countywide
Trust Headquarters	Diabetes and High-Risk Foot Service	Oundle Medical Practice, Glapthorn Road, Peterborough, Oundle, Northamptonshire, Cambs	PE8 4JA	4-5 per month	Countywide
Trust Headquarters	Diabetes and High-Risk Foot Service	Rectory Road Clinic, Rectory Road, Rushden	NN10 0AE	40-50 per month	Countywide
Trust Headquarters	Diabetes and High-Risk Foot Service	Willowbrook Health Centre, Cottingham Road, Corby	NN17 2UR	40-50 per month	Countywide
Trust Headquarters	Diabetes and High-Risk Foot Service	Brackley Health Centre, 68 Halse Road, Brackley, Northants	NN13 6EJ	24-30 per month	Countywide
Trust Headquarters	Diabetes and High-Risk Foot Service	Brook Health Centre, Swinneyford Road, Towcester	NN12 6HD	14-17 per month	Countywide
Trust Headquarters	Diabetes and High-Risk Foot Service	Danetre Hospital, London Road, Daventry, Northants	NN11 4DY	30-40 per month	Countywide
Trust Headquarters	Diabetes and High-Risk Foot Service	Kingsthorpe Clinic, Welford Road, Kingsthorpe, Northampton	NN2 8AG	40-50 per month	Countywide
Trust Headquarters	Diabetes and High-Risk Foot Service	St James Clinic, 116 St James Road, Northampton	NN5 5LQ	40-50 per month	Countywide
Trust Headquarters	Diabetes and High-Risk Foot Service	Battle House, Billing Road, Northampton General Hospital, Northampton,		8 per month	Countywide
Trust Headquarters	Diabetes and High-Risk Foot Service	Weston Favell Health Centre, Billing Brook Road, Weston Favell, Northampton	NN3 8DW	40-50 per month	Countywide
Trust Headquarters	Community Therapy Service	Isebrook Hospital, Beechwood Ward, Irthlingborough Road, Wellingborough, Northants	NN8 1LP	N/A	Countywide
Trust Headquarters	Community Therapy Service	Favell House, Manfield Campus, Kettering Rd Northampton	NN3 6NP	N/A	Countywide
Trust Headquarters	Community Therapy Service	Oakwood Centre, St Mary's Hospital, London Road, Kettering	NN15 7PW	N/A	Countywide
Trust Headquarters	Diabetes MDT	Danetre Hospital, H Block, London Road, Daventry, Northants, NN11 4DY	NN11 4DY	N/A	Countywide

Location site name	Team/ward/satellite name	Address	Postcode	Number of clinics per month	Geographical area served
Trust Headquarters	Diabetes MDT	Far Cotton Rec Centre, Towcester Road, Northampton	NN4 8LG	N/A	Countywide
Trust Headquarters	Diabetes MDT	Diabetes Centre, Kettering General Hospital, Rothwell Road, Kettering, NN16 8UZ	NN16 8UZ	N/A	Countywide
Trust Headquarters	Diabetic Eye Screening Programme	Brackley Health Centre, 68 Halse Road, Brackley, Northants, NN13 6EJ	NN13 6EJ	140-160 per month	Countywide
Trust Headquarters	Diabetic Eye Screening Programme	Brook Health Centre, Swinneyford Road, Towcester, NN12 6HD	NN12 6HD		Countywide
Trust Headquarters	Diabetic Eye Screening Programme	Danetre Hospital, London Road, Daventry, Northants, NN11 4DY	NN11 4DY		Countywide
Trust Headquarters	Diabetic Eye Screening Programme	Highfield Clinical Care Centre, Cliftonville Road, Northampton, NN1 5DN	NN1 5DN		Countywide
Trust Headquarters	Diabetic Eye Screening Programme	Isebrook Hospital, Castle Unit Irthlingborough Road, Wellingborough, Northants, NN8 1LP	NN8 1LP		Countywide
Trust Headquarters	Diabetic Eye Screening Programme	Nene Park, Attley Way, Irthlingborough, Northants, NN9 5GF	NN9 5GF		Countywide
Trust Headquarters	Diabetic Eye Screening Programme	Oakwood Centre, St Mary's Hospital, London Road, Kettering, NN15 7PW	NN15 7PW		Countywide
Trust Headquarters	Diabetic Eye Screening Programme	Oundle Medical Practice, Glapthorn Road, Peterborough, Oundle, Northamptonshire, Cambs, PE8 4JA	PE8 4JA		Countywide
Trust Headquarters	Diabetic Eye Screening Programme	Willowbrook Health Centre, Dental Department, First Floor Cottingham Road, Corby, NN17 2UR	NN17 2UR		Countywide
Trust Headquarters	Dietetics	Highfield Clinical Care Centre, Dietetic Department, Cliftonville Road, Northampton, NN1 5DN	NN1 5DN	80-100 per month	Countywide
Trust Headquarters	Dietetics	Kettering General Hospital, Dietetic Department, Ground Floor, Northfield House, Rothwell Road, Kettering, NN16 8UZ	NN16 8UZ		Countywide
Trust Headquarters	Evening District Nursing Team	Romic House, Garrard Way, Telford Way	NN16 8TD	N/A	Countywide

Location site name	Team/ward/satellite name	Address	Postcode	Number of clinics per month	Geographical area served
		Industrial Estate, Kettering, NN16 8TD			
Trust Headquarters	Evening District Nursing Team	Highfield Clinical Care Centre, Cliftonville Road, Northampton, NN1 5DN	NN1 5DN	N/A	Countywide
Trust Headquarters	Falls Service	Isebrook Hospital, Irthlingborough Road, Wellingborough, Northants, NN8 1LP	NN8 1LP	8-12 per month	Countywide
Trust Headquarters	Heart Failure Specialist Nursing	Dantre Hospital London Rd Daventry NN11 4DY	NN11 4DY	N/A	Countywide
Trust Headquarters	Heart Failure Specialist Nursing	Romic House, Garrard Way, Telford Way Industrial Estate, Kettering, NN16 8TD	NN16 8TD	N/A	Countywide
Trust Headquarters	Intermediate Care Team	Romic House, Garrard Way, Telford Way Industrial Estate, Kettering, NN16 8TD	NN16 8TD	N/A	Countywide
Trust Headquarters	Intermediate Care Team	Highfield Clinical Care Centre, Cliftonville Road, Northampton, NN1 5DN	NN1 5DN	N/A	Countywide
Trust Headquarters	MSK Occupational Therapy	Corby Community Hospital, Cottingham Road, Corby, NN17 2UN	NN17 2UN	32 per month	Countywide
Trust Headquarters	MSK Occupational Therapy	Rectory Road Clinic, Rectory Road, Rushden, NN10 0AE	NN10 0AE	16 per month	Countywide
Trust Headquarters	MSK Occupational Therapy	Oakwood Centre, St Mary's Hospital, London Road, Kettering NN15 7PW	NN15 7PW	40 per month	Countywide
Trust Headquarters	MSK Physiotherapy & ESP	Danetre Hospital, London Road, Daventry, Northants, NN11 4DY	NN11 4DY	1900-2000 per month	Countywide
Trust Headquarters	MSK Physiotherapy & ESP	Highfield Clinical Care Centre, Cliftonville Road, Northampton, NN1 5DN	NN1 5DN		Countywide
Trust Headquarters	MSK Physiotherapy & ESP	Isebrook Hospital, Irthlingborough Road, Wellingborough, Northants, NN8 1LP	NN8 1LP		Countywide
Trust Headquarters	MSK Physiotherapy & ESP	Kettering General Hospital, Rothwell Road, Kettering, NN16 8UZ	NN16 8UZ		Countywide
Trust Headquarters	MSK Physiotherapy & ESP	Nene Park, Attley Way, Irthlingborough, Northants, NN9 5GF	NN9 5GF		Countywide
Trust Headquarters	MSK Physiotherapy & ESP	Northampton General Hospital, A&E, Cliftonville, Northampton, NN1 5BD	NN1 5BD		Countywide

Location site name	Team/ward/satellite name	Address	Postcode	Number of clinics per month	Geographical area served
Trust Headquarters	MSK Physiotherapy & ESP	Nuffield Diagnostic Centre, Cottingham Rad, Corby, Northamptonshire NN17 2UW	NN17 2UW		Countywide
Trust Headquarters	MSK Physiotherapy & ESP	Weston Favell Health Centre, Billing Brook Road, Weston Favell, Northampton, NN3 8DW	NN3 8DW		Countywide
Trust Headquarters	Northamptonshire Integrated Sexual Health	Great Oakley Medical Centre 1 Barth Close Great Oakley Northamptonshire, NN18 8LU	NN18 8LU	8 per month	Countywide
Trust Headquarters	Northamptonshire Integrated Sexual Health	Castle Unit Isebrook Hospital Wellingborough Northamptonshire, NN8 1LP	NN8 1LP	8 per month	Countywide
Trust Headquarters	Northamptonshire Integrated Sexual Health	Rectory Road Clinic Rectory Road Rushden Northamptonshire, NN10 0AE	NN10 0AE	8 per month	Countywide
Trust Headquarters	Northamptonshire Integrated Sexual Health	Ashwood Centre, Mary's Hospital, London Road, Kettering, NN15 7PW	NN15 7PW	20-30 per month	Countywide
Trust Headquarters	Northamptonshire Integrated Sexual Health	Northampton General Hospital, Area R, Cliftonville, Northampton, NN1 5BD	NN1 5BD	20-30 per month	Countywide
Trust Headquarters	Northamptonshire Integrated Sexual Health	Stuart Road Resource Centre Stuart Road Corby Northamptonshire,	NN17 1RJ	8 per month	Countywide
Trust Headquarters	Northamptonshire Integrated Sexual Health	Danetre Hospital, London Road, Daventry, Northants, NN11 4DY	NN11 4DY	8 per month	Countywide
Trust Headquarters	Northamptonshire Integrated Sexual Health	The Lowdown 3 Kingswell Street Northampton Northamptonshire NN1 1PP	NN1 1PP	8 per month	Countywide
Trust Headquarters	Northamptonshire Integrated Sexual Health	Weston Favell Health Centre Billing Brook Road Northampton Northamptonshire, NN3 8DW	NN3 8DW	8 per month	Countywide
Trust Headquarters	Northants Continence Advisory Service	Manfield Court Kettering Road Northampton NN3 6NP	NN3 6NP	N/A	Countywide
Trust Headquarters	Phlebotomy Service	Weston Favell Health Centre, Billing Brook Road,	NN3 8DW	4-5 per week	South/East

Location site name	Team/ward/satellite name	Address	Postcode	Number of clinics per month	Geographical area served
		Weston Favell, Northampton, NN3 8DW			Northampton
Trust Headquarters	Specialist Nursing - Multiple Sclerosis	Isebrook Hospital, Irthlingborough Road, Wellingborough, Northants, NN8 1LP	NN8 1LP	N/A	Countywide
Trust Headquarters	Specialist Nursing - Parkinson's Disease Nurse North of County	Isebrook Hospital, Irthlingborough Road, Wellingborough, Northants, NN8 1LP	NN8 1LP	N/A	Countywide
Trust Headquarters	Specialist Nursing - Parkinson's Disease Nurse South of County	Favell House Manfield Campus, Kettering Rd, Northampton, NN3 6NP	NN3 6NP	N/A	Countywide
Trust Headquarters	Specialist Nursing - Tissue Viability	Isebrook Hospital, Irthlingborough Road, Wellingborough, Northants, NN8 1LP	NN8 1LP	N/A	Countywide
Trust Headquarters	Summers Unit	Ashwood Centre, Mary's Hospital, London Road, Kettering, NN15 7PW	NN15 7PW	N/A	Countywide
Trust Headquarters	Summers Unit	Northampton General Hospital, Area R, Cliftonville, Northampton, NN1 5BD	NN1 5BD	N/A	Countywide
Trust Headquarters	TB Service	Isebrook Hospital, Irthlingborough Road, Wellingborough, Northants, NN8 1LP	NN8 1LP	6 TB Clinics & 6 Drop in clinics all based within KGH/NGH	Countywide

Is the service safe?

Mandatory training

The trust provided mandatory training in key skills to all staff and made sure staff completed it.

During the January 2017 inspection, we found community health services (CHS) for adults had an overall mandatory training compliance rate of 80% which did not meet the trust target of 90%. During this inspection, initial data provided by the trust prior to our inspection indicated there had been a significant deterioration with compliance.

The trust set a target of 90% for completion of mandatory training and the overall compliance in this core service as of 31 January 2018 was 43%.

A breakdown of compliance for mandatory courses between February 2017 and January 2018 for staff in community services for adults is shown below:

Core Services	Grand Total %
Mental Health Act	300%
Falls Prevention Training - Level 1	158%
Falls Prevention Training - Level 2	100%

Core Services	Grand Total %
Infection Prevention (Level 2)	83%
Fire Safety	71%
Information Governance	70%
Resuscitation Level 2 - Adult & Paediatric	67%
Duty of Candour	49%
Conflict Resolution	44%
Safeguarding Adults (Level 2)	39%
Mental Capacity Act DoLS	32%
Safeguarding Adults Level 1	30%
Safeguarding Children (Level 1	30%
Infection Prevention (Level 1)	29%
Safeguarding Prevent Health WRAP	26%
Dementia Awareness (inc Privacy and Dignity Standards)	24%
Learning Disability Awareness	23%
Equality and Diversity	21%
Moving and Handling	20%
Safeguarding Children (Level 2)	20%
Making Every Contact Count	18%
Health, Safety and Welfare	16%
Resuscitation Level 1	13%
Raising concerns and whistleblowing	5%
Core Service Average	43%

The table showed mandatory training compliance was significantly below the trust completion target of 90% in 20 out of 23 mandatory training areas between February 2017 and January 2018. Training compliance was below 50% in 17 out of the 23 areas.

The trust had transferred to a new electronic reporting system in March 2018 and had experienced data quality issues since that time. Staff told us figures were not reflective of the most up-to-date information.

During the June 2018 inspection, we observed senior nurses had local copies of staff training so they could monitor departmental compliance and did not have to rely on potentially inaccurate, trust-wide information. For example, staff within the integrated community care team confirmed they were up to date with their training and we observed the target of 90% mandatory training completion was achieved.

Following the inspection, the trust provided further data that confirmed the trust mandatory training target of 90% was met in the majority subjects as at May 2018. The overall trust compliance was 89% in fourteen subject areas reported in the table below.

Mandatory training completion by core subject May 2017

Core Subject	Grand Total %
Infection Prevention (Level 2)	94%
Moving and Handling (Level 1)	94%
Moving and Handling (Level 2) – Review required at year one	85%

Core Subject	Grand Total %
Moving and Handling (Level 2) – Reviewed at year two	93%
Resuscitation (Level 1)	90%
Resuscitation (Level 2) Adult and Paediatric Basic Life	89%
Resuscitation (Level 3) – Adult Immediate Life Support	47%
Safeguarding Adults (Level 1)	99%
Safeguarding Children (Level 1)	99%
Safeguarding Adults (Level 2)	96%
Safeguarding Children (Level 2)	95%
Safeguarding Children (Level 3)	84%
Freedom to Speak Up training	93%
Safeguarding – Prevent Health Wrap	93%
Core Service Average	89%

The reporting of accurate training data was recorded as a risk on the directorate risk register, and we observed action was being taken to develop the electronic reporting system to support the systematic and accurate reporting of mandatory training completion.

Staff received training through online learning packages, face to face and within practical sessions. The new electronic reporting system was used by staff to monitor compliance and to book on training classes, and access electronic learning. Mandatory training modules included infection prevention and control, basic life support, information governance, fire, equality and diversity, documentation, display screen equipment and safeguarding children and vulnerable adults. Dementia awareness training was also included as an e-learning module as part of mandatory training for all clinical staff.

Safeguarding

Staff understood how to protect patients from abuse and were aware of the requirement to work 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 had the appropriate level of safeguarding training for the services they delivered.

During our January 2017 inspection, the service was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We identified that not all staff had the appropriate levels of safeguarding training for the services they delivered. For example, within the physiotherapy and tuberculosis services, staff treated children, young people and babies with level two safeguarding children training. This was not in line with the *'Intercollegiate document on safeguarding children and young people' (March 2014)* that recommends staff working with children should be trained to level three children's safeguarding. There was no risk assessment for this practice. This meant that staff did not have safeguarding training relevant for their role to appropriately protect patients.

Initial data submitted by the trust for the June 2018 inspection showed not all staff had received mandatory training in the safeguarding of adults and children. Safeguarding adult's and children's level one and two training compliance was below 40%, which was significantly below the trust target of 90%. This data demonstrated a deterioration in safeguarding training compliance since the January 2017 inspection when we found 91% of staff had completed safeguarding children

and adult's level two training. No data was initially submitted concerning safeguarding children level three mandatory training completion.

The trust reported that the move to a new electronic recording system in March 2018 meant data quality was not reliable. New data submitted by the trust in June 2018 demonstrated that over 95% of eligible staff had completed level one and two children and adult's safeguarding training, as at May 2018. Safeguarding children level three training was completed by 85% of eligible staff which demonstrated significant improvement since the January 2017 inspection. We were therefore assured that the majority of staff had the appropriate level of safeguarding training that was in line with national recommendations from the *'Intercollegiate document on safeguarding children and young people' (March 2014).*

We saw information on boards throughout the community health service areas, offering advice and guidance to staff on recognising and responding to abuse. Staff had access to trust safeguarding policies for children and vulnerable adults. This also included guidance and training for staff regarding abuse, such as female genital mutilation (FGM). FGM is defined by the World Health Organisation as 'procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons'. The trust provided a representative to attend a newly formed, children's and adults at risk of exploitation and harm a multi-agency group which monitored FGM activity across the county. Information was shared with staff in supervision and within team meetings.

Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Community health services for adults made 71 safeguarding referrals between 1 January and 31 December 2017, all which concerned adults.

Referrals		
Adults	Children	Total referrals
71	0	71

Looking at adult referrals across the 12-month period, overall there was a variation in referrals throughout the year with a peak of 10 in May and nine in December.

Safeguarding referral forms were accessible online via the trust's intranet and staff knew where to find them. All staff we spoke with knew who the lead was for safeguarding.

Staff told us the actions they would take if they suspected a safeguarding incident; this was in line with policy. For example, one professional told us they raised a safeguarding referral following a disclosure of domestic abuse which enabled a family to be moved to a place of safety. A second member of staff raised a safeguarding referral following a cluster of incidents that occurred at a residential home. The incidents were investigated and the root cause was identified.

Mandatory PREVENT training compliance was 93% which was above the trust target of 90% compliance. Prevent training is a government directive to support vulnerable individuals. Prevent is the duty in the Counter-Terrorism and Security Act 2015 on specified authorities, in the exercise of their functions, to have due regard to the need to prevent people from being drawn into terrorism.

The service controlled infection risk well. Staff collected safety information and shared it with staff, patients and visitors. They used control measures to prevent the spread of infection and all staff we observed followed the trust infection control and prevention policy.

During our January 2017 inspection, the service was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We identified that staff did not always follow the trust infection control and prevention policy. For example, we found infection control issues at the phlebotomy service at Weston Favell Health Centre. Staff had used the same sink to clean personal items and for clinical use to wash their hands, as one of the two sinks was inaccessible. At the June 2018 inspection, we found action had been taken to make both sinks accessible which met the Department of Health best practice guidance: Health Building Note 00-99 – Infection control in the built environment (March 2013), which recommends that all clinical areas should have a dedicated clinical wash-hand basin.

The service had a policy in place for infection prevention and control, which was monitored by the infection prevention team and was available to staff on the trust intranet. Staff could find these when we asked to see them. This included advice and guidance for staff to follow including, hand hygiene and the use of personal protective equipment (PPE).

All staff we met adhered to infection prevention and control measures such as being arms bare below the elbows and wearing personal protective equipment when carrying out clinical tasks. Community nurses had access to PPE such as gloves and aprons when on visits in patient homes. We observed that staff cleaned their hands before and after seeing a patient.

Hand sanitiser dispensers and hand washing facilities were available in all clinical areas we visited and staff working in the community carried hand gel with them. We found two hand gel solutions expired in 2016 in a clinic at Kettering General hospital however; a senior nurse took immediate action to replace these.

We observed staff completing hand hygiene between patient contacts. This was in line with National Institute for Health and Care Excellence (NICE) Quality Standard 61, which states that healthcare workers should decontaminate their hands immediately before and after every episode of direct contact care.

IPC audits were completed in all areas we visited and we observed that 99% compliance was achieved in the most recent audit completed by Wellingborough community nursing team.

Staff had clear processes to follow for the management and disposal of clinical waste. In clinics, staff segregated clinical and non-clinical waste using colour-coded bins. We saw two sharps bins in clinics at Kettering General hospital, which were signed, dated and not overfilled.

Floors and chairs were visibly clean and covered in a wipeable material. Disposable paper rolls were used on examination beds, there were foot-operated waste bins, and universal cleaning wipes were available in clinic rooms to clean equipment and beds. We observed the paper sheet on the examination bed was changed between patient care in one physiotherapy clinic however; the couch was not cleaned with a disinfectant wipe although they were available.

There were cleaning schedules in place at each of the clinics and we saw that clinical checklists were being carried out monthly in clinics.

We observed most curtains were dated and changed when required however, we found the curtains used to separate cubicles in a musculoskeletal physiotherapy clinic at a local NHS trust, did not have a record of the change date. Staff told us Northamptonshire Health Foundation Trust had an agreement with the NHS trust who managed the environmental cleaning service.

The trust undertook Patient-Led Assessments of the Care environments (PLACE). PLACE assessments are self-assessments undertaken by teams of NHS and private/independent health care providers, and are made up of at least 50 per cent members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services for cleanliness. The trust scored 100% for cleanliness that was higher than the England average of 98.4%.

The podiatric surgery professionals followed a standard operating procedure for pre-operative MRSA screening of podiatric patients. This ensured that patients, healthcare workers and others were protected against identifiable risks of acquiring such an infection as specified in the Health and Social Care Act 2008 Code of Practice in the prevention and Control of infection (Criterion 1) July 2015.

Environment and equipment

The service had suitable premises and equipment and mostly looked after them well. We visited several buildings used by patients and found not all buildings had been designed for the services delivered from the premises. Some services were delivered in locations provided by a local acute NHS trust hospital, and the environment in older buildings was not always suitable for their intended use. We observed however, that there were enough seats in waiting areas and fans were provided in areas where there was no air conditioning or windows.

During the January 2017 inspection, the service was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We identified there were not always robust systems in place to manage environment and equipment. We found out of date equipment in a treatment room used by phlebotomists at Weston Favell Health Centre. The room was a shared facility with several GP practices and the equipment was not used by NHFT staff. However, there was no service level agreement in place with the owner of the health centre which meant the accountability and responsibilities were unclear of separate organisations using the building and its occupiers. There was no system or process in place to ensure equipment used by the trust to provide care and treatment to patients was safe to use. We also found out of date medical consumables in treatment rooms and store cupboards used by trust phlebotomists, such as plasters, disinfectant wipes and surgical tape.

During the June 2018 inspection, we observed equipment was stored appropriately in locked cupboards used by NHFT staff only, and that that all equipment and consumables were in date. There was clear accountability and responsibilities to ensure separate organisations using the building had systems and processes to ensure equipment was safe to use.

We observed the treatment room and clinical area at Weston Favell phlebotomy clinic were visibly clean and tidy. Cleaning schedules and fridge temperature checks were recorded daily, which demonstrated improvement since the January 2017 inspection.

Staff were trained to use specialist equipment for example, community Nurses used syringe drivers to deliver doses of drugs to patients in their own homes and had received training in the in the use of syringe drivers. We observed staff competencies were in place to review the safe use of equipment, such as crutches. Demonstrations were also provided in the use of new equipment such as slide sheets used to move patients safely in bed.

The trust had a contract in place for the maintenance and repair of equipment with the electro-biomedical engineering (EBME) department with the relevant local acute NHS trust. Equipment that was due to be maintained was registered with the department and each piece of equipment was labelled showing the due date of its annual inspection. For example, across community health services for adults we observed medical couches were maintained on an annual basis, and stickers confirmed servicing was in date.

The EBME team was contracted to provide monthly reports to the medical device liaison officer detailing equipment maintenance, calibration and repair and a quarterly assurance report to the medical devices and supplies group. We found that most equipment across each location we visited was stored safely, and that servicing was in date. We observed however, six glucose monitoring sets for use by patients with diabetes, had passed their expiry dates in the podiatry service within a multi-disciplinary team (MDT) diabetes centre. A set of glucose blood testing strips had also expired in August 2017. We raised this with a senior nurse who told us the equipment was no longer being used and that it would be removed from the cupboard. During an unannounced visit to the service on 20 June 2018, we observed the equipment was no longer stored in a cupboard in the clinical room.

We saw that the portable electrical testing date on a light had expired in 2015 and fan had expired in 2017 in the podiatry service at a diabetes MDT centre in the grounds of Kettering General Hospital. The electrical testing of a portable defibribillator machine and a mobile suction unit, which was secured in the diabetes MDT reception area, had expired in 2016. An oxygen cylinder had expired in 2015. We raised this with a team leader who told us they would ensure this was brought up to date. During an unannounced visit to the service on 20 June 2018, we observed the equipment had been tested the day following our inspection, and a sticker confirmed the next review date in June 2019. The equipment was therefore safe for patient use.

We observed that the daily checks of the equipment used for emergency cardiopulmonary resuscitation, that included the portable defibrillator and mobile suction unit, had been completed on 14 out of a possible 19 working days in May 2018, and on each relevant working day in June 2018. The signature in the equipment book confirmed the responsible person had checked the equipment and that it was in date and safe for use.

A senior staff member told us the equipment was only checked on days when clinics were held however, the centre was open from Monday to Friday each week. We were not therefore assured that daily testing was always completed, and that the correct procedure was followed to escalate when the electrical testing date of an item of equipment had expired.

The trust had a contract in place with a medical equipment provider to supply equipment for use in people's own homes. Staff ordered mobility equipment and pressure-relieving equipment and they also had access to emergency equipment stores, for smaller pieces of equipment and consumable items, such as wound dressings. Some staff told us there was often a delay with the delivery of large equipment items, such as beds and mattresses. Staff told us feedback was provided directly to the company and that a delay was escalated using the electronic incident reporting system. The trust were aware of the delays and continued to work with the equipment supplier to improve the timeliness of delivery.

A member of the community brain injury team told us a financial bid had recently been approved to purchase new equipment to support upper limb rehabilitation.

Assessing and responding to patient risk

Systems and procedures were in place to assess, monitor and manage risks to patients.

The service was in breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at our January 2017 inspection and was issued with requirement notice with regards to the monitoring of patient risk. For example, community nursing teams within planned care were not using early warning scores in line with trust protocol. Early warning scores are commonly used for the assessment of unwell patients; these observations can detect when a patient's condition requires more intense observation and should be a trigger for further investigation and action, as early intervention can reduce morbidity and mortality in unwell patients.

During the June 2018 inspection, we found the service had embedded the use of a community early warning system (CEWS) to detect the deteriorating patient's psychological changes to ensure medical intervention was requested before the patient's condition started to show actual visible signs of deterioration. The protocol directed that it was the responsibility of the registered nurse to ensure that observations were undertaken by a competent staff member. We observed CEWS observations were stored in patient homes and that every patient had a full set of observations taken on each visit. This included both sitting and standing blood pressure readings. There was a flow chart with instructions of when to escalate a deteriorating patient for medical support, according to the overall score attributed to the CEWS observations. This included information about the management of suspected sepsis.

Many staff had completed situation, background, assessment, recommendation (SBAR) training that provided a structured framework for the effective escalation of a clinical problem. A SBAR checklist was incorporated in the CEWS observation chart to ensure staff followed the procedure.

We observed a staff member triaging calls that were made to the trust single point of access team. This was a nurse-led call centre providing signposting of care pathways for GPs and healthcare professionals who required treatment for one of their patients. The service could provide advice, negotiate care pathways or arrange hospital admission.

We saw that a triage system was set up to assess and respond to patient risk. Following each patient visit, the intermediate care team conducted a verbal handover with a relevant staff member. The discussion included an assessment of patient risk and ensured cases had been escalated as required. Nursing and therapeutic staff spent time on a rotational basis delivering the 'live' handovers. A change to a care plan was made if risk had escalated or decreased and if there was immediate risk of deterioration in the patient, hospital admission was arranged.

The 'live' handover system also supported the lone working procedure as a staff member's location was tracked between each home visit. The service also provided an emergency telephone line for community staff to raise concerns for a patient's or their own safety.

Staff completed risk assessments as part of the electronic or paper patient record. These included the malnutrition universal screening tool (MUST), skin assessment and risk of falls. In the eight patient records we reviewed, we found all risk assessments were up-to-date and that care plans were reviewed as required.

During the January 2017 inspection, there were 1,400 patients county-wide waiting for routine treatment on the podiatry service waiting list. We found there was no system to complete risk assessments of patients on the waiting list and that the service was dependent on patients phoning to say their condition had deteriorated.

During the June 2018, we found there was a system to review the patient waiting list which had reduced since the previous inspection. All patients were sent a letter to inform them of the length of appointment delay along with information and advice. A contact number was provided and a patient could ring for advice if they were concerned about their health, or request to be removed from the waiting list.

As at the January 2017 inspection, we did not see any guidance for staff who may acquire a needle stick injury; there was no risk assessment to support staff. During this inspection we found, there was a policy in place and that a flow chart to support staff was displayed in the clinical areas we visited.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm an abuse and to provide the right care and treatment. However, the trust experienced difficulties throughout 2017/18 with the recruitment of community nurses, and recruitment campaigns were ongoing to mitigate the risks.

During the January 2017 inspection, there were three risks relating to staffing levels across community health services for adults. They included ongoing pressures on staffing levels due to sickness, vacancies and maternity leave, difficulties recruiting band 7 nursing staff and advance nurse practitioners (ANPs), and electronic rostering challenges across the intermediate care team (ICT) and evening district nurse teams.

During the June 2018 inspection, there were three risks relating to staffing recorded on the directorate risk register. They included ongoing pressures in community staffing levels due to sickness, vacancies and maternity leave. Action had been taken to ensure team leads followed the sick leave policy, and engaged staff in planned return to work interviews, and made referrals to support services when required.

The second risk concerned difficulties in the recruitment of band 7 ANPs within district nursing services and the third risk concerned the lack of funding and availability of nurses to support staff with completing a district nurse specialist qualification (DNSQ). This risk had remained open on the risk register since the previous inspection, was rated as a significant risk, and was under ongoing review. In February 2018, the risk was reviewed and there had been no significant improvement with staff recruitment however, ongoing recruitment campaigns continued. Staff told us the situation was representative of national difficulties experienced with the recruitment of district nurses.

To mitigate the risks, bank and agency staff were recruited, training was reviewed individually with nursing staff to support career development, and work was completed with a local university as courses were not readily available. One ANP informed us that three nurses had recently begun the district nurse specialist qualification and that two more candidates had been accepted to attend a future course.

The trust utilised the safer care nursing tool for their staffing levels' acuity and dependency reviews, along with National Institute for Health and Care Excellence guidelines and professional judgement. Demand and capacity reviews had been completed during 2017 in community nurse teams to ensure the right numbers and appropriate skill mix was allocated to a team.

The service had adopted a number of initiatives to maintain safe staffing levels. For example, it was planned to upskill band 3 health care assistants (HCAs) to support their development and enable progression to a band 4 HCA. Competencies had been introduced to enable band 3 HCAs to undertake some nursing tasks for example, male catheterisation. A clinical practice teacher supported staff to achieve competencies and provided mentoring.

Senior nursing staff told us staff sickness and unfilled shifts meant staff moved across clinical areas at times, to ensure safe staffing levels were maintained. The induction programme required nurses to spend a day working in other teams within their region, which enabled them to become

familiar with local team information. This had promoted a culture of improved flexibility in working arrangements to support safe care.

The trust had managed the winter pressures by providing staff with an incentive to work additional hours.

Total numbers – Planned vs Actual

Month	Staffing Group	Planned Staff WTE	Planned Staff – Whole Number / Headcount	Actual Staff	Actual Staff – Whole Number / Headcount
Year 2 - 31/01/2018	Medical & Dental staff - Hospital	5.84	6.00	5.44	13.00
Year 2 - 31/01/2018	NHS infrastructure support	1.00	1.00	1.00	1.00
Year 2 - 31/01/2018	Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	0.28	1.00	0.28	1.00
Year 2 - 31/01/2018	Qualified nursing & health visiting staff (Qualified nurses)	18.61	19.00	17.07	18.00
Year 2 - 31/01/2018	Support to doctors and nursing staff	22.37	23.00	20.74	26.00
Core service total		**48.10**	**50.00**	**44.52**	**59.00**

Vacancies

As of 31 January 2018 the trust reported an overall vacancy rate of 10% in community services for adults.

During our January 2017 inspection, trust data showed a vacancy rate of 27% for qualified nursing and health visiting staff. As at January 2018, trust data showed a qualified nursing and health visiting vacancy rate of 15% which represented a significant improvement.

Staff group	Total number of establishment (as at January 2018)	Total % vacancies overall (excluding seconded staff) (as at January 2018)
Medical & Dental staff - Hospital	6.92	7%
NHS infrastructure support	24.98	9%
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	6.83	-56%
Qualified Allied Health Professionals (Qualified AHPs)	170.61	3%
Qualified nursing & health visiting staff (Qualified nurses)	299.88	15%
Support to doctors and nursing staff	160.95	11%
Support to ST&T staff	41.85	1%
Core service total	**712.02**	**10%**

Turnover

Between February 2017 and January 2018, the trust reported an overall turnover rate of 9% in community services for adults.

Staff group	Total number of substantive staff	Total number of substantive staff leavers in the last 12 months	Total % of staff leavers in the last 12 months
Medical & Dental staff - Hospital	4.2	0	0%
NHS infrastructure support	1.0	0	0%
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	0.3	0	0%
Qualified nursing & health visiting staff (Qualified nurses)	17.1	2.8	17%
Support to doctors and nursing staff	20.2	1.7	7%
Core service total	**42.82**	**4.41**	**9%**

Sickness

Between February 2017 and January 2018, the trust reported an overall sickness rate of 4% in community services for adults.

Staff group	Total % permanent staff sickness overall
Medical & Dental staff - Hospital	0%
NHS infrastructure support	2%
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	7%
Qualified Allied Health Professionals (Qualified AHPs)	3%
Qualified nursing & health visiting staff (Qualified nurses)	5%
Support to doctors and nursing staff	5%
Support to ST&T staff	5%
Core service total	**4%**

Nursing – Bank and Agency Qualified nurses

Between February 2017 and January 2018, the trust reported the total number of bank and agency shifts usage for qualified nursing staff.

We are unable to provide details on the percentages of shifts filled as this data was not submitted as part of the RPIR.

Total Shifts Filled by Bank Staff	% Usage of Bank Staff	Total shifts Filled by Agency Staff	% Usage Agency Staff	Total shifts NOT filled by Bank or agency staff
5760	Not provided	5507	Not provided	374

Additional staff were used when the needs of the patients required this. Senior staff confirmed they aimed to use the same agency nurses where possible to provide continuity to both patients and the staff team.

Senior staff within the community district nursing teams confirmed they had high bank and agency use, and data submitted by the trust confirmed this. For example, between February 2017 and January 2018, 5,760 total shifts were filled by bank staff and 5,507 total shifts were filled by agency staff. This represented a significant increase in the numbers of total shifts filled by bank and agency staff from data submitted for the January 2017 inspection. For example, between October 2015 and September 2016 1,905 total shifts were filled by bank staff and 79 total shifts were filled by agency staff.

Community nursing staff we spoke with confirmed their caseloads were flexible and manageable. Senior staff told us that staff's caseloads were regularly reviewed and incorporated into their supervision.

Nursing - Bank and Agency Healthcare Assistants

Between February 2017 and January 2018, the trust reported the total number of bank and agency shifts usage for healthcare assistants.

We are unable to provide details on the percentages of shifts filled as this data was not submitted as part of the RPIR.

Total Shifts Filled by Bank Staff	% Usage of Bank Staff	Total shifts Filled by Agency Staff	% Usage Agency Staff	Total shifts NOT filled by Bank or agency staff
2031	Not provided	**0**	Not provided	**64**

Medical locums

No shifts were filled by bank or agency staff between February 2017 and January 2018 across the entire core service.

Therapeutic staff

A service lead reported that a deficit in staffing in the diabetes and high-risk foot clinic during the previous two years had impacted on patient waiting lists. We observed this was recorded as a risk on the regional risk register. The service had links with a local university to encourage recruitment and the service had secured a bid from NHS England to support additional staff recruitment.

Physiotherapists and podiatrists undertook succession planning and held recruitment days at a local university when they interviewed candidates for vacant positions.

Suspensions and supervisions

During the reporting period, this core services reported that there were four cases where staff have been either suspended or placed under supervision. Three staff were suspended and one was placed under supervision.

Quality of records

Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.

The service continued to develop the electronic patient record system. The system worked on the principle of one patient, one record and enabled clinicians to see relevant information from other services such as GPs. The system supported the delivery of contemporaneous record keeping and a mobile application was designed to provide access to information at the point of care. The system was secure and accessed by a smartcard. There were search functions within the system that were not available within paper records.

Many staff that we spoke with told us that the electronic system worked well in their service and that they had had input into how the system would work for them, and the information they wanted to record. However, not all community nurses gave such a favourable review, telling us that the system was slow and time consuming to use in a mobile capacity. Some staff told us there was poor network coverage in some areas and, to ensure records were contemporaneous, professionals updated records in their cars or in locations where there was a good network.

We were told that pages would take a long time to open and complete. A number of incidents had been recorded by community nurses about connectivity issues and the electronic system remained under development.

We observed the electronic patient information system and saw that each clinical field had its own specialist assessments built in to the system. For example, the community nursing services assessment area included tabs to access the malnutrition universal screening tool (MUST), a pressure ulcer risk assessment (Braden score), waterlow score (pressure area/skin risk assessment), SSKIN (surface, skin inspection, keep moving, incontinence, nutrition/hydration), CEWS (community early warning score), and a falls assessment. Each tab gave a link to the relevant NICE guidance.

The community brain injury service staff continued to develop specialist assessment screens within the electronic patient record system to support the holistic assessment and pathways relevant to the service. Occupational therapy and musculoskeletal physiotherapy services were transitioning to the new electronic patient record system at the time of our inspection.

We examined seven sets of community nursing patient records. Plans of care and patients' progress were documented and updated. The records showed that patients, their relatives or carers were involved in the planning of their care.

We observed three home visits and found records were completed in a consistent manner. Patient records were accurate, complete, legible, up-to-date, and stored securely.

During one episode of care in the patient's home environment, we observed a prescription was issued to a patient by a non-medical prescribing ANP. The prescription was recorded contemporaneously and the GP was notified on the trust electronic patient recording system with use of a mobile tablet.

Each service had its own business continuity plan in the event that records were not accessible at the time of the patient visit. For example, the intermediate care team told us at the time of a cyber-attack, they printed out paper records within a short time period before the electronic system was shut down.

Medicines

Medicines were prescribed, dispensed, administered, recorded and stored in accordance with best practice. Patients received the right medication and the right dose at the right time.

The service had advanced nurse practitioners (ANP) and some specialist nurses who were non-medical prescribers. Non-medical prescribers are health professionals who have undergone

additional training and are qualified to prescribe some medication. This meant that patients did not have to wait to see their GP to have changes to existing prescriptions or new medication prescribed. A senior member of staff explained that leading staff within the community nursing teams were encouraged to complete the training to become prescribers. One patient told us "…it's great they can now prescribe, I don't have to go to my GP to get a prescription for what they recommend".

Patient group directions (PGDs) provide a legal framework that allows some registered health professionals to supply and administer specified medicines to a pre-defined group of patients, without them having to see a doctor. There were PGDs in place for specified medicines for both registered nurses and podiatrists. This ensured the service complied with the National Institute for Health and Care Excellence (NICE) guidance when prescribing medication for individual patients. Staff attended the medicines management training to attain competencies.

A lead pharmacist and lead infection prevention and control nurse reviewed non-medical prescriber's, antimicrobial prescribing six monthly to ensure it was safe. The information was fed back to the infection prevention and control assurance group and the medicines management committee.

We saw that patient allergies had been documented in patient records in their own home and on the electronic patient record system. We observed an episode of patient care where a check list of allergies was used to ensure safe patient care.

We observed that insulin pens were marked with the date they were opened to ensure they were not used past the expiry date. A screen shot of insulin prescriptions was scanned into patient records to evidence when they were made, and by whom to support safe patient care. We observed care plans in patient homes were updated with the prescription information.

We observed anti-inflammatory, local anaesthetic, and anaphylaxis medication that is used to treat an adverse reaction, were stored appropriately in a locked cupboard in a clinical room used by physiotherapy extended scope practitioners (ESPs). The clinical room was situated within the musculoskeletal (MSK) physiotherapy department at a local NHS hospital. The temperature of the room was recorded on each week day the ESP clinic was open, but not at weekends when the department was closed. We observed the temperature was recorded as being within the accepted range of below 25 degrees, on each day a recording was taken between April and June 2018. The temperature was recorded at 24.5 degrees on two occasions. Staff told us they put the air conditioning on if there was a risk the room temperature may rise above 25 degrees.

We observed that clinical room temperatures where medicines were stored, was recorded as a risk on the directorate risk register. A recent review of the risk confirmed that the risk to safe medicine storage was minimal however, temperatures remained under review.

Safety performance

Safety Thermometer (February 2017 to February 2018)

The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm free' during their working day. For example, at shift handover or during ward rounds. This is not limited to hospital; patients can experience harm at any point in a care pathway and the NHS Safety Thermometer helps teams in a wide range of settings, from acute wards to a patient's own home, to measure, assess, learn and improve the safety of the care they provide. Safety Thermometer data should also not be used for attribution of causation as the tool is patient focussed.

The below information relates to district nursing teams and intermediate care teams within the trust.

The trust reported 61 new pressure ulcers, during the period February 2017 to February 2018. Peaks of ten were seen in March 2017 and then 12 in August 2017. In terms of prevalence, rates were reasonably consistent at less than 1.5%. The only exception was in August when they rose to 2.5%.

The trust reported 105 falls with harm from February 2017 to February 2018. Again, rates were reasonably consistent around the mean of 8, with peaks of 11 in March 2017 and 10 in November 2017. In terms of prevalence the highest was in September, with 2.35% of falls with harm recorded.

The trust reported 34 Catheter & UTI's between the same dates as above. A peak of seven instances was seen at the start of the period, in February 2017. In terms of prevalence this was the highest in August 2017, with 1.04%

From February 2017 to February 2018, the trust recorded 6698 cases of 'harm free' care. In terms of prevalence this was very consistent throughout the year, hovering around the mean of 92.74% throughout the period.

Advanced Nurse Practitioners ensured safety thermometer data was submitted monthly and feedback was provided in daily hubs or team meetings to share best practice to aim to increase harm free patient care. We observed incidents where harm had occurred were appropriately reported on the trust electronic incident reporting system. At the time of our January 2017 inspection, we observed that the NHS safety thermometer results were not displayed for teams to see. During the June 2017 inspection, we saw data was up-to-date and displayed on notice boards.

Incident reporting, learning and improvement

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.

Staff had received training on the electronic reporting system and staff told us they were encouraged to report incidents, and could access the trust incident management policy.

All staff we asked about incident reporting were aware of their responsibilities and could give us examples of incidents reported. During our inspection, we observed a telephone referral from the single point of access service to a community nursing service concerning a delay in patient care was reported as an incident.

Data received from the hospital showed from January 2017 and December 2017 there were a total of 2,212 incidents reported on the trust electronic reporting system under the specialty levels district and community nursing. Incidents were categorised by severity. Of the 2,212 reported incidents 905 resulted in no harm, 1,162 incidents resulted in low harm, 142 resulted in moderate harm, and three resulted in severe harm. The incidents categorised as severe were reported and investigated under the serious incident process as detailed under the serious incident heading below.

The most common incident reporting themes were implementation of care and ongoing review (1,279); medication (203); documentation (71); access/admission/transfer/discharge (70); documentation (71).

Incidents reported under the category of 'implementation of care and ongoing review' included pressure ulcer incidents. A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure. A review of incidents identified an increase in the reporting of pressure ulcer incidents in community settings during 2017. This led to the introduction of a pressure ulcer action plan, which aimed to share and improve best practice to reduce and improve on reporting of grade two pressure ulcers. Care plan templates in the electronic patient recording system were updated to incorporate SKINN bundle assessments (skin surface, keep moving, incontinence, nutrition and hydration) to prompt staff to review all health factors and care plans to maintain skin integrity. Learning was shared across community nursing services including with bank staff, it was reinforced in supervision, and messages shared with learning and development to ensure competencies were reviewed to reflect change to practice.

The trust had a variety of methods to share lessons learnt from a review of incidents, such as team training and away days; team meetings, workshops, a 'staff room' electronic pin board, and newsletters. Some staff attended a conference during 2017 where information of learning from incidents was shared. A monthly learning lessons exchange group was held within the trust to share themes and learning from incidents across clinical areas, including community health services.

The Chief Executive Officer sent out monthly 'Need to know' emails to team managers with a section on sharing lessons learnt. Lessons were cascaded to staff in team meetings and daily huddles. One staff member told us they had reported incidents when patients had been discharged from hospital without the required training to support self-care and management of an enteral feeding tube. (A tube where a nutritional feed is delivered directly into the stomach). A review of incidents identified a need for a change in practice. A dietitian provided training for patients and/or their carers before a hospital discharge, and learning was shared with ward staff to ensure appropriate referrals were made across the county.

Staff described the principle and application of duty of candour, Regulation 20 of the Health and Social Care Act 2008, which relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant person) of 'certain notifiable safety incidents' and provide reasonable support to that person. All staff we spoke with had a good understanding of the principles of being open and honest when something went wrong and gave examples of when duty of candour was maintained. One staff member told us they had apologised to the patient following a medication incident and told them that there had been a change in practice as a result.

Serious Incidents - STEIS

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include 'never events' (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in community services for adults, which met the reporting criteria, set by NHS England between, January and December 2017. Of these, the most common type of incident reported was 'Sub-optimal care of the deteriorating patient meeting SI criteria'.

Incident Type	Number of Incidents
Sub-optimal care of the deteriorating patient meeting SI criteria	2
Pressure ulcer meeting SI criteria	1
Treatment delay meeting SI criteria	1
Medication incident meeting SI criteria	1

Incident Type	Number of Incidents
Core Service Total	**5**

Serious Incidents (SIRI) – Trust data

From January and December 2017, trust staff in this core service reported six serious incidents.

None involved the unexpected death of a patient.

The most common types of serious incidents were ‘Treatment delay meeting SI criteria’ with two and also ‘Sub-optimal care of the deteriorating patient meeting SI criteria’ with two.

The number of the most severe incidents recorded by the trust incident reporting system is not comparable with that reported to Strategic Executive Information System (STEIS). This gives us less confidence in the validity of the data.

Incident Type	Number of Incidents
Treatment delay meeting SI criteria	2
Sub-optimal care of the deteriorating patient meeting SI criteria	2
Pressure ulcer meeting SI criteria	1
Medication incident meeting SI criteria	1
Core Service Total	**6**

All serious incidents were investigated using a root cause analysis tool, taking into account the factors which may have contributed to the incident. For example, we observed the root cause analysis investigation was completed following the reporting of a pressure ulcer incident that met the serious incident criteria. We saw that a thorough investigation had been undertaken and that recommendations and a change in practice had been implemented as a result.

Prevention of Future Death Reports

The Chief Coroner’s Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last 12 months, there had been no prevention of future death reports sent to the trust.

Is the service effective?

Evidence-based care and treatment

Policies were aligned and referenced to national guidance, such as National Institute for Health and Care Excellence (NICE) guidelines. Trust policies were up to date and assessed to ensure they did not discriminate based on race, nationality, gender, religion or belief, sexual orientation or age. Staff we spoke with knew how to access policies relevant to their specialty area and knew who was responsible for providing their national clinical guidance. Staff were aware of these policies and gave us examples of how they followed guidance when delivering care and treatment for patients.

All new NICE guidelines were discussed at a directorate clinical governance meeting and shared within a directorate management team (DMT) meeting. These ensured senior managers were aware of the guidance and its impact on service delivery. A clinical lead was allocated to oversee

its implementation and, where changes in practice were required, an action plan was developed and monitored through the directorate governance meetings and DMT.

Local managers told us new policies and guidance were discussed in team meetings and at team 'huddles', and staff signed to say they had read them.

The service had a series of care bundles in place based on national guidelines, such as NICE and Royal College of Physicians. This included guidance for the assessment and treatment of medical conditions such as dementia care, chronic obstructive pulmonary disease, hyperglycaemia (high blood sugar), sepsis (blood infection) and acute kidney injury. Sepsis screening tools were based on NICE guidance (NG51).

Community nursing teams had been provided with new Doppler machines (ultrasound machines used to detect arterial insufficiencies in the assessment and management of chronic leg ulcers). This was based on best practice guidelines: Scottish Intercollegiate Guidelines Network (SIGN 1998), Royal College of Nursing Institute (1998).

A six-week, national diabetes and prevention programme was offered to patients at risk of, or living with type 2 diabetes to support with the management and monitoring of the condition. The educational course was based on up-to-date, evidence-based research and supported NICE Quality Standard 6 (QS6).

The community speech and language therapy services for patients who were undergoing rehabilitation following a stroke were delivered in line with the NICE guidance (CG162): Stroke rehabilitation in adults (2013). This included providing swallowing and direct impairment therapy for patients with dysphagia, teaching patients other methods of communication such as gestures and the use of communication props and supporting the patient to access information that enables decision making.

Nutrition and hydration

Staff reviewed clinical observations to ensure patients had enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.

Clinical staff had access to a malnutrition universal screening tool (MUST) to screen patients and identify risks of malnourishment, and we saw this was used consistently where required. A risk assessment, using a MUST screening tool was carried out a minimum of three monthly for those patients with a low risk of developing pressure ulcers, and a minimum of monthly for those patients with a high risk of developing a pressure ulcer. A patient's nutritional needs were reviewed which was important in preventing and managing pressure ulcers.

Community staff told us they could discuss with, and refer to, the trust's dietitians or speech and language therapists if their patients needed a formal assessment of their ability to eat and drink, or about nutritional needs.

Dietitians reviewed nutrition prescription charts for patients in acute wards to support the management of nutrition and hydration on discharge. Training was also provided to ward staff, patients and their carers to support effective care of percutaneous endoscopic gastrostomy (PEG) feeding, used where patients cannot maintain adequate nutrition with oral intake.

A community group was provided for patients who had been diagnosed with coeliac disease to provide dietary, gluten-free advice and support.

Pain relief

Pain relief was well managed. Patients prescribed pain relief to be given 'when required' were able to request this when they needed it. Patients told us they were asked by staff if they were in any pain and medicines were provided in line with the patients' prescriptions.

A pain assessment, including the causes of pain, level of pain and location of pain was carried out by community nurses at every visit for those patients with pressure ulcers or other wounds. We observed episodes of care in patient's homes when discussions took place around appropriate repositioning techniques and pressure relieving equipment.

We observed, and patients told us, that staff from all specialties assessed and supported the management of patients' pain. Non-medical prescribers were employed in many areas across the service and offered appropriate analgesic medication when required.

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

Community adult services contributed in a number of national and local audits relating to patient safety and treatment. We saw that specialities discussed audit results as part of their local governance and, where necessary, action plans to address developments were in place.

Audits – changes to working practices

The trust has participated in eight clinical audits in relation to this core service as part of their Clinical Audit Programme.

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
Quarterly Record Keeping Audit	All clinical services both community and inpatient participate in the audit	Clinical	Quarterly	All areas have specific designed questions for their areas.
Identifying Improvements in Coeliac Care	Dieticians	Clinical	30/06/2017	*Emphasise an individual review appointment can explore individual diets and address individual concerns. *Highlight on the appointment letter and when patients are arranging attendance to the group session that this will provide generic information relevant to all patients with Coeliac Disease. *Encourage patients to request and attend annual reviews with either their gastroenterologist, GP or Dietitian.
Identifying quality of puree meals in care home setting	Dieticians	Clinical	30/06/2017	*Ensure patients requiring modified diet are offered a choice of high quality foods, consistent with the main menu. *Improve knowledge and skills of care home staff responsible for menu management and puree

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
				meal preparation. *Ensure consistent provision of thickened liquids as guided by the Speech and Language Therapist recommendations
National Parkinson's UK Audit	Specialist Nurses Parkinson's Disease	Clinical	Ongoing	
National Audit of Intermediate Care:	Intermediate Care Team	Clinical	01/12/2017	
Adherence to the 2011 BASHH guidelines for management and partner notification in patients diagnosed with gonorrhoea	Integrated Sexual Health Service	Clinical	31/12/2017	
To audit FRSH emergency contraception guidelines.	Integrated Sexual Health Service	Clinical	Ongoing	
To monitor compliance with the IUD/IUS procedure protocol	Integrated Sexual Health Service	Clinical	Ongoing	

We observed specialties across the county reviewed the individual services they provided to improve patient outcomes. For example, the trust had funded an additional part-time psychologist to support the community brain injury service when successful multi-disciplinary, rehabilitation services demonstrated improved patient outcomes. A project had evidenced improved financial savings and quality of care when patients moved from residential to community settings.

The community brain injury service had recently delivered a support and education session to patients accommodated in a residential setting at their request. Patient feedback was collated and resulted in the development of a six weekly, tea and coffee support group.

The intermediate care team (ICT) provided intensive community support to prevent hospital admissions and facilitate early discharge. The team monitored patient outcomes to support service delivery. For example, one team lead told us that only 2% of patients seen by the ICT progressed to long term care. The podiatry service audited the number of pressure ulcers and amputations. The outcomes would be measured against the increase in staff numbers within the service, to evidence if this would correlate with any reduction in the number of future pressure ulcers and amputations.

The musculoskeletal (MSK) physiotherapy service provided a chronic back pain management programme that was run by an occupational therapist, physiotherapist and a clinical psychologist. The programme was based on research evidence of what helps sufferers improve their lives. Staff monitored patient outcomes which were positive.

The MSK physiotherapists used a start back screening tool (SBST) to measure outcomes. This tool was initially completed by a GP to review the level of risk before referral to the MSK team, and physiotherapists assessed the patient again at the completion of therapy. An audit of completed SBSTs was completed annually to measure the effectiveness of therapeutic interventions.

We observed an action plan in place following a record keeping audit within one community nursing team. A reminder was provided to all staff to evidence all phone calls in individual patient records and to ensure discharge letters were attached within the electronic system

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. Staff we spoke with confirmed they had completed all mandatory training and competency assessments and told us they were given time to complete electronic learning.

Throughout our inspection, we found staff received training to support the delivery of care and individual's developmental needs. For example, most advanced nurse practitioners (ANPs) in community health services had completed non-medical prescribing (NMP) courses that supported the delivery of effective care. Some qualified community nurse staff had completed advanced clinical skills training and most community nurses and completed training in catheter care, venepuncture, syringe drivers, leg ulcer care, and wound care.

Therapeutic staff completed specialist training to support their roles.

All staff spoke positively about the investment the senior management team made to individual and team development.

Community nurses attended a monthly away day when mandatory and new training was discussed, learning was shared, and speakers from specialist areas provided updates on best practice initiatives.

All bank and agency staff completed a local induction sheet to ensure they became familiar with the patients, the surroundings and their role and expectations. Areas covered included, understanding of job role, location of trust policies such as resuscitation, fire safety and moving and handling and pressure area standards.

Senior staff oversaw staff competencies which included for example; the administration of insulin, leg ulcer management, health promotion, and the use of syringe drivers. A syringe driver helps reduce symptoms by delivering a steady flow of injected medication continuously under the skin. Competencies were based on best practice guidelines such as NICE. The intermediate care team had developed a community simulation room where competencies, such as wound dressings, could be practiced in a class room setting.

We saw systems in place for nursing staff requiring re-validation to be supported. All new staff attended a trust induction programme that covered topics such as the trust values and mandatory training.

Senior staff across the service were encouraged to attend a leadership matter's one-day course that was held periodically when topics such as safeguarding, leadership skills were discussed. A quarterly course was available to staff across the trust and was run by external speakers.

Staff within the diabetic podiatry service had their competencies assessed in line with the Podiatry Integrated Career and Competency Framework for Diabetes Foot Care (TRIEPodD-UK, 2012). The competency framework ensured that patients with diabetes had their feet cared for by healthcare professionals with the appropriate skills. A band 4 podiatry assistant national podiatry qualification was offered to health care assistants to support development.

All new staff within the diabetes and high-risk foot service engaged in a preceptorship where they were supported by a highly skilled clinician who had won a regional award for training and mentoring.

The community brain injury service delivered weekly sessions to support to assist professionals in the intermediate care team with distinguishing between brain injury and mental health problems. This enabled patients to be directed to the appropriate care pathway.

Staff from the podiatry service provided education to staff within a patient contact service where referrals were received and triaged. The education was also shared with GPs to support the early identification of appropriate pathways.

Many staff within the musculoskeletal physiotherapy service had completed or were completing post-graduate training, and two professionals were studying for a master's degree at the time of our inspection.

Clinical Supervision

The trust has provided some context on supervision. The NHFT Supervision Policy requires an individual to have had a minimum of two supervision sessions per quarter. The Trust had introduced a new system of recording supervision centrally for all staff. The Trust was utilising ESR and had introduced Employee Self Service (myESR) and Manager Self Service (myTEAM) enabling staff and teams to record appraisal and supervision dates electronically. Utilisation of this system, for this purpose, was still in its infancy and central publication of data/reporting through ESR Business Intelligence was still being developed to support variances and exception reporting such as maternity leave and sickness. To provide assurance during the transition phase, teams continue to maintain local comprehensive team level data to ensure Trust compliance with Policy. The ESR record is being developed from these comprehensive records."

The trust had a supervision policy which reported that two clinical supervisions must be provided to staff every three months. A new electronic recording system had been introduced that enabled staff and team managers to record appraisal and supervision dates electronically. The system remained under development and aimed to provide accurate trust-wide, divisional, team and individual data reports to support compliance with the supervision policy.

From October and December 2017 the average clinical supervision rate for the core service was 95% against the trust's target of 90%.

Team	Clinical Supervision Required (at latest quarter)	Clinical Supervision Delivered (at latest quarter)	Clinical supervision rate (%)
270 12 GU Clinic (B305)	14	13	93%
270 12 GUM South (B313)	8	8	100%
Core Service Total	**22**	**21**	**95%**

Appraisals for permanent non-medical staff

From April and December 2017, 92% of permanent non-medical staff within the community services for adults' core service had received an appraisal compared to the trust target of 90%.

Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
669	**617**	**92%**

Appraisals for permanent medical staff

From April and December 2017, 100% of permanent medical staff within the community services for adults' core service at the trust had received an appraisal compared to the trust target of 90%. This only applied to one team in this core service.

Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals
1	1	**100%**

Staff across the service told us development opportunities were identified during their appraisals and that they felt supported to request additional training at other times as required. Band 7 nurses completed appraisals with Band 6 nurses and supported Band 6 staff with completing appraisals with the rest of the team.

Multidisciplinary working and coordinated care pathways

Clinicians in the trust worked collaboratively with each other and with other external providers in the area to ensure that people received person-centred care and received that care at the right level and in the right place. There was an integrated approach to reduce delayed discharges, avoidable admissions to acute beds and a reduction in residential and nursing home placements.

We saw good examples of multidisciplinary working throughout the services. Community nursing teams referred patients to other specialist teams when necessary, such as podiatrists, dietitians, the continence team, physiotherapists and speech and language therapists.

We saw that the single point of access team worked well with other teams both internally and externally to signpost patients to the most appropriate care pathway. The team was able to take referrals from local GPs and other healthcare professionals.

The Northamptonshire diabetes multidisciplinary team (NDMT) was an integrated countywide specialist diabetes service, supporting care closer to home for patients with type 1 and 2 diabetes. The specialist team included nurses, dietitians, podiatrists and wellbeing workers, assisted by a team of support workers and supported clinically by a diabetologist.

Musculoskeletal physiotherapists provided assessment, diagnosis and treatment for patients with musculoskeletal pain and dysfunction such as pain, stiffness, muscle weakness, instability and reduced mobility of joints and muscles. The service was a multi-disciplinary therapist team including physiotherapists, occupational therapists and extended scope practitioners (ESPs). Treatment provided included; physiotherapy classes, exercise therapy and mobilisation and manipulation techniques.

The trust had an intermediate care team (ICT). The ICT aimed to ensure that people being discharged from hospital received appropriate care in the right place to enable their rehabilitation, and that patients in the community could avoid being admitted to hospital by receiving appropriate enhanced care in the best place. Multidisciplinary teams in each base in the model worked together to ensure that patients received the right level of care, whether this was at home, or within an intermediate residential or nursing home. The multidisciplinary team included community nurses, therapists, a community psychiatric nurse, a dietitian, and a speech and language therapist. A consultant for palliative care and a consultant for older persons also provided some sessions within the ICT MDT.

ICT held MDT meetings on a weekly basis and the team completed a review of each patient and set of key actions for discharge planning.

Community health services provided a county-wide, community brain injury service that was a psychology-led, multidisciplinary service that provided specialist neuro-rehabilitation to adults who had experienced an acquired brain injury. A specialist assessment identified the various ways in which the brain injury has affected each individual person, and a multi-disciplinary program was put together to help the person work towards an agreed personal rehabilitation goal. The MDT included a physiotherapist, an occupational therapist, a case manager, two psychologists, a psychology assistant, two rehabilitation practitioners with administrative support. Referrals to speech and language and dietitian services were facilitated when required.

Community nursing staff attended multi-disciplinary team (MDT) meetings with GPs, Age UK, and surgery nurses.

Health promotion

The service supported people to live healthier lives and care was planned holistically using health assessments where appropriate.

Every effort was made to promote self-care with patients and carers, and achievable and realistic goals were set to improve their health. The trust actively promoted improving the health of the local population and keeping well, such as obesity and weight management, smoking cessation, healthy eating, and diabetic care. For example, patients were trained to self-administer insulin injections and use syringe drivers, and diabetes patients were also given dietary advice and coaching to stabilise their condition. Patients who had wounds that had healed were taught self-care to prevent wounds from re-occurring.

A diabetes specialist nurse who had completed a recognised ‘Dose Adjustment for Normal Eating’ (DAFNE) course, delivered education sessions about normal eating and insulin adjustment to people living with type 1 diabetes. We observed patient feedback and one comment said “I’m so glad I attended this course. There was lots of useful information that will help me manage my condition. Thank you very much”.

A prediabetes course was available to people at risk of developing diabetes and self-referrals, nurse or GP referrals could be initiated.

Patients with a confirmed brain injury could attend a six-week ‘understanding brain injury’ group, or a four-week ‘fatigue management’ group to support self-care.

The trust had workplace wellbeing charter for staff that offered access and advice to services such as counselling, sleep and stress webinars, immunisations and staff physiotherapy amenities.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

We observed that patient consent was recorded on patient records we reviewed. Details of discussions with patients about their care and treatment were recorded on patient records and we observed nurses discussing with patients about the treatment they were proposing to carry out and the risks and benefits in line with trust policy.

Most staff explained they would use the MCA noting the presumption of capacity, before determining if they needed to seek further advice for patients who might refuse treatment or disengage from services. Some staff gave good examples of supporting patients to make decisions. They showed good awareness of when they might need to deviate from the presumption of capacity in line with the MCA.

There was a record of mental capacity assessment and best interests form attached to the electronic patient record to reference information and decisions. The mental capacity act and deprivation of liberty safeguards was part of mandatory training for staff and was undertaken every two years.

One nurse explained how they had been part of best interests' decision meeting when a patient lacked capacity, to support a patient with receiving care and treatment in accordance with their assessed wishes.

All staff told us they routinely sought patient consent to treatment and recorded this in line with trust policy. Patients told us staff were very good at explaining what was happening to them prior to asking for consent to carry out procedures or examinations. This was in line with Department of Health guidance.

Community nurses and other clinicians referred patients who were experiencing mental ill health to the adult community mental health team when required.

Deprivation of Liberty Safeguards

The trust told us that there were no Deprivation of Liberty Safeguard (DoLS) applications made to the Local Authority between January and December 2017 for this core service. Staff told us they were aware of the process to follow if a DoLS application was required to safeguard a patient, and that risk assessments were completed to ensure a referral was made if required.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

All patients we spoke with were highly complementary of the care they had received in community health services (CHS) for adults and many had used the services for a length of time. Patients and their relatives told us staff were extremely friendly and helpful. The main concerns patients had were about limited car parking and length of wait to attend some appointments.

Patients were treated with respect and compassion throughout their care within the service. Staff responded sympathetically to queries in a timely and appropriate way. We observed caring

interactions with patients whilst they were booking in at the main reception or being assisted in the departments. Throughout our inspection, we saw patients were treated with compassion, kindness, dignity, and respect. We received comments such as, “This is great, I should have come sooner, it’s a wonderful service”; “There is a lovely atmosphere here, no one has rushed me”; and “This is an excellent service, I always receive good advice”.

Staff respected patients’ privacy and dignity by ensuring seating in reception areas was far enough away from the reception desk to maintain confidentiality.

Staff ensured that consultations and examinations took place, where possible, in closed examination rooms that were soundproof and had appropriate signage on the door to indicate when the room was in use. There were no individual cubicles however, at the muscular skeletal physiotherapy environment at Willowbrook health clinic. Treatment areas were divided by curtains which meant a patient’s privacy and dignity could be compromised. To mitigate the concern, there were notices to advise patients that they could request a room to ensure confidentiality.

Staff respected patients’ social, cultural, and religious needs. We observed positive interactions between staff, patients, and relatives. Staff introduced themselves and took time to interact in a considerate and sensitive manner.

The service sought feedback from patients on whether they would recommend the services to friends and family. They told us that feedback was generally over 90% positive and in community nursing services the feedback was generally between 98-100% positive. For example, we observed 96% of patients stated they would recommend the diabetes multi-disciplinary team in one NHS location during March 2018.

The PLACE assessment for the period of March to June 2017 showed the hospital scored 93% for privacy, dignity, and well-being, which was higher than the England average of 84%. The place assessment for privacy, dignity and well-being, focuses on key issues such as the provision of outdoor and recreational areas, changing and waiting facilities, access to television, radio and telephones. It also includes the practicality of male and female services such as bathroom and toilet facilities, and ensuring patients are appropriately dressed to protect their dignity.

The NHS Friends and Family Test is a satisfaction survey that measures patients’ satisfaction they have received. The test data for all patients in February 2018 showed 98% of respondents would recommend the hospital against an average of 94% respondents. The response rate in February 2017 was 69% which was better than the average England response rates for NHS patients which was 59%.

Emotional support

Staff provided emotional support to patients to minimise their distress.

Staff throughout the department understood the need for emotional support. We spoke with patients and relatives who all felt that their emotional wellbeing was cared for. Staff had a good awareness of patients with complex needs and those patients who may require additional support should they display difficult behaviours during their visit to outpatient clinics, or within their home environment.

Patients we spoke with told us they knew who to contact if they had any worries about their care and said staff had supported them emotionally as well as physically. One patient told us they were pleased that their anxieties were taken seriously, discussed and addressed.

Community nurses told us that they would spend as long as necessary with a patient and their family when providing palliative care and were supported by the palliative care team. We

accompanied staff on some home visits and saw staff took the time to get to know the patients and tailored their care to meet their individual needs.

All outpatient services offered patients a chaperone and departments clearly displayed signs in waiting areas and consultation areas. Patients were given the opportunity to be accompanied by a friend or relative and there were chaperones available when personal care was provided. For example, female nurses or healthcare assistants could provide emotional support and act as chaperones when required.

Physiotherapists assessed a patient's cognition and any sensory impairment and provided an individualised approach to support their needs.

The diabetes multi-disciplinary teams provided a psychological wellbeing service to support patients who struggled to cope with their diabetes. Individual, goal orientated interventions were planned with the patient to work towards improving their emotional wellbeing.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. Patients and relatives said they felt involved in their care. They had been given the opportunity to speak with the staff looking after them. Relatives we spoke with said they had been given time with community health staff to ask questions.

All patients told us they were provided with a good, clear explanation about their condition.

Staff issued patients with a urinary catheter passport before or after insertion of a urinary catheter. This enabled the patient and those close to them to record information about their catheter care, to improve understanding and involvement, and to support the best possible care.

Staff encouraged patients to give feedback through satisfaction questionnaires and the Friends and Family Test and we observed iWantGreatCare paper feedback forms on display in all areas we visited, with web site information for patients who preferred this method of communication.

Is the service responsive?

Planning and delivering services which meet people's needs

The trust worked closely with commissioners, stakeholders and other providers to plan and deliver integrated health and social care in a way that met the needs of local people. Adult community services continued to be transformed and developed to meet the health needs of the population across the county.

Services were continually reviewed and developed to aim to provide equity in service provision to the local population. For example, dialysis was provided in three sites across the county, and localised weight management clinics had been set up when it was identified that travelling had been a barrier for attendance.

The speech and language team provided a county-wide service and delivered services in a range of settings such as within acute hospitals, community clinics, residential and nursing homes and the patient's home to meet people's needs.

Multi-disciplinary (MDT) diabetes teams were situated on three main sites across the county to meet local needs and provided a service in locality based clinics for patients who needed to be accommodated urgently, and for those with complex needs. The number of diabetes multidisciplinary clinics had increased from two to three, based on a demographic change and

increased public awareness of the risks. Education and support sessions were often provided in local community centres to meet the needs of patients within their localities.

The trust worked with local groups to develop the dementia strategy 2016 to 2019 to meet the needs of the local population. In support of one key strategic aim that was to provide support to those living with dementia and their carers, the service provided dementia training to carers and to staff within residential care homes. In addition, all community nursing staff had undertaken training in the specific needs of patients living with dementia.

Community nursing teams designed their services in hubs situated in GP centres to meet the needs of the local population. Staff visited patients at home depending on their clinical needs. There were four community nursing teams across the county, and demand and capacity reviews meant teams had been split into geographical sub-teams to reflect patient need. This ensured the right nurse with the right skills was available to support patient care.

Therapists and nurses planned and performed visits together to provide joined up care for patients.

The intermediate care team (ICT) provided rapid assessment, treatment and monitoring of patients who had experienced recent trauma or deterioration in their physical health and were at risk of hospital admission. The multi-disciplinary team model was planned to ensure patients received care tailored to their needs.

A urinary catheter passport had been introduced for patients to carry with them. This contained record of date of insertion and catheter care and management. A urinary catheter passport ensures catheterized patients receive the optimum standard of care by improving communication between hospital, community and the patient. The passport was issued to patients after insertion of a urinary catheter.

Meeting the needs of people in vulnerable circumstances

The service took account of patient's individual needs. Staff met the complex needs of patients in vulnerable circumstances, for example, those living with dementia or those living with a learning disability. Staff in all areas tailored their services in response to the needs of vulnerable patients.

Staff told us that if a patient was identified with a diagnosis of dementia or a known learning disability, they would work alongside other community professionals such as the community psychiatric nurse to provide the support suitable to the needs of the patient.

Staff identified vulnerable patients through the trust's electronic system and had awareness of their individual needs. Dietitians worked with acute inpatients and on discharge to the community to provide continuity that supported all vulnerable patients, including those with mental health needs.

The diabetes and high-risk foot service provided assessment, diagnosis and treatment for high risk and diabetic patients with additional medical needs and who were vulnerable.

We observed adjustments were made for people with a disability, impairment or sensory loss, to meet their communication needs. There was a facility on the electronic patient record system to alert staff to additional requirements a patient may have, for example if they were hard of hearing or had cognitive issues. Hearing loops were available in the main hospital site waiting areas, which helped those who used hearing aids to access services on an equal basis to others. An interpreting service for patients who did not speak English and British sign language interpreters were available when required and staff knew how to access them. We observed posters on

display in waiting areas that asked patients to indicate their language by pointing to their country's flag to enable the appropriate interpreter to be requested.

The physiotherapy service had a range of pictorial leaflets to support all patients without a significant visual impairment. The service also sent videos to patient's mobile phones to demonstrate the exercises they needed to follow.

The occupational hand therapy service provided education on securing a splint, for example, to people caring for patients with a learning disability or mental health need.

We saw appointment letters, which contained clear information about appointments and what to expect. Booking administrators sent information about how to get to the hospital and specialist information depending on which community outpatient clinic they were attending.

Not all patient information leaflets were available in different languages however, they could be requested and some leaflets were also available in large print, Braille, on audio tape, and disc. Clinics were accessible to patients with a physical disability, as patient lifts were available. There was ramped access to the hospital sites and health centres. Wheel chairs were available in the front entrance of hospital sites for patients to use, along with wheelchair accessible toilets.

High-back chairs were available in most waiting areas to accommodate older patients or those with mobility issues. We also observed that bariatric chairs were also available in clinic waiting areas and that bariatric wheelchairs and trolleys were accessible in community and NHS trust hospitals.

Diabetes education was provided to vulnerable, African women who received support from a local voluntary organisation.

Patient Led Assessment of the Care Environment (PLACE) for March to June 2017 showed the hospital scored 97% for dementia, which was better than the England average of 77%. The place assessment for dementia was included for the first time in 2015, and focuses on key issues such as, flooring, decoration (for example contrasting colours on walls), signage, along with seating and availability of handrails, which can prove helpful to people living with dementia.

The PLACE assessment for the period of March to June 2017 showed the hospital scored 95% for disability, which was better than the England average of 83%. The place assessment for disability was included for the first time in 2016, and focuses on key issues of access including wheelchair, mobility (e.g. handrails), signage and provision of such things as visual/ audible appointment alert systems, hearing loops, which could prove helpful to people living with disability.

Staff within the community brain injury service supported patients with accessing a disability employment advisor to help with finding a job or gaining new skills.

All bands of nursing and therapeutic staff, such as occupational therapists and physiotherapists, wore the same coloured uniforms. A stripe worn on the shoulder of the uniform enabled trust staff to identify the band, or specialism of an individual staff member. This enabled vulnerable patients such as the frail elderly, or those living with dementia or mental health conditions, to better identify the person visiting them in their home.

The waiting area in the podiatry service at Corby Community Hospital had no receptionist and there was no information on display to advise patients of who was working that day, or if they were required to alert somebody that they had arrived. Staff told us there were plans to introduce an electronic check-in system. There was also no clock on the wall for patient's information.

We observed that there was no receptionist at the musculoskeletal (MSK) physiotherapy centre situated within a local NHS trust hospital, during one day of our inspection. Staff told us the

reception usually had cover five days a week however, not always during periods of sickness or annual leave. In mitigation, we observed staff greeted patients and informed us there were plans to introduce an electronic check-in system.

In one podiatry clinic there was a display of shoes that could be purchased from various local manufacturers to provide patients with information about the range of footwear that could support specialist adaptions. All podiatrists were qualified to prescribe specialist footwear and assistants could make the footwear within the trust.

Access to the right care at the right time

People could access the service when they needed it. Waiting times from referral to treatment were in line with good practice. The trust had increased staff resource in podiatry services in response to an increase in referrals.

Accessibility

Community services used the 18 week referral to initial assessment time and 26 week assessment to treatment time, local and national targets. We observed all targets were met during 2017. Patients using the services could either by referred by their GP or consultant, or self-refer.

The patient contact centre received and monitored all musculoskeletal, podiatry, therapy and diabetic retinal screening calls. These calls were made through GP referrals, consultant and self-referrals. The service monitored the number of patients who were due to exceed the 18-week referral to treatment time. The trust met the 18-week referral to treatment time

Patients who required intensive support to minimise the risk of hospital admission or who required support to facilitate hospital discharge, could access the ICT. Should the patient's health deteriorate due to illness or trauma, they would be referred back to the service as often as necessary to reduce the need for a hospital admission. A team lead reported that on occasions the team had been unable to accept new referrals as they did not have staffing capacity to meet the number of visits required. The closure was normally for a few hours at a time and was rarely for a whole day. We were told that the service had been closed for new referrals on approximately 10 occasions for a number of hours since January 2018.

Staff told us the trust advocated a standard of quality of care across the county and demand and capacity reviews of community nursing teams meant there was improved equity for patients accessing a service.

Staff managed patients who did not attend clinics (DNAs) by text reminders. All patients who missed their appointment were followed up and offered a second appointment within 28 days. If they did not attend on the second appointment the hospital would contact the referrer who would be notified of the non-attendance, and would need to re-refer the patient.

Staff told us the trust had invested in extra wording in the follow up text messages sent to patients who did not attend appointments. This provided additional information to remind a patient of the next appointment, or steps to take to cancel or rearrange an appointment.

Some services, such as podiatry services, provided three patients with the same appointment time. This was to maximise the number of patients seen, as staff told us there may be DNAs or delays caused by patient transport services. One patient, however, told us they had to wait more than an hour for their appointment.

We observed an episode of patient care in a podiatry clinic and saw a same day, urgent referral to the specialist podiatric surgery service was made. The podiatry service ensured rapid access for appropriate patients to vascular and rheumatology clinics.

Staff from the community brain injury service provided a rolling information sharing session to the intermediate care team to ensure the right people could access the service at the right time.

The community brain injury service accepted four to five new referrals each week and accommodated urgent referrals at short notice. Initial assessments were completed at the hospital location however; staff responded to complex referrals and undertook some referrals at a patient's home address.

The musculoskeletal (MSK) physiotherapy service provided 'urgent' and 'super urgent' slots on a daily basis to enable immediate access to the service. We observed patient feedback concerning the MSK service. The comment stated the staff member "went above and beyond by changing my appointment to fit around my working pattern". Staff told us however, the waiting list had increased since an electronic referral MSK single point of access system was introduced in March 2018. Referrals were triaged by an extended scope practitioner and allocated to the appropriate pathway. The trust had recognised the impact on service delivery and had responded by funding an increase in agency staff.

During our inspection, we saw a health care assistant change their visit schedule to prioritise an urgent referral.

Stroke patients were issued with computer tablets loaded with speech and language therapy supported applications which enabled access to the service in between appointments. Urgent access to the speech and language team was provided based on clinical need.

Many nursing staff across the service told us that a delay with local authority social care assessments impacted on case-load management. For example, a financial and care assessment to determine a person's eligibility for funded personal care support was often delayed for more than a month. This meant some patients could not be removed from community nurses' caseloads until appropriate support was provided. To mitigate the risk and ensure the right patients had access to the service, team leads regularly reviewed individual cases, reduced the number of visits where possible, and reallocated cases to health care assistants during the transition period.

Referrals

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'assessment to treatment'.

The trust met all the local and national targets set.

Name of hospital site or location	Name of in-patient ward or unit	Service Type	Days from referral to initial assessment			Days from initial assessment to onset of treatment		
			Target	Local or National?	Actual (mean)	Target	Local or National?	Actual (mean)
Countywide	Adult Dietetics	Adult Dietetics	91	Local	15	126	Local	15
North of County	MSK Hand Therapy	MSK Hand Therapy	91	Local	15	126	Local	15
Countywide	Diabetic Foot & High-Risk Podiatry Service	Diabetic Foot & High-Risk Podiatry Service	91	Local	40	126	Local	40

Name of hospital site or location	Name of in-patient ward or unit	Service Type	Days from referral to initial assessment			Days from initial assessment to onset of treatment		
			Target	Local or National?	Actual (mean)	Target	Local or National?	Actual (mean)
Countywide	Podiatric Surgery	Podiatric Surgery	91	National	37	126	National	37
Countywide	Intermediate Care Team	Intermediate Care Team	2	Local	0	2	Local	0
Countywide	Specialist Nursing - Heart Failure Nurse	Specialist Nursing - Heart Failure Nurse	91	Local	20	126	Local	20
North of County	Specialist Nursing - Multiple Sclerosis	Specialist Nursing - Multiple Sclerosis	91	Local	28	126	Local	28
Countywide	Specialist Nursing - Parkinson's Disease	Specialist Nursing - Parkinson's Disease	91	Local	48	126	Local	48
Countywide	Adult's Continence Service	Adult's Continence Service	91	Local	16	126	Local	16
Countywide	Diabetes MDT	Diabetes MDT	91	Local	0	126	Local	0
Countywide	Adults Speech & Language Therapy Services	Adults Speech & Language Therapy Services	91	Local	19	126	Local	19
Countywide	Falls Service	Falls Service	91	Local	35	126	Local	35
Countywide	Community Therapy Rehabilitation Team	Community Therapy Rehabilitation Team	91	Local	30	126	Local	30
Countywide	Community Brain Injury	Community Brain Injury	91	Local	32	126	Local	32
Countywide	MSK Physiotherapy & ESP	MSK Physiotherapy & ESP	91	Local	34	126	Local	34
Countywide	MSK Spinal Pilot	MSK Spinal Pilot	91	Local	25	126	Local	25
Countywide	Adult Dietetics (Renal)	Adult Dietetics (Renal)	91	Local	2	126	Local	2
Countywide	Adult Dietetics	Adult Dietetics	91	Local	15	126	Local	15

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff.

Complaints

Community services for adults received 41 complaints from January and December 2017. The majority of complaints (22) were about 'all aspects of clinical treatment' (11 of these were either partially or full upheld). No complaints had been referred to Parliamentary and Health Service Ombudsman (PHSO). The number of complaints had risen by 17% from January to December 2016 when the trust received a total of 34 complaints relating to community health services for adults.

The service had a clear process and policy in place for dealing with complaints, staff we spoke to were aware of the complaints procedure. We saw information about how to raise a complaint was available throughout community health services for adults, and the hospital website had a section detailing how to make a complaint. Complaints could be made in person, by telephone, and in writing by letter or email. Patients were also invited to give feedback by the IWantGreatCare web page that was available on the trust website and

The complaints process ran alongside a quarterly complaints review committee which was chaired by the Chief Executive Officer (CEO). The committee was attended by the director of nursing, service users, carers and governors to develop the complaints processes, learning and sharing of lessons. Data confirmed that 100% of complaints were responded to within the agreed timeframe.

Staff told us that new complaints and learning from complaints were discussed at relevant management groups and staff meetings. We reviewed two sets of minutes from monthly team meetings that demonstrated complaints were a regular agenda item. We observed a complaint about a medication incident in a home environment was discussed in a meeting attended by senior nurses, occupational therapists and physiotherapists. The group shared learning following a review of the complaint, that included ensuring recording of discussions in patient records was explicit.

Total Complaints	Fully upheld	Partially upheld	Not upheld	Ongoing	Withdrawn	Referred to Ombudsman
41	9	17	5	3	7	0

Compliments

The trust received 285 compliments during the last 12 months from January to December 2017 for this core service. This accounted for 22% of all compliments received by the trust as a whole.

Is the service well-led?

Leadership

The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Senior managers had full oversight of concerns and issues affecting the day-to-day working of adult community teams and succession planning was a clear priority.

The community health services for adults were divided into planned and unplanned care. Both planned and unplanned care was led and managed by a head of service respectively. Each specialism was led by a clinical team leader who reported directly to the service manager. Staff

across community health services for adults spoke highly of the chief executive officer (CEO) and senior executive team. Professionals reported the CEO invested highly in staff welfare that was balanced with the delivery of quality, patient care. The majority of staff told us the senior management team were visible and that the CEO prioritised learning and development to support the provision of excellent patient care. One senior manager told us the CEO was 'compassionate, looks after staff, and has made a huge difference. I wouldn't want to work anywhere else'.

Community nursing services continued to undergo a nursing transformation service redesign. This involved the realignment of community teams to local GP practices. The redesign was taking place to improve communication with staff; improve integration of community nursing teams with specialist nursing services to provide improved care pathways; achieve alignment of roles with the management accountability framework; and achieve cost improvement programme savings targets.

Advanced nurse practitioners told us that they felt supported by line managers if they needed to escalate an issue and they also felt fully informed about the redesign of the service.

Senior staff we spoke with said they generally had the capacity to lead their services effectively.

Staff across community health services for adults reported that there was strong local leadership and that leaders were both visible and supportive. Nursing and therapeutic staff told us that they felt supported by the local management team.

One local manager told us "I believe in leading by example. I wouldn't expect my team to do anything that I wouldn't do. We have an open and honest approach in the team". A senior podiatrist told us they felt their concerns were '…listened to and acted upon. I can phone the service manager at any time if I require support'.

Staff felt they had good training and development opportunities and found their managers friendly and supportive. The trust ran a leadership matters programme that included topics such as staff engagement and values and behaviour expected of leaders within the trust. Many senior nursing and therapeutic staff had attended leadership training.

Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The vision for the service was in line with the trust overarching vision, which was to be a leading provider of outstanding, compassionate care. All staff we spoke with were aware of the vision for the service. The vision was encompassed in a set of values known as 'Pride' which were: People first, Respect and compassion, Improving lives, Dedication and Equality (PRIDE).

The vision and values were developed in corroboration with staff and were reinforced through the recruitment and induction programme.

The trust had a strategy that focused on three objectives; quality for patients, people, and performance. The first objective, quality for patients, included areas such as pressure ulcer prevention, early recognition of the deteriorating patient, and an annual clinical audit and quality improvement programme. The second objective, people, focussed on improving the overall staff engagement score and developing a consistent approach to valuing and recognising staff. The third objective, performance, focussed on supporting delivery to home and community settings and increased integration with health and social care services.

Community health services for adults continued to develop in line with the trust transformation programme to achieve the clinical strategic aims, including the provision of integrated care closer

to home. Services across the county had been realigned, and developments continued to meet the government objectives in prevention and public health.

All staff were positive about the service vision and developments. Therapeutic and nursing staff of different bands and experiences told us they had been kept informed and felt part of the transformation. Three senior nurses told us they felt "…very much part of the decisions that are being made – nothing is being imposed". The staff told us they felt they were given ownership of the developments within their areas that set out to achieve the local and overarching vision and strategy for community health services for adults. This was an improvement on the January 2017 inspection when district nurses told us they had not been involved in the planning of the strategy.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Many staff told us they were proud to work at the trust and felt valued for the contribution they made to patient care. One staff member reported "The trust has gone from strength to strength, and patient centred care is paramount. The ethos is working together".

Staff morale was good amongst all services. Staff we spoke with enjoyed working at the trust; they shared their views about the service openly and constructively. All staff we spoke with and observed were caring and passionate about the service and the care they provided to people who used the service.

Staff were dedicated to improving the health and wellbeing of patients while focussing on improving patient's independence in their own homes.

Staff had opportunities for professional development. They told us they had annual appraisals and supervision sessions. Registered nurses had support to complete requirements for their revalidation. Staff felt supported to develop and managers told us they supported people to develop.

Governance

There was a governance framework that ensured responsibilities were clear while quality and risks were understood and managed.

Head of services attended monthly directorate meetings where senior managers discussed performance, risk, governance human resources.

Quality performance reports were circulated to senior managers. All staff groups attended staff meetings which were structured and included standing agenda items that included an overview of serious incidents and staffing levels. Staff confirmed these meetings were valuable and informative.

At the time of the January 2017 inspection, not all clinical audits undertaken across community health services for adults were listed on the trusts audit programme. During the June 2018 inspection, we found the trust had an oversight of all audits being carried out in community health services for adults.

The trust made clinical policies and guidelines available for all staff via their intranet. These were available to staff at all times. Staff showed they knew how to access relevant policies.

Senior clinicians had access to governance systems that enabled them to monitor the quality of care provided. This included the provider's electronic incident reporting system and electronic staff training record. The service did not, however, always have governance systems to maintain

oversight of equipment maintenance schedules where services were provided by a local NHS trust.

Feedback from patients was consistent across the community health for adult's services.

Community nursing teams adhered to the trusts protocol to detect deteriorating patients and all staff were aware of the protocol. Community early warning scores were routinely being carried out on patients who appeared to be deteriorating.

All staff had a clear understanding of their roles and understood what they were accountable for and to whom. Staff were supported in their daily role and were clear of expectations to report incidents and issues.

Management of risk, issues and performance

The services risk management and performance management arrangements was robust and managers had good oversight of the risks identified within the service. For example, difficulties in recruiting to community nursing roles and the training of district nurses were recognised risks.

There were developmental roles in place where staff recruited to band 6 posts could be trained to gain competencies to progress to band 7 roles.

Managers acknowledged that recruiting staff to the service was a challenge. Actions to address this risk area included continuous advertising of vacancies, training of health care assistants, for example, health care assistants were being trained to catheterise patients.

There were arrangements in place for recording risks. There was a clear local risk register for adult's services that was reviewed monthly. There was a total of 25 risks on the risk register at the time of our inspection. Two of which were significant, thee of which were high risk, 14 were moderate risk, and six were low risk. Senior staff we spoke with were aware of the risks on the risk register and told us, and we observed that all risks marked 'significant' were escalated up to the trust's overarching risk register.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The trust had made significant investments in the last three years and had moved patient records and patient administration onto a new electronic system. Prior to this the trust used a number of different IT systems and paper records. Most services in the adult community division now used the system, and there were clear plans to extend its use across all services.

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The trust mission statement was "Making a difference for you, with you". The statement reinforced the importance of engagement with the patient and their family/carers. It also emphasised the value of the benefits of good staff engagement leading to high quality, safe care.

The trust provided a 'staff room' page on the intranet. The 'staff room' page promoted staff engagement and provided an opportunity for innovation and shared learning.

The trust had developed a dementia strategy 2016 to 2019 in collaboration with partner agencies such as local clinical commissioning groups, a local authority, a dementia alliance group, carer's groups, and local NHS trusts. The strategy aimed to reduce the risk of dementia; deliver timely

access to diagnosis and treatment; and provide appropriate support to those living with dementia and their carers.

The community brain injury service ran group programs for both people with brain injury and their family and carers. At the time of the inspection, programs included ‘understanding brain injury’ and ‘fatigue management’, and a tea and coffee morning was also held every six to eight weeks.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

The community nursing teams had introduced a ‘trauma box’ that was being ‘rolled out’ to residential homes to support the interim treatment to skin tears. This aimed to improve safe patient care whilst reducing the number of urgent community nurse visit requests.

The trust encouraged innovation and community nurses across the county had initiated projects to review and improve the provision of safe patient care. One team of nurses aimed to deliver training in residential homes to support care staff to administer insulin to patients with diabetes. A further initiative concerned the amalgamation of nurse-led, wound dressing and catheter care clinics that aimed to reduce the number of appointments some patients would need to attend.

Some qualified nursing staff were completing research at the time of our inspection to establish if the use of wipes to clean long-term leg wounds, instead of washing legs in buckets, reduced the risk of infection.

The community brain injury service was developing a specialist, initial assessment template in corroboration with IT services at the time of the inspection. The template would be built in to the trust electronic patient recording system to support shared access to records with multi-disciplinary professionals, as well as GPs.

A staff member in the community brain injury service was completing research in collaboration with a local university to review the effects of stimulation on people with a brain injury.

The muscular skeletal physiotherapy service was developing a ‘move clinic’ in collaboration with community therapy, who received similar referrals for patients who had fallen. The aim was to make services more effective by reducing assessments and to ensure patients received appropriate services.

A podiatrist from the podiatric and high-risk diabetes service had delivered ‘poster’ presentations at international conferences. Poster presentations are short presentations outlining findings from research to share best practice recommendations. Presentations included ‘Rapid access to vascular surgeons within diabetic ulcer clinics’ and ‘Auditing safety of independent prescribers for podiatry and adverse effects’. One podiatrist had delivered training to doctors in ‘offloading’ pressure in the management of diabetic foot ulcers.

Accreditations

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

There were no details provided in the RPIR for accreditations relating to this core service.

One band 7 nurse had been awarded the title of ‘Queen’s Nurse’ for their commitment to community nursing and education. The award recognised the individual’s dedication to improving patient care and provided learning and leadership opportunities.

The community brain injury service had been nominated for the trust team end of 2018, annual award.

A community nurse won an Unsung Hero Award in 2018 that is a national award for NHS staff and volunteers who had gone above and beyond the call of duty.

Community health inpatient services

Facts and data about this service

Northamptonshire Healthcare Foundation Trust (NHFT) provides inpatient services across three community hospital sites within Northamptonshire. The inpatient services provide 24-hour patient care for sub-acute medical patients who have a combination of medical, physical and neurological requirements.

We carried out an announced inspection from 5 June to 7 June 2018. During our inspection we visited all three community inpatient hospital settings; Corby Community Hospital, Danetre Hospital and Isebrook Hospital. All three hospitals provide a range of services including: specialist neurological rehabilitation, stroke rehabilitation and nutritional advice which is delivered by a variety of healthcare professionals.

Beechwood ward is a specialist inpatient rehabilitation unit based at the Isebrook hospital site. It provides sub-acute medical care and rehabilitation therapy including rehabilitation for the younger person (16-65 years of age).

Hazelwood ward is a 34-bedded in-patient setting on the Isebrook Hospital site. The ward provides care and physical rehabilitation for adult patients following an acute illness such as a stroke.

Corby Community Hospital is a 22-bedded inpatient ward providing physical rehabilitation for adult patients. The hospital provides multi-disciplinary working with the integrated care team to avoid acute admissions to the main trust site.

Danetre Hospital is a 28-bedded inpatient ward which provides physical rehabilitation for patients following acute illnesses, as well as, step- up care from the community for the management of sub-acute medical conditions. The hospital also provided palliative end of life care.

During the inspection, we spoke with 11 staff of various grades including the senior matron, ward matrons, ward sisters, nurses, student nurses, therapists and housekeeping staff. We spoke with12 patients and their families, observed care and treatment and looked at 16 patients’ medical records and 38 patients’ prescription charts.

The service was last inspected in January 2017 and at that inspection the community inpatient service was rated requires improvement in the safe and effective domains. The caring, responsive and well led domains were rated good, with an overall rating of requires improvement. During this inspection, we looked at the changes and considered any progress that had been made within the community inpatient services.

Information about the sites, which offer community inpatient services at this trust, is shown below:

Location site name	Team/ward/satellite name	Patient group	Number of beds	Geographical area served
Corby Community Hospital	Adult Community Beds	Mixed	22	Countywide but consideration given to local residents
Danetre Hospital	Adult Community Beds	Mixed	28	Countywide but consideration given to Daventry and south Northampton
Isebrook Hospital	Adult Community Beds-Beechwood Ward	Mixed	15	Countywide
Isebrook Hospital	Adult Community Beds-Hazelwood	Mixed	34	Countywide but consideration given to local residents

Percentage of patients that are children

The trust reported that 0% (zero) of patients attending community health inpatient services within the last 12 months were identified as being child aged 17 years or under.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The trust was in the process of updating their electronic record system. This meant that when we originally requested training data, the data provided did not reflect actual staff mandatory training compliance. The electronic record system allowed staff to monitor their compliance, book training classes and access eLearning. During our inspection we received updated evidence which stated that the overall training compliance for May 2018 was 98%.

The trust set a target of 90% for completion of mandatory training and their overall training compliance was 44% against this target.

A breakdown of compliance for mandatory courses as of 31 January 2018 for medical/dental and nursing staff in community inpatient services is shown below:

Core Services	Grand Total %
Fire Safety	**115%**
Infection Prevention (Level 1)	**100%**
Infection Prevention (Level 2)	**82%**
Information Governance	**78%**
Resuscitation Level 2 - Adult & Paediatric	**77%**
Falls Prevention Training - Level 2	**74%**
Resuscitation Level 3 - Immediate Life Support	**68%**
Safeguarding Adults Level 1	**67%**
Safeguarding Children (Level 1	**67%**
Duty of Candour	**37%**
Conflict Resolution	**36%**

Core Services	Grand Total %
Equality and Diversity	34%
Learning Disability Awareness	29%
Dementia Awareness (inc Privacy and Dignity Standards)	28%
Health, Safety and Welfare	27%
Mental Capacity Act DoLS	27%
Making Every Contact Count	24%
Safeguarding Adults (Level 2)	23%
Safeguarding Children (Level 2)	22%
Moving and Handling	21%
Safeguarding Prevent Health WRAP	18%
Raising concerns and whistleblowing	16%
Resuscitation Level 1	9%
Staff and Pt. Safety (Quality & Safety)	6%
Venous Thromboembolism	4%
Core Service Average	44%

Training compliance - May 2018.

NHS Conflict Resolution (England) - Three Years	98%
Equality, Diversity and Human Rights – Three Years	99%
Fire Safety - One Year	97%
Health, Safety and Welfare - Three Years	99%
Information Governance - One Year	100%
Infection Prevention and Control - Level One - Three Years	100%
Infection Prevention and Control – Level Two - One Year	99%
Moving and Handling - Level One - Three Years	99%
Moving and Handling - Level Two – One Year	99%
Resuscitation - Level One	93%
Resuscitation - Level Two - Adult & Paediatric Basic Life Support - One Year	92%
Resuscitation - Level Three - Adult Immediate Life Support - One Year	88%
Safeguarding Adults - Level One - Three Years	100%
Safeguarding Children (Version 2) - Level One – Three Years	100%
Safeguarding Adults - Level Two - Three Years	99%
Safeguarding Children (Version 2) - Level Two – Three Years	99%
Safeguarding Children (Version 2) - Level Three - Three Years	N/A
Freedom to Speak Up - One Off	99%
Safeguarding - Prevent Health WRAP - One Off	98%
Mandatory Training Overall Compliance	97.8%

(Source: Additional Information Request - RP 1021- 20180604)

Previous overall mandatory training compliance from March2018/ May 2018

Hospital	March	April	May

Beechwood Ward-Isebrook Hospital	98%	99%	99%
Hazelwood ward – Isebrook Hospital	97%	98%	98%
Danetre Hospital	93%	95%	96%
Corby Community Hospital	98%	99%	98%

During our inspection, we spoke with staff regarding mandatory training. Staff were responsible for booking and completing their own mandatory training. However, ward matrons told us that they monitored compliance and reminded staff about completing their mandatory training. Training was available either by using the trust e learning computer training or by classroom based learning.

Staff completed mandatory training in dealing with medical emergencies such as resuscitation level 1 and level 2. The resuscitation training included basic life support and intermediate life support knowledge and automated external defibrillation(AED) training.

However, resuscitation level 3 training was non-compliant at 88%. The senior matron informed us that the service had not met the training compliance target due to staff being on maternity leave.

Staff on the community inpatient wards had received training on 'Sepsis'. Compliance for sepsis training for Corby Community Hospital, Danetre Hospital, Beechwood Ward Isebrook Hospital and Hazelwood ward Isebrook Hospital were 97%, 90%, 96% and 93% respectively. Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. Sepsis pathways show how to recognise sepsis and the steps that are necessary to treat patients appropriately. This meant that if a patient had a sepsis appropriate action and treatment would be given.

The ward matrons informed us that medical device training had been completed and updated in line with trust policy, compliance for medical device training was 94%. Medical devices included vital signs monitoring equipment and syringe driver machines. The community hospitals produced standards for each piece of equipment specifying training requirements necessary to use the devices. Refresher training was available to maintain standards of staff's ability in the use of the medical equipment.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. All staff had received safeguarding training on how to recognise and report abuse.

During our inspection we saw defined systems, processes and standard operating procedures to keep people safe and safeguarded from abuse, using local safeguarding procedures whenever necessary.

Nursing staff told us they were aware of their responsibilities to safeguard patients and demonstrated how they could access the trust policy on the intranet. Staff were aware that there was a safeguarding lead within the trust and told us they knew how to contact her for advice. Staff could explain the process for raising concerns.

The trust had a dedicated safeguarding team, which included clinical nursing staff. The team could support staff across all hospital sites, keep them informed on safeguarding issues and provide additional training when required.

Staff within the community inpatients services had not completed safeguarding level 3 training. The senior matron told us that level 3 training had been completed by the ward matron on Beechwood ward, however no other staff had completed this training. Guidance from the trust stated that level 3 training was not applicable. The Intercollegiate document for safeguarding children and young people recommends that level 3 clinical training should be provided to staff working with children, young people and/or their parents/carers if they are potentially contributing to assessing, planning, intervening and evaluating the needs of a child or young person. Beechwood ward admitted patients from the ages of 16-65 years of age. There had been no child aged 17 years or under admitted to the community health inpatient services within the last 12 months.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Community inpatient services made seven safeguarding referrals from1 January 2017 to 31 December 2017, of which seven concerned adults and zero children.

Referrals		
Adults	**Children**	**Total referrals**
7	0	**7**

There were two peaks identified in adult referrals across the period in February and July 2017 with two each.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. During our inspection, we found the environment to be clean and staff followed the trust policy on infection prevention and control.

There were posters on display encouraging staff and visitors to clean their hands using the hand sanitiser provided. Hand sanitiser was available within the ward corridors and the patient ward areas.

We observed a range of staff including nurses, health care assistants, therapists and ward hostesses using hand sanitiser and washing their hands when entering ward bay areas and before each new patient contact. This is in line with the National Institute for Health and Care Excellence (NICE) Quality Statement 61 (Statement 3). Staff we spoke with had a good knowledge of the trust hand hygiene policy and knew how to follow the five moments for hand hygiene guidance. This is defined by the World Health Organisation as the key moments when health-care workers should perform hand hygiene.

We observed staff groups complying with the 'arms bare below the elbow' policy. This is an infection prevention and control plan to prevent the transfer of infection from clothing that could be

contaminated, and allows clinical staff to wash their hands thoroughly. However, during our inspection we saw two general practitioners not adhering to this guidance, we escalated this to the senior matron who assured us that this would be addressed and action taken.

Personal protective equipment (PPE), such as gloves and aprons were available in sufficient quantities on all wards within the community hospitals. Staff used PPE appropriately when performing tasks where there was a risk of contamination.

The community hospital inpatient wards had side rooms available to isolate patients suspected of having an infection. During our inspection we saw that precautions had been taken with a patient who had been transferred to the hospital with a MRSA. MRSA is a type of bacteria that is resistant to some antibiotics. This means infections with MRSA can be harder to treat than other bacterial infections. The ward staff had contacted the trust infection prevention team who had suggested measures to reduce any possible transfer of the infection, staff ensured all necessary actions had been taken.

During this inspection we noticed that there had been one outbreak of *C* diff within the inpatient wards from June 2017 to June 2018. C. diff is also known as Clostridium difficile, it is a bacterium that can infect the bowel and cause diarrhoea. Strict infection control measures have helped to reduce the risk of hospital acquired C diff.

'I am clean' stickers were in use across wards which indicated that equipment was clean and ready for use. Stickers were dated, and we observed equipment being cleaned prior to the stickers being used.

Audits were carried out regarding infection control compliance. Areas included general environment, clean and dirty utility rooms, storage and equipment, waste management and sharps. Hand hygiene was monitored through regular audits and included the audit of clinical and non-clinical staff. Hand hygiene audits between January to May showed that all inpatient community wards achieved above 90% in their respective ward audits.

Waste management processes were in place. There were separate colour coded arrangements for general waste, clinical waste and sharps bins. Bins were not overfilled and sharps bins were closed, labelled and dated. However, we observed that a clinical waste bag had been attached to a patient vital signs monitor at Danetre hospital. This was being used to dispose of temperature probe covers and other used patient items. It is recognised practice to ensure that all patient waste is disposed of in appropriately sealed bins, this reduces the risk of cross contamination between patients. We brought this to the attention of the senior sister who removed the clinical waste bags immediately. We did not notice any clinical waste bags on equipment at the other community hospital inpatient wards.

Kitchen ward areas were clean and free from clutter, we saw that all food products and patients own food was labelled and in date.

PLACE Assessments

These self-assessments are undertaken by teams of NHS and private/independent health care providers, and include at least 50 per cent members of the public (known as patient assessors). They focus on the environment in which care is provided, as well as supporting non-clinical services such as cleanliness, food, hydration, the extent to which the provision of care with privacy and dignity is supported and whether the premises are equipped to meet the needs of people with dementia against a specified range of criteria.

The 2017 PLACE score for cleanliness and environment at Northampton Healthcare NHS Foundation Trust is 99.9%. The trust scored higher than the England average for all four aspects overall.

Site Name	Core Service(s) provided	Cleanliness	Condition Appearance and maintenance	Dementia Friendly	Disability
Isebrook Hospital	CHS – Community Inpatients CHS – Community Dental	100%	96.9%	92.0%	96.1%
Danetre Hospital	CHS – Community Inpatients CHS – Community Dental	100%	98.5%	98.1%	97.8%
Corby community Hospital	CHS – Community Inpatients	98.9%	98.8%	98.6%	97.7%
Trust Overall		**99.9%**	**98.2%**	**96.6%**	**95.2%**
England Average		**98.6%**	**92.7%**	**80.6%**	**86.1%**

Environment and equipment

The service generally had suitable premises and equipment and looked after them well.

Within the community inpatient bed spaces, each patient was provided with a bed, armchair, locker and an over bed table. We saw that all the community inpatient wards were a combination of single rooms and multiple bedded bays. All accommodation was single sex with separate male and female bathroom and toilet facilities for each bay area and side rooms.

On our previous inspection in June 2017 we saw that wards at the community inpatient hospitals were in a poor state of repair. During this inspection we noticed that refurbishment had been undertaken to improve the patient and staff environments. A refurbishment plan was underway at Corby Community hospital to improve its patient and staff surroundings. The senior matron within the community inpatient services was aware of the required building regulations to provide a safe purpose-built ward environment.

Emergency medical equipment such as resuscitation trolleys and hypoglycaemia (low blood sugar) boxes were checked daily according to trust policy. The resuscitation trolleys had a lockable seal which meant that the trolley could not be tampered with.

Emergency call bells, piped oxygen and suction were available behind each patient's bed space at Danetre hospital. However, during the inspection, we saw that within the ward areas at Corby Community Hospital and on Beechwood ward and Hazelwood ward at Isebrook Hospital, there was no piped oxygen or suction. Department of health guidance HTM08-03 bed head services, suggests that management should periodically reassess the equipment available to ensure they remain adequate for the intended purpose. The risk had been mitigated by senior staff ensuring that portable oxygen cylinders were available and that potable suction units were present on the resuscitation trolley. However emergency call bells were present at each patient bed head in all wards we visited

Suitable equipment was available to prevent patients suffering pressure ulcers in line with Royal College of Nursing for the management of pressure ulcers. Patients identified at being at risk of developing pressure ulcers had access to pressure-relieving support surfaces and strategies for example, mattresses and cushions 24 hours a day. Patients assessed as having a grade 1-2

pressure ulcer could be placed on a high-specification foam mattress or cushion with pressure-reducing properties. Patients assessed as having grade 3-4 pressure ulcers, were provided with an alternating pressure mattress or a continuous low-pressure system**.**

Disposable items, for example syringes, needles, and fluid giving sets were within their expiry dates. All equipment was serviced internally. A record of equipment maintenance was kept centrally within the trust. Equipment was found to have been electrically tested and had yearly expiry dates that were visible and clearly written.

We observed a wide variety of mobility equipment used and stored within the ward areas. Systems were in place to remove broken or faulty equipment. Any equipment that was not safe was repaired or replaced as necessary. Staff told us that equipment would be removed from service immediately a problem was identified. During our inspection we saw that all equipment was serviced according to manufacturer's instructions**.**

Some bariatric equipment was available in the ward areas. For example, a larger sized chair and hoist and a larger size commode. Staff told us that bariatric equipment was available from an equipment store or to rent from external companies.

Hoists were available within all the ward areas which meant staff could provide safe and effective manual handling processes. This was in line with the manual handling operation regulation 2002. Some bed spaces within the ward areas had overhead hoist equipment, so that a patient could be moved safely while reducing any unnecessary risk to the patient or the staff member.

All inpatient wards at the community hospitals had access to fire escapes. Staff told us that fire lectures and tests were routinely carried out by external companies. On our previous inspection one of the community wards had experienced a fault with the fire alarms, during this inspection no concerns relating to fire systems were reported.

Assessing and responding to patient risk

There were effective systems in place to recognise and respond to deteriorating patients' needs. Risks were assessed and patient safety was monitored.

The National Early Warning System (NEWS) is used to identify deteriorating patients in accordance with NICE Clinical Guidance (CG) 50: 'acutely ill adults in hospital: recognising and responding to deterioration' (2007). The trust used standardised NEWS charts to document patient observations, such as blood pressure, pulse, oxygen levels, and temperature. Staff we spoke with said the system worked well and staff responded appropriately to patients with elevated NEWs scores.

Staff were trained in basic life support (BLS) and intermediate life support (ILS) as part of mandatory training. Staff we spoke with were aware of the processes in place necessary to escalate a deteriorating patient. Resuscitation trolleys were present on all the community ward areas. Each community site had a different process to follow when requiring assistance with a deteriorating patient, we were assured that safe systems were in place and all staff knew what to do. For example, staff at Corby community hospital and Danetre hospital would seek advice from the 111 NHS medical service or transfer the patient directly to the trust via an ambulance emergency call.

Within the all the community inpatient ward areas, laminated resuscitation processes were present. This meant ward staff would have guidance to initiate the correct actions required during an emergency. There was also guidance as to how to recognise a patient with sepsis, how to operate an oxygen cylinder and the correct use of portable suction units.

Risk assessments were carried out on patients when they were admitted to the community services. This included risk assessments for falls, malnutrition, and pressure ulcers. These were documented in the patient's records and included actions to mitigate any identified risks. Assessments were updated weekly or following any changes, such as a new fall. The service used nationally recognised risk assessments such as the Malnutrition Universal Screening Tool (MUST) and Waterlow score. MUST is a five-step screening tool to identify patients, who are malnourished, at risk of malnutrition (under nutrition) or obese. The Waterlow score gives an estimated risk for the development of a pressure ulcer in a patient. We observed that patients identified at risk were placed on care plans and were monitored more frequently by staff to reduce the risk of harm. We saw evidence that all initial assessments were completed within 24 hours.

During our inspection, we observed a lunchtime handover; staff received a full report of the patient's condition and actions of care. On all the community inpatient sites we saw staff greeting the patients by name and discussing their care with them.

Danetre Hospital accepted patients requiring blood transfusions. The staff employed within the inpatient ward had received blood transfusion training. Staff trained in the administration of blood was 72% compliant, with a further 25% of staff waiting for training dates. Staff were aware of the risks to patients when receiving blood.

Falls assessments were completed on each patient on admission and updated daily. The trust had a falls policy which staff were aware of and followed. During our inspection we observed a falls incident, all staff responded in a timely and effective manner, they followed standard trust protocol, and a medical assessment was completed prior to moving the patient. Patient falls alarms were in use for those patients deemed to be at a high risk. The National Service Framework (NSF) for Older People – Standard 6 states "To reduce the number of Falls which result in serious injury and ensure effective treatment and rehabilitation for those that have fallen." A falls policy should be followed and falls risk assessments should be completed daily.

Staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

Staffing levels, skill mix and caseloads were planned and reviewed so patients received safe care and treatment at all times, in line with relevant tools and guidance.

The Safer Nursing Care tool (SNC) was used by the community hospitals to calculate staffing requirements across the inpatient services. The SNC tool determined acuity and dependency levels of patients in hospitals; it was used to assess the care needs of patients, estimated care hours and suggested care arrangements. This meant that appropriate skill mix and staffing levels were planned, which met the Royal College of Nursing safe staffing guidance.

Each hospital ward displayed a board, which showed the number of nursing staff that should be on duty and the number there actually were. We saw the established staffing and the actual staffing levels were the same or greater on most wards. Where qualified staff availability was lower than required on some shifts, unqualified staff made up the staffing numbers. Ward matrons would also work on the clinical shifts to support the skill mix.

Some staff told us sometimes they felt there were insufficient numbers of staff. During our inspection, we did not see any evidence of patient care being compromised. Wards were busy, but we observed patients' call bells were answered within a timely manner. We did not see any incidents that had been reported as a direct result of lower staffing numbers.

During our previous inspection in 2017, we saw that staffing levels were below the required patient ratio. At this inspection, senior staff told us that there had been a skill mix review which had led to the development of new roles. These included, rehabilitation care assistants, therapy assistants and ward housekeeping roles. This meant that there were enough staff to ensure that all aspects of patient care were given.

The service had introduced the assistant practitioner role. An assistant practitioner works under the supervision of a qualified health care professionals. The community hospitals were also in the process of introducing the nursing associate role. The nursing associates work alongside other care professionals on the ward areas. After completion of their course, qualified nursing associates would be registered with the Nursing and Midwifery Council. This would allow nursing associates to perform some of the roles of a qualified registered nurse, for example, performing dressings, and completing medicine rounds.

A student nurse education facilitator had been appointed to provide support and assistance for student nurses. The role of the education facilitator had improved communication and training with the student nurses, which in turn had increased the uptake of permanent jobs following completion of their qualification.

Where staffing levels were being maintained using bank staff, regular bank staff were used where possible to promote continuity of care and minimise risk. New bank staff received a short induction to orientate them to the community inpatient wards prior to commencing their shifts.

Safer Staffing levels

Staff fill rates compare the proportion of planned hours worked by staff (Nursing, Midwifery and Care Staff) to actual hours worked by staff (day and night). Mental health trusts are required to submit a monthly safer staffing report and undertake a six-monthly safe staffing review by the director of nursing. This is to monitor and in turn ensure staffing levels for patient safety. Hence, an average 70% fill rate in January 2016 for nursing staff during the day means; In January 70% of the planned working hours for daytime nursing staff were actually 'filled'.

The below table covers staff fill rates for registered nurses and care staff during October, November, and December 2017.

At Hazelwood Ward at Isebrook hospital staffing levels across the three months for day registered nurses was below the minimum threshold (<90%). In addition, the ward had over filled shifts for day and night care staff for the same period (>125%).

Key

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	Oct 2017				Nov 2017				Dec 2017			
Beechwood	93.0	106.4	101.6	100.0	98.2	122.2	95.2	103.3	91.5	107.2	93.8	106.9
Danetre	106.3	104.1	94.9	109.7	102.5	110.0	100.3	100.0	98.8	97.1	96.9	100.2
Corby	117.0	86.0	99.9	94.2	106.1	92.3	100.2	100.8	102.4	93.3	99.9	111.4
Hazelwood	87.8	152.4	105.0	172.7	88.8	128.6	105.0	155.3	88.2	121.3	99.9	149.0

Total numbers – Planned vs Actual

Year one

Location	Month (specify Date)	Staffing Group	Planned Staff WTE	Planned Staff – Whole Number / Headcount	Actual Staff	Actual Staff – Whole Number / Headcount
Corby Community Hospital	Year 1 – 31/03/2017	Medical & Dental staff - Hospital	1.23	2.0	1.00	1.00
Isebrook Health Campus	Year 1 – 31/03/2017	Medical & Dental staff - Hospital	3.00	3.0	3.00	3.00
Danetre Hospital	Year 1 – 31/03/2017	NHS infrastructure support	1.71	2.0	1.71	3.00
Corby Community Hospital	Year 1 – 31/03/2017	NHS infrastructure support	1.38	2.0	1.39	2.00
Isebrook Health Campus	Year 1 – 31/03/2017	NHS infrastructure support	1.80	2.0	0.80	1.00
Isebrook Health Campus	Year 1 – 31/03/2017	Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	1.46	2.0	1.00	1.00
Danetre Hospital	Year 1 – 31/03/2017	Qualified Allied Health Professionals (Qualified AHPs)	5.61	6.0	4.12	7.00
Corby Community Hospital	Year 1 – 31/03/2017	Qualified Allied Health Professionals (Qualified AHPs)	4.23	5.0	3.45	3.00
Isebrook Health Campus	Year 1 – 31/03/2017	Qualified Allied Health Professionals (Qualified AHPs)	12.13	13.0	10.81	11.00
Danetre Hospital	Year 1 – 31/03/2017	Qualified nursing & health visiting staff (Qualified nurses)	21.51	22.0	20.64	27.00
Corby Community Hospital	Year 1 – 31/03/2017	Qualified nursing & health visiting staff (Qualified nurses)	16.00	16.0	12.47	17.00
Isebrook Health Campus	Year 1 – 31/03/2017	Qualified nursing & health visiting staff (Qualified nurses)	27.85	28.0	18.56	29.00
Danetre Hospital	Year 1 – 31/03/2017	Support to doctors and nursing staff	22.79	23.0	15.07	20.00
Corby Community Hospital	Year 1 – 31/03/2017	Support to doctors and nursing staff	17.20	18.0	12.72	15.00
Isebrook Health Campus	Year 1 – 31/03/2017	Support to doctors and nursing staff	46.23	47.0	35.67	45.00
Danetre Hospital	Year 1 – 31/03/2017	Support to ST&T staff	1.66	2.0	3.48	6.00

Location	Month (specify Date)	Staffing Group	Planned Staff WTE	Planned Staff – Whole Number / Headcount	Actual Staff	Actual Staff – Whole Number / Headcount
Corby Community Hospital	Year 1 – 31/03/2017	Support to ST&T staff	0.00	0.0	1.00	1.00
Isebrook Health Campus	Year 1 – 31/03/2017	Support to ST&T staff	4.00	4.0	6.16	9.00
Core service total			**189.8**	**197.0**	**153.0**	**201.0**

Year two

Location	Month (specify Date)	Staffing Group	Planned Staff WTE	Planned Staff – Whole Number / Headcount	Actual Staff	Actual Staff – Whole Number / Headcount
Corby Community Hospital	Year 2 – 31/01/2018	Medical & Dental staff - Hospital	1.23	2.00	1.00	1.00
Isebrook Health Campus	Year 2 – 31/01/2018	Medical & Dental staff - Hospital	3.00	3.00	3.00	3.00
Danetre Hospital	Year 2 – 31/01/2018	NHS infrastructure support	1.71	2.00	1.71	3.00
Corby Community Hospital	Year 2 – 31/01/2018	NHS infrastructure support	1.38	2.00	1.39	2.00
Isebrook Health Campus	Year 2 – 31/01/2018	NHS infrastructure support	0.80	1.00	0.80	1.00
Isebrook Health Campus	Year 2 – 31/01/2018	Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	1.60	2.00	1.60	2.00
Danetre Hospital	Year 2 – 31/01/2018	Qualified Allied Health Professionals (Qualified AHPs)	4.88	5.00	4.12	7.00
Corby Community Hospital	Year 2 – 31/01/2018	Qualified Allied Health Professionals (Qualified AHPs)	3.38	4.00	2.60	3.00
Isebrook Health Campus	Year 2 – 31/01/2018	Qualified Allied Health Professionals (Qualified AHPs)	12.38	13.00	10.11	11.00
Danetre Hospital	Year 2 – 31/01/2018	Qualified nursing & health visiting staff (Qualified nurses)	20.68	21.00	21.28	27.00
Corby Community Hospital	Year 2 – 31/01/2018	Qualified nursing & health visiting staff (Qualified nurses)	15.60	16.00	14.67	17.00
Isebrook Health Campus	Year 2 – 31/01/2018	Qualified nursing & health visiting staff (Qualified nurses)	27.58	28.00	25.59	29.00

Location	Month (specify Date)	Staffing Group	Planned Staff WTE	Planned Staff – Whole Number / Headcount	Actual Staff	Actual Staff – Whole Number / Headcount
Danetre Hospital	Year 2 – 31/01/2018	Support to doctors and nursing staff	23.98	24.00	15.27	20.00
Corby Community Hospital	Year 2 – 31/01/2018	Support to doctors and nursing staff	18.58	19.00	13.56	15.00
Isebrook Health Campus	Year 2 – 31/01/2018	Support to doctors and nursing staff	46.36	47.00	40.41	45.00
Danetre Hospital	Year 2 – 31/01/2018	Support to ST&T staff	1.89	2.00	4.21	6.00
Corby Community Hospital	Year 2 – 31/01/2018	Support to ST&T staff	0.00	0.00	1.00	1.00
Isebrook Health Campus	Year 2 – 31/01/2018	Support to ST&T staff	4.20	5.00	6.16	9.00
Core service total			**189.2**	**196.0**	**168.5**	**202.0**

Vacancies

Between February 2017 and January 2018, the core service reported an overall vacancy rate of 18% in community inpatient services.

As of January 2018, the vacancy rate in community inpatient services was at 11%, in line with the trust vacancy rate for the same period but slightly above the trust target of 10%.

	Registered nurses			Health care assistants			Overall staff figures		
Ward/Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Beechwood Therapists	0	0	0	0	0.8	0%	1.6	6.5	24%
Beechwood Ward	2.2	11.2	20%	1.5	17.4	9%	3.8	28.7	13%
Corby community beds	0.9	15.6	6%	5.0	18.6	27%	6.0	40.2	15%
Danetre community beds	-0.6	20.7	-3%	8.7	24.0	36%	6.6	53.1	12%
Isebrook Community beds	-0.2	16.3	-2%	4.4	28.1	16%	2.9	59.2	5%
Physical Rehab	0	0	0	0	0	0	0.0	1.6	0%
Core service total	**2.3**	**63.9**	**4%**	**19.7**	**88.9**	**22%**	**20.8**	**189.2**	**11%**
Trust total	**141.2**	**1260.38**	**11%**	**123.7**	**990.5**	**12%**	**279**	**2560.1**	**11%**

Turnover

From February 2017 to January 2018, the core service reported an overall turnover rate of 6.4% in community inpatient services.

All nurses leaving the service were given the opportunity of an exit interview with the senior matron. This helped identify any themes to understand why staff left. Some staff left due to promotion within the organisation or for promotion to another healthcare provider.

As of January 2018, the turnover rate in community inpatient services was at 6%, below the trust turnover rate for the same period but below the trust target of 8-12%.

Ward/Team	Total number of substantive staff (Current)	Total number of substantive staff leavers in the last 12 months	Total % of staff leavers in the last 12 months
Beechwood Therapists	4.9	0.8	13%
Beechwood Ward	23.9	1.0	4%
Corby Community Beds	32.2	1.0	3%
Danetre Community Beds	44.6	3.1	7%
Isebrook Community Beds	54.3	4.2	8%
Physical Rehab – Pain Clinic	1.0	0.0	0%
Core service total	**160.9**	**10.0**	**6%**

Sickness

From February 2017 to January 2018, the core service reported an overall sickness rate of 8% in community inpatient services.

Staff who had a period of sickness absence had a return to work/welfare interview immediately upon their return. The purpose of the interview was to ensure the staff member was fit to be back at work, and to ensure any reasonable assistance required was identified. The service monitored their sickness and absence and had policies in place to ensure that absence monitoring was carried out correctly.

As of January 2018, the sickness rate in community inpatient services was at 10%, above the trust turnover rate for the same period and above the trust target of 4.2%.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Beechwood Therapists	0%	1%
Beechwood Ward	8%	10%
Corby Community Beds	9%	8%
Danetre Community Beds	13%	7%
Isebrook Community Beds	10%	8%
Physical rehab – Pain Clinic	18%	68%
Core service total	**10%**	**8%**

Nursing – Bank and Agency Qualified nurses

From February 2017 to January 2018, the trust reported the total number of bank and agency shifts usage for qualified nursing staff.

We are unable to provide details on the percentages of shifts filled as this data was not submitted as part of the RPIR.

Total Shifts Filled by Bank Staff	% Usage of Bank Staff	Total shifts Filled by Agency Staff	% Usage Agency Staff	Total shifts NOT filled by Bank Staff	Total shifts NOT filled by Agency Staff
1487	Not provided	901	Not provided	166	Not provided

Nursing - Bank and Agency Healthcare Assistants

From February 2017 to January 2018, the trust reported the total number of bank and agency shifts usage for healthcare assistants.

We are unable to provide details on the percentages of shifts filled as this data was not submitted as part of the RPIR.

Total Shifts Filled by Bank Staff	% Usage of Bank Staff	Total shifts Filled by Agency Staff	% Usage Agency Staff	Total shifts NOT filled by Bank Staff	Total shifts NOT filled by Agency Staff
2954	Not provided	730	Not provided	385	Not provided

Medical locums

Nine (<1%) of shifts were filled by bank staff and 18 (1%) were filled by agency staff between 1 February 2017 and 31 January 2018 across the entire core service.

Staffing Type (Consultant, Middle grade, Doctor in Training)	Total Number of Shifts available	Total Shifts Filled by Bank Staff	% Usage of Bank Staff	Total shifts Filled by Agency Staff	% Usage Agency Staff	Total shifts NOT filled by Bank Staff	Total shifts NOT filled by Agency Staff
Consultant	720	1	<1%	18	3%	0	0%
Middle Grade	1200	7	1%	0	0%	0	0%
Doctor in Training	0	1	0%	0	0%	0	0%
Totals	**1920**	**9**	**<1%**	**18**	**1%**	**0**	**0%**

Consultant cover

The trust has advised that for community inpatient services, they have one on call consultant including weekends and nights, providing telephone cover.

Suspensions and supervisions

During the reporting period (1 January 22017 and 1 February 2018), the community inpatient service reported that there was one case where a member of staff had been placed under supervision.

Quality of records

Staff kept appropriate records of patients care and treatment. All patient records were kept in secured areas.

The community hospitals had recently implemented an electronic record system. The system used was one of the accredited systems in the government's programme of modernising IT in the NHS. All staff had received training and felt confident in using the recording system.

Care pathways were mostly completed in line with recommendation. We looked at 16 patient records, one patient record did not have a fully completed care pathway. The aim of a care pathway is to enhance the quality of care by improving risk-adjusted patient outcomes and promoting patient safety.

We found three ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) forms completed appropriately during our inspection. The forms were completed in line with British Medical Association, Resuscitation Council (UK) and the Royal College of Nursing, October 2014 guidance. However, we found that two DNACPR forms were kept as paper copies in the patient notes, this was not documented on the electronic record system. This meant that the completed forms were not easy to access and may have led to the wrong treatment being given we discussed this with the senior matron at the time who rectified the issue immediately, and ensured all staff were aware of the correct procedure.

Medical notes contained appropriate clinical details and entries were made by the medical teams following ward visits. There was evidence of referrals to other members of the multidisciplinary team (MDT), for example speech therapists and dieticians. Members of the MDT documented information in the electronic system and patients’ medical notes to ensure that information was shared appropriately.

Documentation was comprehensively reviewed and monitored by senior staff. Ward matrons undertook a qualitative recordkeeping audit each month, these audits were completed to ensure good record keeping, was followed and was compliant with the trusts standards. Action plans were done following the audits to ensure all standards were achieved.

Medicines

The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.

On our previous inspection in January 2017, we saw that medication was not being managed safely at Danetre Hospital and Corby Community Hospital. However, on this inspection the administration of medicines was appropriately recorded on drug charts. Action plans had been implemented to ensure medications and medicine charts were completed accurately and any inconsistencies were reported on and investigated.

Staff managed medicines consistently and safely. We found all treatment rooms were secured and had a key code entry system. All cupboards and fridges containing medicines were locked within

treatment rooms. We saw that controlled drugs were stored in separate locked cupboards with restricted access to the keys.

At Corby Community hospital there were no omissions in the administration records since February 2018. Danetre Hospital had improved from 8.9% of patients missing one or more doses in April 2018 to 5.74% in May 2018. The target is 5% and 0% for critical medicines. During this inspection saw one occasion where a gap for the administration of a critical medicine (anticoagulant) had not been reported and investigated as per policy.

When drugs were being administered we saw the use of the red tabard system which advised staff and members of the public not to disturb the nurse who was administering the medication. This is a recognised national approach to improve the effectiveness of a drug round and reduced incidence of medication errors.

Liquid medicines were given to patients in green medicine cups. This alerted patients and staff that a medication was present. This also ensured that housekeeping staff did not remove them before the patient had finished.

Emergency medicines were readily available, were stored securely and checked regularly. On Hazelwood ward we found that the contents of the hypoglycaemic box (medicines used to treat low blood glucose) were out of date. However, these were replaced immediately when brought to the attention of ward staff.

When transdermal (skin medication) patches were used there was no mechanism available for the recording of the site of application. This ensures that the medicine patch is rotated as recommended by the manufacturer to reduce any skin allergy reaction. However, staff at Danetre had devised their own method of recording to allow patients to have their patches rotated appropriately daily.

Medicines were easily obtained out of hours should they be required and if necessary prescriptions for community pharmacists (FP10s) were used to obtain supplies. The tracking of FP10s had been identified by the trust already as a risk and steps were being taken to reduce the risks if prescriptions went missing. Some wards had already started to put a revised tracking system in place.

Patient’s allergies were generally recorded on their prescription charts. During our inspection at Danetre hospital we found three cases where it hadn’t been completed and one of these patients had been prescribed penicillin. Their allergy status was confirmed immediately.

Pharmacy staff regularly visited the wards and provided a clinical pharmacy service, they checked prescriptions were correct, conducted audits and advised staff on the safe use of medicines. There was no input to the discharge letters from NHFT pharmacy staff when patients were discharged from the service.

The community hospitals had a service level agreement with an outsourced pharmacy company to provide medicines supplies to the hospitals within the trust.

Safety performance

The service used safety-monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.

The senior hospital staff explained the actions they took to minimise the risk of avoidable harm. They monitored the use of and completion of risk assessments and fluid charts. This data was not displayed publicly but was available for the nursing staff electronically.

Ward staff also discussed issues relating to patient harm reviews during the safety huddles, they raised them with staff directly.

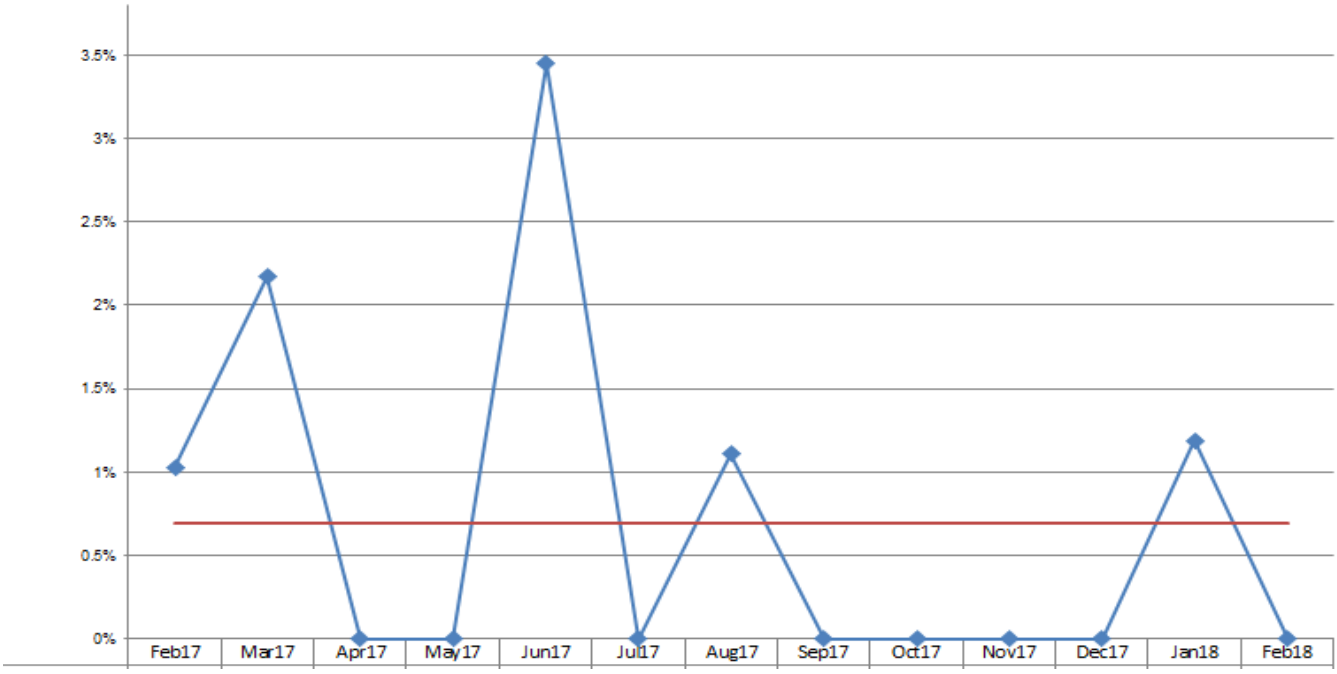
Safety Thermometer (February 2017 to February 2018)

The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm free' during their working day. For example, at shift handover or during ward rounds. This is not limited to hospital; patients can experience harm at any point in a care pathway and the NHS Safety Thermometer helps teams in a wide range of settings, from acute wards to a patient's own home, to measure, assess, learn and improve the safety of the care they provide. Safety Thermometer data should also not be used for attribution of causation as the tool is patient focussed.

Caveat: The information provided below is pertaining to community inpatient services only.

New Pressure Ulcers

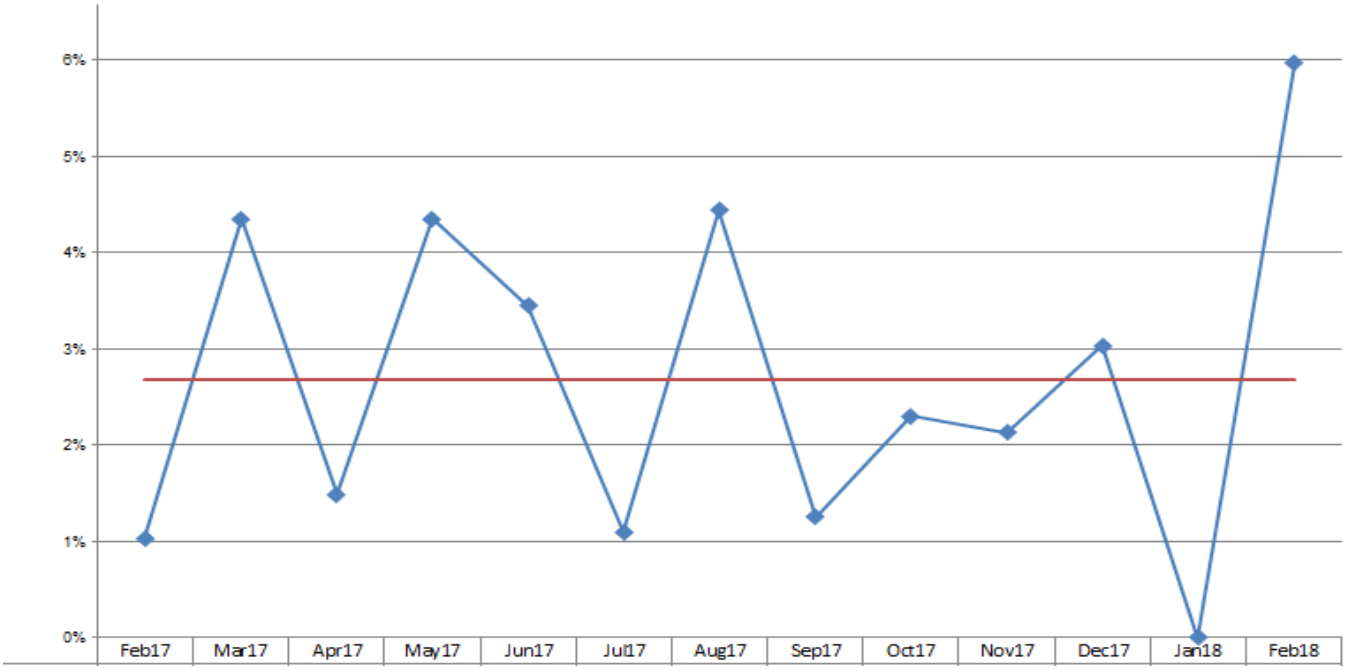
The trust reported seven new pressure ulcers between February 2017 and February 2018.



	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
Prevalence %	1.03	2.17	0	0	3.45	0	1.11	0	0	0	0	1.19	0
No	1	2	0	0	2	0	1	0	0	0	0	1	0

Catheter & UTI

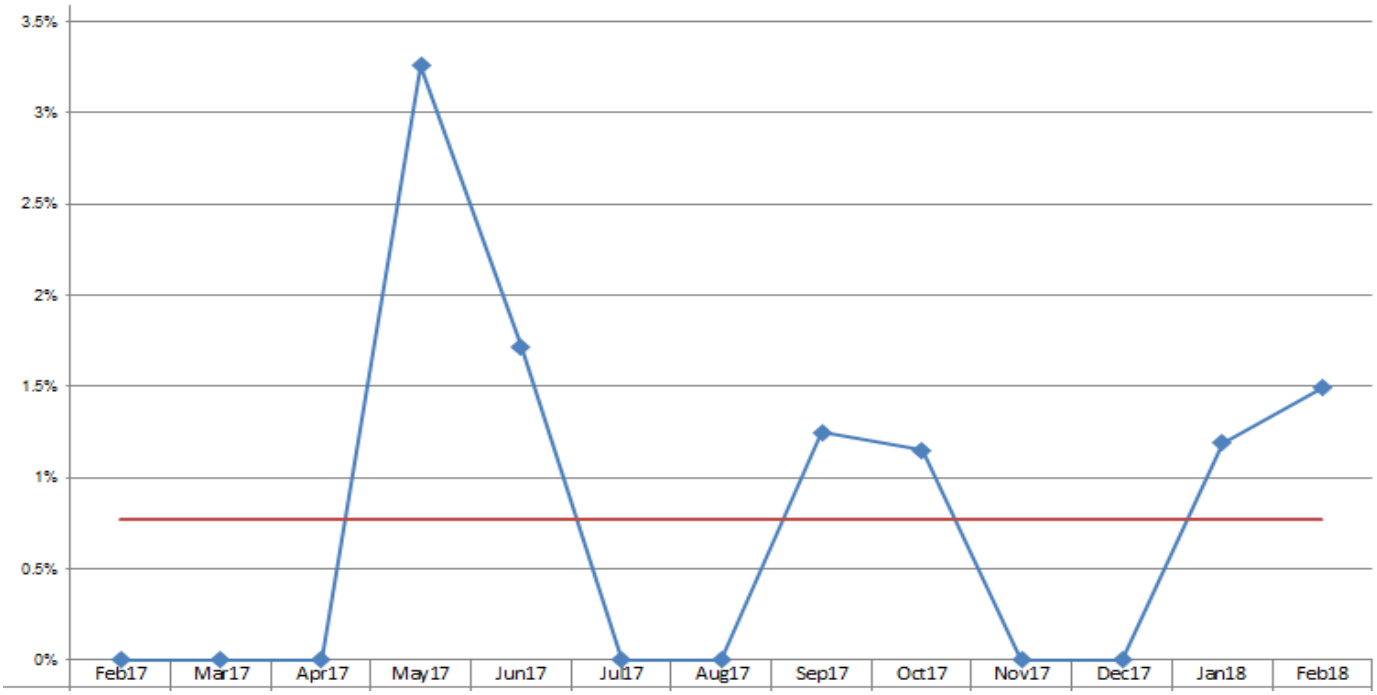
The trust reported 28 catheter & UTI between February 2017 and February 2018.



	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
Prevalence %	1.03	4.35	1.49	4.35	3.45	1.10	4.44	1.25	2.30	2.13	3.03	0	5.97
No	1	4	1	4	2	1	4	1	2	2	2	0	4

Falls with Harm

The trust reported eight falls with harm between February 2017 and February 2018.



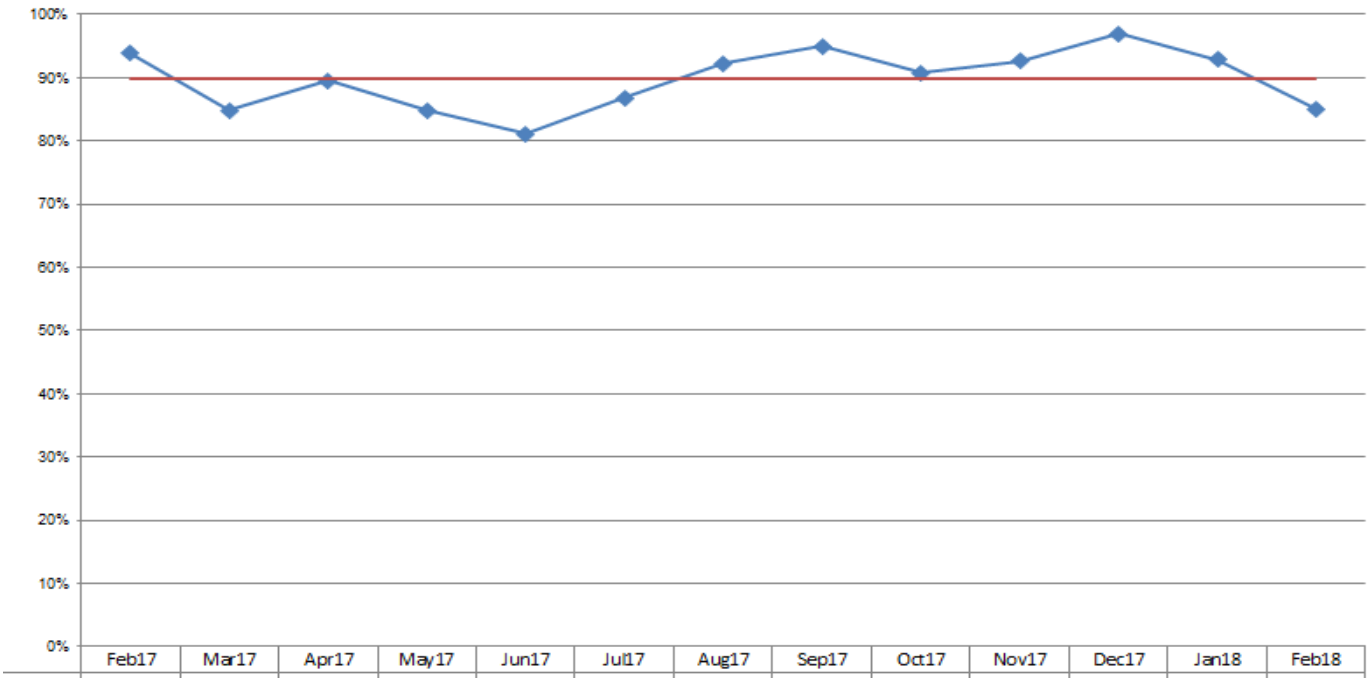
	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
Prevalence %	0	0	0	3.26	1.72	0	0	1.25	1.15	0	0	1.19	1.49

No	0	0	0	3	1	0	0	1	1	0	0	1	1

Harm Free Care

The trust reported 957 cases of harm free care between February 2017 and February 2018,

Across the period, community inpatients reported the most number of harm free care instances in February 2017 with 91. However, December 2017 had the highest prevalence rate with 96.97% (64).



	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
Prevalence %	93.81	84.78	89.55	84.78	81.03	86.81	92.22	95.00	90.80	92.55	96.97	92.86	85.07
No	91	78	60	78	47	79	83	76	79	87	64	78	57

Incident reporting, learning and improvement

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

Staff understood their responsibilities regarding reporting incidents. The trust used an electronic reporting system on which all staff had been trained to use.

Managers investigated incidents and shared learning with the whole team and the wider service. Examples of incidents that were reported included medication errors, pressure ulcer incidents and falls. Teams and the organisation learnt from incidents and there was evidence of clear action planning following reviews.

The community hospitals had learning lessons noticeboards, bulletins and the ‘staffroom’ (information on learning) which is a section on the intranet where incidents are shared. The lessons learnt information showed incidents that had happened, outcomes and hints to prevent it reoccurring. For example, a lesson learnt from an incomplete nursing registration form.

Incidents were addressed at a weekly internal assurance meeting and a monthly trust wide learning lessons exchange meeting. These meetings identified any issues or themes arising from reported incidents. Learning from incidents was shared with staff during monthly team meetings and learning development sessions.

Staff we spoke with understood their responsibilities regarding duty of candour. Matrons explained that if any incident caused harm to a patient that a formal letter was issued by an appropriate member of staff and the incident was discussed with the patient and family. The patient received a follow up letter after with the incident report and conclusions at the end of the investigation.

Serious Incidents - STEIS

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include 'never events' (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in community inpatient services, which met the reporting criteria, set by NHS England between, January 2017 and December 2017. Of these, the most common type of incident reported was slips/trips/falls meeting SI criteria.

Incident Type	Number of Incidents
Slips/trips/falls meeting SI criteria	1
Core Service Total	**1**

Serious Incidents (SIRI) – Trust data

Between 1 January 2017 and 31 December 2017, trust staff in this core service reported one serious incident.

Of these, none involved the unexpected death of a patient.

The most common types of serious incidents were 'slips/trips/falls meeting SI criteria' with one.

The number of the most severe incidents recorded by the trust incident reporting system is comparable with that reported to Strategic Executive Information System (STEIS). This gives us more confidence in the validity of the data.

Incident Type	Number of Incidents
Slips/trips/falls meeting SI criteria	1
Core Service Total	**1**

Prevention of Future Death Reports

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no prevention of future death reports sent to Northamptonshire Healthcare NHS Foundation Trust.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Policies were up to date and followed guidance from the National Institute for Health and Care Excellence (NICE) and other professional associations. Local policies, such as the infection control policy were written in line with national guidelines. Policies were available on the trust intranet and clinical staff we spoke with knew how to access them.

Relevant NICE guidelines, quality standards and other good-practice guidance, for example prevention and management of pressure ulcers and stroke rehabilitation were used. This provided patients with long-term conditions a clear personalised care pathway and aimed to improve the rehabilitation for people who have had a stroke.

Patients were assessed using recognised risk assessment tools. For example, the risk of developing pressure damage was assessed using the Waterlow Score, a nationally recognised practice tool. Staff undertook falls risk assessments and completed post-fall check lists following patient falls.

The community hospitals had implemented the safer bundle NHS improvement approach which was introduced following our previous inspection. The safer bundle approach uses five elements of best practice to improve systems of patient outcomes and discharge transfers.

The five elements of the SAFER patient flow bundle are:

S – Senior review.

A – All patients will have an expected discharge date and clinical criteria for discharge.

F – Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards.

E – Early discharge.

R – Review.

The therapy team also measured patient care through evidence based practice by using the Rivermead mobility index and the Barthel scoring system. The Rivermead Mobility Index is an audit that aims to evaluate the effectiveness of physiotherapy on mobility following a stroke. While the Barthel index is used to measure achievements in activities of daily living (ADL) such as eating, bathing and dressing. We saw these patient assessments in use within the records we reviewed.

There was a Black Minority Ethic BME development network. The trust had developed this network to provide an autonomous and effective voice for BME patients, staff, service users, carers and community. Staff we spoke with said they had not used the system however they knew where to access the network.

Nutrition and hydration (only include if specific evidence)

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other preferences**.**

Nutrition and hydration assessments were completed on all appropriate patients in the care records reviewed. Nursing teams used MUST assessments. Patients were screened on admission

for malnourishment and the dietician assessed all patients whose nutritional needs were highlighted. Patients were weighed on admission and weekly thereafter to ensure nutritional needs were met.

Food and fluids were within patients' reach and patients who required assistance with eating and drinking were identified in the initial care assessment. Fluid balance charts were completed only for patients whose hydration was an identified issue. Patient hydration was monitored during the hourly care rounds and recorded in the patient records. We looked at food and fluid records and found these were complete, accurate and current.

Protected meal times took place on all the wards we visited. This allowed patients to eat without being interrupted and meant staff were available to offer assistance where required. Patients told us that the food was of good quality and that they had plenty to eat and drink throughout the day.

Staff had access to advice from dietitians and speech and language therapists (SALT). Dieticians and SALTs visited the hospital on request and were available to give telephone advice.

The trust had an ongoing food strategy which reviewed menus with dietician involvement and considered ward patient profiles.

Pain relief

Patients' pain was assessed and managed appropriately.

Patients told us that their pain was adequately controlled. They told us that pain relief was offered and given immediately it was requested. Pain scores were recorded using a numeric rating scale on the NEWS record sheet. We saw this was being used correctly.

The Abbey pain scale is an assessment for pain in patients who cannot verbalise how they are feeling, for example, patients who have dementia or communication difficulties, Staff we spoke with were aware of this pain assessment.

Patients were offered pain control before therapy sessions. This provided patients with pain relief in order to complete their rehabilitation sessions. This meant that they continued their therapy and increased their long-term mobility.

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

Monthly data was collected via audits for record keeping compliance, falls, pressure ulcers, discharge procedure data and length of stay data. This data was disseminated in the monthly clinical dashboards and was monitored by the appropriate service leads. Senior staff told us the dashboard data was used to identify trends and improve the service by altering polices or working practices.

Information about the outcomes of patient's care and treatment, both physical and mental where appropriate, were routinely collected and monitored. This was done through local audits and national audits. For example, the national audit of inpatient falls and the management of patients following a fractured hip (HIP sprint) audits.

The community inpatient services had recently participated in the Sentinel Stroke National Audit Programme (SNAP). This was to improve the community hospitals outcome performance in line with national standards of patients undergoing rehabilitation programmes. The trust were awaiting the data from the royal college of physician's audit programme.

Audits – changes to working practices

The trust have participated in 10 clinical audits in relation to this core service as part of their Clinical Audit Programme.

Audit name / title	Audit scope	Type of audit	Date completed	Key concerns	Key actions following the audit
Quarterly Audit of MUST	All Inpatient Services within the Trust participate in the audit	Clinical	Quarterly	MUST was introduced via the QS to ensure that people's nutrional needs were being monitored and acted upon. J6	*After discussion with the Palliative Care Team, the audit tool was adapted to bring it in line with Trust policy. The results from Quarter 3 2017/18 highlight that where it was deemed clinically inappropriate to conduct a MUST assessment, the reason for this was recorded in 100% of the records audited Initially the audit was undertaken by the Quality team. This led to a disconnect between audit results and actions on the wards. Later, this was shared with key clinicians in areas and since then the MUST totals have improved as a result of ownership and greater understanding of MUST. All staff were offered MUST training to better understand the underlying key themes of malnutrition and the impact this can have on MH.
Quarterly Audit of NEWS	All Inpatient Services within the Trust participate in the audit	Clinical	Quarterly	NEWS was introduced to the Trust to ensure that peoples observations could not only be monitored, but acted upon if there was an alert. There had been a disconnect previously, whereby Observations were not routinely done, thereby, leaving a risk that a symptom may be missed.	*Weekly audit outcomes to continue to be monitored by the Executive Team and Quality Forum with issues escalated to the Forum *For areas of non-compliance ward managers to discuss results with the staff responsible for completing the audit to ensure factual accuracy in reporting training on NEWS was delivered to all MH staff face to face and further on-line learning would be completed if required.
Quarterly Record Keeping Audit	All clinical services both community and inpatient participate in the audit	Clinical	Quarterly	the Record keeping audit was produced to ensure that Records were kept within the agreed policy and that all staff were aware of the importance of good record keeping.	All areas have specific designed questions for their areas.
Quarterly Photographic ID Audit	All Inpatient Services within the Trust participate in the audit	Clinical	Quarterly	The Photo ID audit was introduced to ensure that all staff were complaint with Trust policy and to minimise risks of medication errors.	since commencement of this audit, areas that were non-concordant have placed action plans on the units to ensure this protocol is followed and show improvement.

Audit name / title	Audit scope	Type of audit	Date completed	Key concerns	Key actions following the audit
National Audit of Inpatient Falls – Community Hospitals round 2:	All Community Inpatient Units	Clinical	01/06/2017	*The Trust has no specific MDT working group specifically for falls *The Trust does not have an executive director who has a specific falls prevention role *Walking aids for newly admitted patients are not available 7 days a week *Not all patients were asked about their falls history and no patients were asked about their fear of falling *Few patients had a vision assessment *Few patients had been given written falls prevention advice, despite this being widely available	*Updated qualitative record keeping audit to cover post falls protocol adherence and bed rails assessment *Poster campaign and individual training for falls champions about lying and standing blood pressure *Updated falls prevention in hospital leaflets circulated and training given *Documentation changes to ask further questions about fear of falling and detailed falls history on admission *Community beds pharmacist addressing medication issues around falls *Falls lead and counterparts across the county developing a visual assessment tool for staff and associated training *The re-implementation of low level equipment assessor training for therapy assistants
HIP Sprint Audit	All Community Inpatient Units	Clinical	Ongoing	National Picture: *43% missed a day's therapy as no physio was available *10% of community physios had no handover from the hospital team *patients waited an average of 15 days to start therapy at home	*National Report published 9th February 2018 - awaiting Trust level data
Is MUST be implemented correctly at Hazelwood ward?	Community Inpatient Unit - Hazelwood	Clinical	30/09/2017	*Areas for improved practice include ensuring comprehensive completion of food record charts, correct use of oral nutritional supplements only when indicated by a Dietitian and continuing to ensure weekly MUST assessments are completed for all patient	• When completing food record charts ensure that the amounts of each meal eaten by the patient are recorded. This particularly applies to evening meals for patients on food record charts throughout the ward. • Oral nutritional supplements should only be given under the direction of a Dietitian when indicated by ACBS criteria. • Ensure weekly MUST scores are recorded on a Saturday, even with patients whose MUST have been completed mid-week on admission to prevent time periods of over one week between MUST assessments.
In-Patient Hypoglycaemia Management Audit	All Community Inpatient Units	Clinical	Ongoing		

Audit name / title	Audit scope	Type of audit	Date completed	Key concerns	Key actions following the audit
Audit of Medicine Reconciliation Record Forms at St Mary's and Berrywood Adult Mental Health Inpatient Wards, Palliative Care Inpatient Wards and the Community Hospital Inpatient Wards	All Community Inpatient Units	Clinical	Ongoing		
Audit of compliance with the Policy for Primary Thromboprophylaxis at St Mary's and Berrywood Adult Mental Health Inpatient Wards and the Community Hospital Inpatient Wards	All Community Inpatient Units	Clinical	Ongoing		

Competent staff

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Role specific training requirements were allocated to staff for example, band five nurses were expected to complete medicine management training and diabetes awareness.

Managers had oversite of the staff training compliance. The community hospitals also provided a list of competencies that were non-compulsory. Staff we spoke with said they had completed the extra training sessions to provide evidence of ongoing professional development. For example, continence and promotion assessment and domestic abuse

Senior nursing staff we spoke with had attended a leadership management programme. This course had helped them to develop leadership skills and necessary tasks needed to manage a community inpatient ward. This included sessions such as difficult conversations with staff, return to work interviews and appraisal training.

Therapy staff we spoke with said that the trust supported them in the learning beyond registration programme. This programme is a scheme funded by Health Education East Midlands to provide additional professional training for qualified health professionals. It features a range of educational activities that encourages further post registration qualifications. A physiotherapist at Danetre hospital was in the process of completing a Masters in stroke patient rehabilitation.

The trust's appraisal policy stated that all staff were required to have an annual appraisal. Staff we spoke with told us it was a useful process for identifying any training and development needs. Between March 2107 and March 2018, 92% of permanent community inpatient nurses had received an appraisal which was greater than the trust target of 90%.

Clinical supervision was available for nursing staff. Clinical supervision is an activity that brings skilled supervisors and practitioners together to reflect upon their practice. All staff within the trust were expected to have a minimum of two supervision sessions per quarter. Staff within the community inpatient wards achieved 93% compliance.

All staff had been assigned dementia and delirium training. Delirium is a confused state in patients which presents as restlessness, illusions, and incoherence, occurring in intoxication and fever. The aim of the training was to provide emotional support and practical assistance to vulnerable patients with dementia and delirium and to identify the risk factors for delirium patients. Danetre hospital, Corby Community hospital and Hazelwood Ward (Isebrook Hospital) and Beechwood ward (Isebrook Hospital) compliance for the dementia and delirium training was 93%, 100%,98% and 97% respectively.

Clinical Supervision

The trust's measure of clinical supervision data is 90% (sessions delivered, hours of supervision delivered etc.) From 1 January 2017 to 31 December 2017, the average clinical supervision rate for the core service was 93% against the trust's target of 90%.

Team	Clinical Supervision Target	Clinical Supervision Delivered	Clinical supervision rate (%)
Beechwood Ward	90%	70	83%
Corby Community Beds	90%	102	86%
Danetre Community Beds	90%	153	97%
Isebrook Community Beds	90%	59	108%
Core Service Total	**90%**	**384**	**93%**

Appraisals for permanent non-medical staff

As of May 2018, 96% of permanent non-medical staff within the community inpatient services core service had received an appraisal compared to the trust target of 90%.

Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
175	168	96%

Appraisals for permanent medical staff

As of May 2018, 100% of permanent medical staff within the community inpatient services core service at the trust had received an appraisal compared to the trust target of 90%.

Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
2	2	100%

Multidisciplinary working and coordinated care pathways

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Relevant professionals were involved in the assessment, planning and delivery of patient care. We observed good working relationships between a range of health professionals both within the trust, and from external agencies.

We observed good working relationships between staffing groups and comprehensive multidisciplinary team (MDT) working practices. We observed a close working relationship between the allied health and nursing leads. The staff included nursing staff, rehabilitation assistants, occupational therapists, physiotherapists, matrons and area leads. Updates regarding specific patients were shared, specific patient care needs were discussed and any relevant incident learning during ward handovers.

A formal MDT meeting occurred weekly where all the therapy staff from each hospital were present. All relevant staff attended including occupational therapists, medical staff, care managers and bed management coordinators. Junior therapists and bank staff were encouraged to attend the meeting and present their views on patient care needs and potential improvements to working practices. There was a strong emphasis on maintenance at home and admission avoidance strategies. Documented discussions were held around patient's care needs.

Staff on the inpatient wards had a close working relationship with care managers, that were employed by the local county council. This allowed a more robust and effective planning of discharge systems.

Health promotion

Staff reviewed patient needs in a holistic manner. Patient care goals and post discharge care was discussed with the patient and their family. Staff assessed all new patients individually and identified if any additional support would be required. Staff we spoke with highlighted their close MDT working as different professions would communicate regularly, discuss relevant issues and discuss management of monitoring and treatment.

We saw a wide range of health promotion material available to patients during our inspection. There were posters displayed outside wards with contact details for dementia services. The wards provided a range of health information leaflets for patients and relatives, including dementia information, pressure ulcers and falls prevention whilst in.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Staff understood the trust's process for completing the necessary guidance. Staff demonstrated an understanding of fluctuating capacity and ensuring patients were in the best environment to enable them to make informed decisions about their care. We were shown the trusts MCA and DoLS policy, which discussed how and where to record assessments of capacity and making best interest decisions. For example, therapists explained that they would apply for a DoLS if there was a confused patient and needed a falls alarm or other falls prevention equipment.

Deprivation of Liberty Safeguards

Northamptonshire Healthcare NHS Foundation Trust told us that 66 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority between 1 January 2017 and 31 December 2017. Of which, three were pertinent to community inpatient services.

CQC received 54 direct notifications from Northamptonshire Healthcare NHS Foundation Trust between (1 January 2017 and 31 December 2017).

	Number of DoLS applications made by month												
	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Total
Applications made	0	0	0	0	0	0	0	3	0	0	0	0	**3**
Applications approved	0	0	0	0	0	0	0	0	0	0	0	0	**0**

Is the service caring?

Compassionate care

Staff continually cared for patients with compassion. Feedback from all patients confirmed that staff treated them well and with kindness.

Staff interacted with patients and relatives in a respectful and considerate manner. They respected patients' privacy and dignity. Staff knocked on doors before entering rooms and ensured care and treatment was provided behind curtains or closed doors. We observed all staff speaking with patients in a kind compassionate and sensitive way in a variety of situations.

We spoke with 12 patients and six relatives across all community inpatient sites. Patients and relatives, we spoke with told us staff were kind and caring and they received "good care".

Patients said that:

- staff go out of their way to help if they can
- Care is excellent, all the nurses look after me well
- The staff have been very helpful and the doctors listen, they are all very good
- Care is first-rate, nurses, cleaners and kitchen staff have all been brilliant".

We saw many positive examples of nursing staff and patient interaction; for example; staff showed good awareness of the local area. We saw staff talking to patients about living locally and appeared to understand village life.

Patients and relatives constantly praised the staff who supported them and said they were exceptionally kind and caring. Patients felt listened to and involved in all aspects of their care. Staff had a detailed knowledge of patients' needs and preferences and treated them with dignity and respect. For example, Staff were aware that a patient had nutritional and cultural nutritional needs, these were addressed and accommodated.

We observed many examples of allied health professional staff and patient interaction such as physiotherapy staff actively engaging patients to achieve their personal goals. We observed a patient who was having difficulty standing from a chair, being given compassionate guidance from the physiotherapist resulting in the patient standing safely. We also saw a patient who had had a stroke receive physiotherapy, the patient received lots of encouragement which made the patient feel they were improving.

PLACE - data in relation to privacy, dignity and wellbeing

These self-assessments are undertaken by teams of NHS and private/independent health care providers, and include at least 50 per cent members of the public (known as patient assessors). They focus on the environment in which care is provided, as well as supporting non-clinical services such as cleanliness, food, hydration, the extent to which the provision of care with privacy and dignity is supported and whether the premises are equipped to meet the needs of people with dementia against a specified range of criteria.

Analysis:

The 2017 PLACE score for privacy, dignity and wellbeing at Northamptonshire Healthcare NHS Foundation Trust is 93.1%. The trust scored higher than the England average overall.

Site Name	Core Service(s) provided	Privacy, Dignity and Wellbeing
Isebrook Hospital	CHS – Community Inpatients CHS – Community Dental	91.3%
Danetre Hospital	CHS – Community Inpatients CHS – Community Dental	95.2%

Site Name	Core Service(s) provided	Privacy, Dignity and Wellbeing
Corby community Hospital	CHS- Community Inpatients	83.9%
Trust Overall		**93.1%**
England Average		**83.7%**

Emotional support

Staff provided emotional support to patients to minimise their distress.

We observed that staff constantly provided emotional support to patients when they displayed anxiety during their rehabilitation activities. Therapy staff actively provided emotional support to patients in order to help them achieve their individual care goals. We saw therapists talking with patients before their therapy sessions, asking them how they were feeling and if they needed any pain management.

Staff always empowered patients within the inpatient wards at the community hospitals and actively listened to their wishes. Peoples individual preferences and needs were reflected in how the care was delivered. During our inspection we saw therapists discussing exercise regimes with the patient, the patient requested that shorter sessions divided over the day would be better for her, as she became tired during long sessions. This was adapted and the patient's wishes were accommodated.

The trust had been recognised by the John's campaign service. John's campaign acknowledged the trust was committed to working in partnership and encouraged carers to attend admission assessments to promote early and productive communications. The services had carers' rooms where carers could take a 'time out'. There was overnight accommodation available at all services. All carers were welcome to visit any time.

There were arrangements that supported the emotional and spiritual needs of patients. Patients and their relatives had access to religious services. Patients from other faiths were also accommodated. For example, we saw quiet rooms were available at Danetre hospital, this was to support patients' individual needs when required.

Counselling services within the community hospitals were available by a referral system. The senior management told us they were in the process of applying for funding to employ a psychologist. NICE clinical guidance (CG 162) suggests that a stepped approach to psychological care is recommended for rehabilitation patients. This meant that extra provision would be given towards emotional support and the management of depression.

Understanding and involvement of patients and those close to them

Staff always recognised when patients and those close to them need additional support.

Staff consistently communicated with people so that they understood their care, treatment and condition. We saw staff explaining a treatment process to a patient. Staff recognised when people who used services needed additional support to help them understand and be involved in their care and treatment and enable them to access this. We observed staff speaking to patients so they understood their relevant treatment options.

The inpatient ward teams ensured that all patients and relatives felt they could contribute to individualised care pathways. This encouraged patients and relatives to understand and manage the care requirements needed to maintain independence. We saw staff reassuring and supporting

patients and their families to promote patient's individuality. For example, the ward matron on Beechwood ward, sat down and spoke with a patient and their family, regarding the necessary requirements that would be needed to discharge the patient home safely.

We observed staff continuously engaging with people respectfully and effectively by kneeling, maintaining eye contact and using the appropriate use of touch. It was obvious the management team and staff valued people and treated them as their own family members. They consistently spoke in soft tones and frequently held patient's hands. We saw staff displaying deep empathy, clearly understanding each person's feelings without demeaning them.

Patient feedback notice boards were present on the inpatient wards. On Beechwood ward we saw a notice board, patients wrote on stickers expressing how they felt following there discharge and how they were progressing. Each patient attended a follow up session after they had been discharged. We saw one note that celebrated the reduced use of a wheelchair and how the whole team had helped them reach this goal.

Is the service responsive?

Planning and delivering services which meet people's needs

The trust planned and provided services in a way that met the needs of local people.

All the community inpatient wards had information boards. The information boards displayed guidance on visiting times, mealtimes, telephone numbers and displayed pictures of staff uniforms so patients and relatives knew healthcare professionals' nursing grades. All staff wore name badges to help visitors and patients clearly identify who they were talking with.

Adjustments were made for patients living with a physical disability, which included wheelchair access, lifts, patient moving, handling equipment and facilities for bathing.

The wards had long periods of time, most of the day, when they were open to visitors. The wards protected mealtimes to ensure patients could eat their meals without interruption. Family members were encouraged to attend at lunchtime if the patient required assistance with eating so that they could provide support.

The service understood the different requirements of the local people it served by ensuring that it actioned them through the planning, design and delivery of services. Services were planned in a way which ensured flexibility and choice. For example, a patient requested to be cared for at Corby Community hospital as relatives lived nearby, rather than be transferred out of the area, this request had been accommodated.

The community inpatient wards all had fundraising schemes to improve the services provided. For example, Beechwood ward were in the process of fundraising to improve the patients outside areas.

Beechwood ward had self-contained flats for patients following neurological conditions. This helps to support patient's recovery and their long-term outcome in returning to the community. Patients and staff felt this provided a structured approach when planning discharge pathways.

Mixed sex breaches

Mixed Sex Breaches are defined by CQC as a breach of same sex accommodation, as defined by the NHS Confederation definition. Also included is the need to provide gender sensitive care,

which promotes privacy and dignity, applicable to all ages, and therefore includes children's and adolescent units. This means that boys and girls should not share bedrooms or bed bays and that toilets and washing facilities should be same-sex. An exception to this might be in the event of a family admission on a children's unit, in which case brothers and sisters may, if appropriate, share bedrooms, bathrooms or shower and toilets.

Community inpatient services reported no mixed sex breaches during the 12-month period from 1 February 2017 and 31 January 2018

Meeting the needs of people in vulnerable circumstances

The service took account of patients' individual needs. Patients were assessed on admission to identify any additional support needs.

The community inpatients service had recently launched the Butterfly scheme. The Butterfly Scheme provides a system of hospital care for people living with dementia. Hospital staff are given training to use appropriate skills recognised within the butterfly scheme to enable appropriate care to patients with dementia or other memory impairment.

Patients within the ward areas had focus signs placed by their bed space. This ensured that staff working within the area were aware of possible risks associated with the patient's specific care. For example, falls awareness, dementia care and skin frailty.

Psychiatric support was available for patients through the psychiatric liaison team. Psychological support following a stroke is recognised to assist peoples cognitive and mood disorders.

Patients had access to therapy rooms and gym areas. Therapy sessions included physical exercise, relaxation therapy, breakfast clubs and craft sessions. This provided holistic care to patients helping them achieve maximum independence in daily living activities and improving their wellbeing.

Within the community inpatient areas there was access to translation services and hearing loops (induction loop used by people with hearing aids). This ensured that communication with patients and relatives was facilitated. Translation and interpretation services were available through the trust which was supplied by an external company.

The community hospitals also provided facilities to reduce the effects of hospitalisation over a long period of time. Patients who have been hospitalised over a long period need to create structure to their days to reduce feelings of self-worth and loneliness. Each community inpatient ward had a day room where patients could mix with each other, a hairdresser and volunteers helped with craft sessions which therefore increased social interaction.

Access to the right care at the right time

People could access the service when they needed it. Arrangements to admit, treat and discharge patients were in line with good practice.

Admissions and discharges of patients were planned by patient flow coordinators and a ward coordinator, who was based at Danetre community hospital. Admissions and discharges are arranged in conjunction with the main hospital trust and local General Practitioners. The community hospitals have a specific referral and admission protocol.

Referral and Admission Protocol:

Step Down is when a patient is medically stable prior to being transferred and has clear pathways regarding individualised patient care.

Step up (specific for Danetre Community Hospital) is when patients require some medical intervention in a non-acute hospital setting

Records were updated daily to provide effective discharge planning. The electronic record system had a discharge planning tab which was updated by discharge coordinators and the MDT teams. On admission targets for discharge planning were allocated: patients admitted for rehabilitation were targeted for a four-week discharge date from admission whilst patients were allocated a six-week post admission discharge date.

Corby community hospital had a care manager on site to facilitate complex discharges. The care manager was employed by Northamptonshire county council. When patients were ready for discharge, the care managers arranged family meetings to discuss care placements, financial support and any mental health arrangements.

The community hospitals used a patient discharge needs assessment(PDNA) form. The PDNA form allows the staff referring the patient to complete all the necessary information to ensure the patient obtains their necessary treatment and care. The form includes information such as, referring organisation, patient daily requirements, current NEWS score and mental state.

The acute hospital trusts within the area, transferred patients to the community hospital for rehabilitation. The community hospitals had received 19 inappropriate transfers from the main trusts over the past year. Most inappropriate transfers were due to elevated NEWS caused by a sepsis. Investigations were completed in the inappropriate transfers of patients. These included enhanced documentation such as current blood results and pre- transfer NEWS scores. This meant that any elevations and discrepancies could be flagged up before transferring the patient to the community wards.

Accessibility

The largest ethnic minority group within the trust catchment area is White British with 85.7% of the population.

	Ethnic minority group	Percentage of catchment population (if known)
First largest	White British	85.7
Second largest	White Other	4.7
Third largest	Asian/Asian British	3.7
Fourth largest	Black African/Caribbean/Black British	2.4

Waiting times

The trust has provided some narrative for inpatient waiting times, however very little pertains to community inpatient services.

Bed occupancy

The trust provided information regarding average bed occupancies between 1 February 2017 and 31 January 2018.

Danetre Ward reported bed occupancies at above the nationally recommended minimum threshold of 85% over this period.

Team	Average bed (Range)
Beechwood	78.9% - 98.8%
Corby Community	69.8% - 98.2%
Danetre	90.9% - 98.8%
Hazelwood	77.7% - 99.3%

Average length of stay data

The trust provided information for average length of stay for the period 1 February 2017 to 31 January 2018.

The information for this core service suggests that all wards in the core service presented a broadly similar length of stay for this period.

Team	Average length of stay (Range)
Beechwood	31 – 73
Corby Community	28 – 60
Danetre	22 – 45
Hazelwood	41 – 78

Referrals

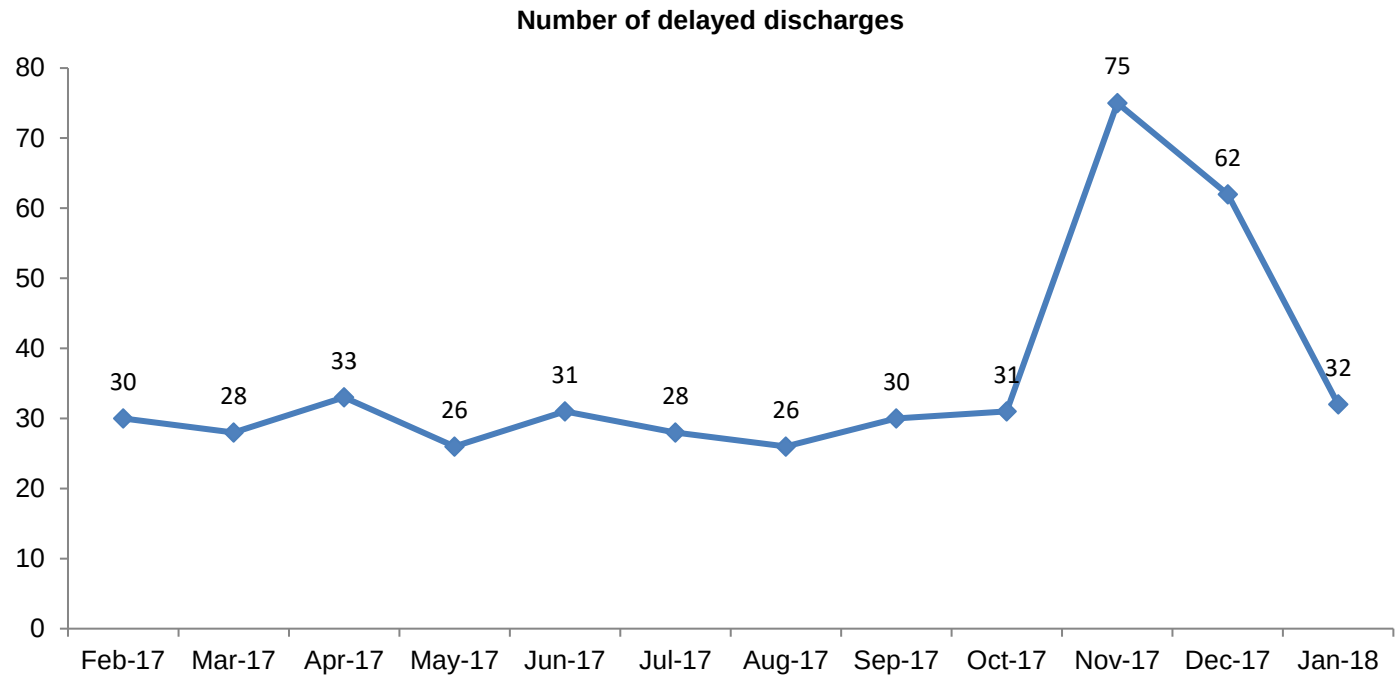
The trust has identified services as measured on ‘referral to initial assessment’ and ‘assessment to treatment’. However, there was no data pertaining to community inpatient services.

Delayed discharges

Between 1 February 2017 and 31 January 2018, there were 427 delayed discharges within this core service. This amounts to 51% of the total discharges (831)

Total Discharges	Total Delayed Discharged	% Delayed Discharges
831	427	**51%**

The graph below shows the trend of delayed discharges across the 12-month period. The graph shows a spike in November 2017 and December 2017 for the core service.



Within the community hospitals patients experiencing delayed discharges were discussed at a weekly 'internal tracking' meeting. The senior staff felt that the main cause of delayed discharge was due to the problems in obtaining appropriate accommodation relating to specific patient needs. As a result, these patients stayed in hospital longer than intended. The senior staff were working with the main trust and the local County Council to improve patient flow.

Northamptonshire age UK supplied a hospital discharge and community team. This provided short term support to patients requiring help from long term illnesses. This was a countywide service available for all community inpatients.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Patients knew how to make a complaint or raise a concern, and were encouraged to do so. Information about the complaint process was clearly displayed within the hospital. Staff we spoke with could describe the complaints process and explain how they would advise patients to raise a complaint.

Nursing staff understood the process for receiving, handling and responding to concerns and complaints. Staff reported complaints as an incident on the trust's electronic incident reporting system.

Patients we spoke with knew how to raise concerns and make formal complaints. Posters detailing how to make a complaint were displayed on the wards and information was provided in leaflets for inpatients. Patients told us the nursing staff were approachable and if they wished to raise a concern they would do this by speaking with the nurses who were caring for them at that time.

The hospital had a patient advice and liaison service (PALS) and complaints team. A making things better leaflet was produced to ensure patients and relatives were aware of how to raise good care, ideas to improve the service and any concerns.

All feedback received was reviewed. Each ward had a learning poster to display their 'you said – we did' actions. The ward managers updated the 'you said – we did' action posters each month.

Complaints

Community inpatient services received six complaints between 1 January 2017 and 31 December 2018. The main complaints themes were in relation to all aspects of clinical treatment.

Total Complaints	Fully upheld	Partially upheld	Not upheld	Withdrawn	Referred to Ombudsman	Upheld by Ombudsman
6	0	2	2	2	0	0

Compliments

The trust received 1,291 compliments during the last 12 months from 1 January 2017 and 31 December 2017. Of these, 199 related to community inpatient services, which accounted for 15% of all compliments received by the trust as a whole.

The community inpatients wards received compliment cards and thank you letters form patients and relatives.

Is the service well-led?

Leadership

The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

The management group for the community inpatients consisted of a senior matron, service manager and a clinical practice and service development manager. The management team participated in the services on call management rota. Each ward had a ward matron who specifically addressed issues relating to their own clinical area.

Ward matrons told us their senior matron and management team were supportive. The senior matron divided her time between all the community hospitals. Ward matrons said they could contact the senior matron at any time if necessary.

Nursing staff reported that there was strong local leadership on the wards and that the senior matron and ward matrons were both visible and supportive. Nursing staff told us that they felt supported by the local management team.

The senior matron reported to the deputy director of nursing from the foundation trust. The senior matron told us that they were very supportive and she felt able to express any concerns. A meeting was held with the deputy director of nursing every six weeks to discuss issues such as patient flow, communication with the acute trusts and learning from incidents.

Ward matrons and ward sisters attended leadership training. The trust ran a leadership matters development programme which cover aspects such as staff engagement and the values and behaviours expected on leaders within the trust. Monthly operational meetings were held for the ward matrons and wards sisters within the community inpatient wards to ensure they felt supported and up to date with any new processes.

There was clear guidance for leaders. Leadership behaviours within the trust were recognised as: being authentic, working together, taking responsibility and embracing change. Nurses and therapy staff felt that the senior matron and ward matrons achieved these standards well.

Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The community hospitals did not have local strategy's, the NHFT vision and strategies were embedded well within the community hospitals.

The trusts vision was 'to be a leading provider of outstanding, compassionate care.' This vision was part of the mission road map. The NHFT road map showed a pathway of directed statements aimed to provide a clear statement of working for both patients and staff.

The trust followed the PRIDE values of working to encompass the trusts vision. Pride values were:

• People first, working together for patients in everything we do.

• Respect, dignity and compassion by valuing each person as an individual.

• Improving lives by improving health, wellbeing and people's experience of the NHS.

• Dedication to quality of care and getting the basics right.

• Everyone and equality counts, using resources wisely for the whole service.

Staff employed within the trust knew and understood the trust values. The staff had been given laminated fobs with the PRIDE values including the roadmap pathway for the trust. Staff felt this was a good idea as they could relate well to the roadmap system.

The trust worked with their staff and other service users to develop the trusts strategy. The strategy used the acronym DIGBQ these are**:**

•Develop in partnership.

•Innovate.

•Grow our staff capability.

•Build a sustainable organisation.

•Quality and safety at the foundation of all we do.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

There was a culture of group working within the inpatient community hospitals. Staff we spoke with felt that they were listened to by the senior management teams and could openly raise concerns.

Across all areas staff said they were committed and passionate about the care they provided to patients. They reported feeling proud to work within the community hospitals and were positive about the job they did. Staff we spoke with said they felt respected and valued by senior management and the ward matrons and each other.

The trust had developed a 'living our pride values' booklet. The booklet discusses how important it is for staff to respect each other and uses the example of bullying and harassment in the work place. The staff within the community inpatient wards were aware of the freedom to speak up guardian and would speak up if they felt they needed to. All the staff we spoke with did not express or know of any concerns relating to the booklet.

The trust provided a 'staff room' page on the intranet. The 'staff room' page connected colleagues together so they could discuss innovations, learning and read policy updates. There was also a workplace wellbeing charter for staff that offered access and advice to services. Such as counselling, sleep and stress webinars, immunisations and staff physio amenities.

The community inpatient wards had team engagement days. The team engagement days allowed staff to reflect upon their roles and the service needs. Staff felt this was a good idea as they could liaise with other staff from the community hospital wards.

Governance

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

There were effective processes and systems of accountability. Staff were clear about their roles and what they were accountable for. Hospital senior management, ward matrons, and nursing staff across all inpatient services demonstrated awareness of the trusts governance arrangements. They described the actions taken to monitor patient safety and risk. This included a quality dashboard, incident reporting and the undertaking of audits.

Performance monitoring was done via a quality dashboard using information gathered by ward matrons on the safe delivery of care. The quality dashboard results were shared at team meetings and at governance meetings to ensure local actions were undertaken.

Governance arrangements to monitor quality, performance and safety were in place and provided assurance to the trust board. The senior community matron attended a safety wide meeting with the deputy director of nursing and all the other service leads from the trust. Outcomes from this meeting were cascaded to the ward matrons and sisters at monthly operational meetings within the community hospitals.

Arrangements with partners and third-party providers were governed and managed. Local general practitioners attended quarterly governance meetings at Danetre hospital. During these meetings quality indicators were discussed including effective discharge processes.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The community hospital inpatient wards had individual risk registers. Risks identified within each of the community inpatient wards were logged on the trusts divisional risk register. The risk register was reviewed regularly and contained description of the risk, ratings and controls in place, gaps in control, assurances and action plan. Managers and senior staff were aware of the risks in their individual service areas.

Potential risks due to seasonal fluctuations in demand or the impact of adverse weather were considered when planning the service. Annual leave requests during high demand times such as school holidays and national holidays were carefully reviewed and discussed with the senior matron; this helped ensure adequate staffing levels could be maintained.

There clear lines of accountability including clear responsibility for cascading information to the senior management team, nursing staff and MDT teams. During our inspection we saw evidence in meeting minutes that quality and risk information was reviewed and actioned.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The service participated in local and national audits this provided a systematic approach to processing information. The actions required from the completed audits were presented at the

trust improvement meetings. Staff we aware of the audits undertaken at a ward level and national level.

The service used an electronic patient record system which was accessible to all staff. Staff used the system effectively to monitor and improve the quality of care to patients. All staff we spoke with during the inspection said that the new system was of benefit to patients and staff.

The trust has a robust information governance policy. Information governance manages and controls information through the trusts policy's and protocols. The community hospitals ensured that confidentiality, privacy, and security of patients and staffs personal information had robust safety measures in place. When there had been information governance breaches within the trust, actions and lessons learnt were discussed at governance meetings. There had been no breaches in information within the community hospitals over the past year.

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The staff within the trust were given a staff hand book. In the staff handbook it discussed the trust's vison 'to be the leading provider of quality integrated care for health and wellbeing services'. The booklet explained the importance of ensuring that staff felt engaged and valued. The handbook expressed the need to achieve quality services throughout the trust by integrated learning from all areas in the trust.

Patient and relatives' views concerning the community inpatient wards were actively encouraged by the staff. Ward staff worked closely with relatives and patients to improve the services provided. The staff and relatives on Beechwood ward were in the process of fundraising for a new piece of garden equipment that had been suggested by patients and relatives.

Patients and other service users were involved in the improvement of the services based at the trust. The trust encourages patients, relatives and local organisations to be involved through a variety of ways, these include:

•Patient and involvement stories

•Membership of working groups

•Staff recruitment and selection

•PLACE inspections

•Staff training

•Quality focus groups

•Becoming a member of NHFT

•Bespoke project groups

•Volunteering.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

During our previous inspections staff had said there was a lack of innovation. At this inspection we saw that staff had improved their services through government innovations and locally suggested

ideas. For example: the butterfly scheme had increased staff awareness of how to provide help for dementia patients.

Danetre hospital had recently received accreditation to the gold standard service framework. Gold standards framework provides a clear standardised training to all staff providing end of life care. The ward matron felt that having a standardised tool to work towards improved staffs understanding of the outcomes required in becoming accredited.

There was learning from internal incidents and reviews within the community hospital wards. A recent serious incident prompted all of the nursing and MDT team rethink their falls prevention processes. As a result of the learning outcomes the community inpatient team were in the process of adapting there hourly intentional rounding observations.

Staff within the community inpatient wards felt they had learning from incidents, accreditations and audits that were undertaken within the trust. All staff we spoke with felt the trust and senior management team at the community hospitals supported their ideas and promoted further training. The senior management team felt that the NHFT leaders supported them and provided all the necessary assistance when implementing new service changes.

Accreditations

NHS Trusts were able to participate in a number of accreditation schemes whereby the services they provided were reviewed and a decision was made whether or not to award the service with an accreditation. A service would be accredited if they were able to demonstrate that they met a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The trust provided information relating to ‘accreditations’ however, none were pertinent to community inpatient services.

Mental health services

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

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Berrywood Hospital	Adult Inpatients - Marina ICU	7	Male
Berrywood Hospital	Adult Inpatients Acute - Bay Ward	17	Female
Berrywood Hospital	Adult Inpatients Acute - Cove Ward	17	Male
Berrywood Hospital	Adult Inpatients Acute - Harbour Ward	12	Mixed
St Mary's Hospital	Adult Inpatients - Shearwater ICU	7	Female

St Mary's Hospital	Adult Inpatients Acute - Avocet Ward	15	Male
St Mary's Hospital	Adult Inpatients Acute - Kingfisher Ward	10	Mixed
St Mary's Hospital	Adult Inpatients Acute - Sandpiper Ward	15	Female

Is the service safe?

Safe and clean environment

Nursing staff undertook daily visual risk assessments of the wards. This entailed staff walking around each ward, checking fire exits, any potential hazards, and the general condition of the ward areas. Staff reported any concerns to the ward manager.

Over the 12 month period from 1 February 2017 to 31 January 2018 there were no mixed sex accommodation breaches within this core service. During inspection however, there was one mixed sex accommodation breach on Harbour ward. The trust had reported via their internal incident reporting system, and had notified the Care Quality Commission. A female had been admitted into a male bed. However, the bedroom was at the end of the corridor close to communal areas, and had an en-suite toilet and shower. The staff had additional safeguarding measures in place through use of observations. This was being used as a short-term measure.

Both psychiatric intensive care wards at Berrywood hospital and St Mary's hospital were single sex. Four of the acute wards across the service were also single sex; Avocet, sandpiper, Bay and Cove wards. The service had two mixed sex wards, which were Kingfisher and Harbour wards. Both wards had separate male and female areas which complied with the Department of Health guidance on eliminating mixed sex accommodation. Each bedroom had en-suite facilities, and both wards had a separate female lounge.

There were blind spots on each of the wards, where staff could not always easily observe patients. However, the ligature risk assessments demonstrated how staff managed this and reduced risk. Each ward office held a map, which identified the most significant risk areas on the ward, which was colour coded. This gave all staff a straight forward reference point.

There were ligature risks on eight wards within this core service. The trust had undertaken recent (from 10 September 2017 onwards) ligature risk assessments at two locations. No wards had not had a ligature risk assessment in the last 12 months.

All eight of the wards presented a high level of ligature risk due to bedroom doors and windows in unsupervised areas, observational blind spots in areas such as the dining room, bedroom corridor, activity room, interview room, bedrooms, patio and single gender lounge.

The trust had taken actions to procure new bedroom anti ligature fittings for doors and windows, patients to be individually risk assessed for identification of potential self-harm behaviours, application of observation policy, zonal nursing, daily security checks, monthly health and safety checks, co-produced care planning, local induction for bank and agency staff, ward induction for substantive staff, review of ligature risk assessments at least twice yearly, handovers each shift, environmental risk assessments and immediate reporting of any damaged/compromised areas to GFM in order to mitigate ligature risks.

All staff had access to alarms across the service so that assistance could be sought from additional staff if necessary. Additional alarms could be provided for visitors. Patients did not have call bells in bedrooms, however there was always staff present in communal areas, and an allocated staff member undertook routine observations. Therefore, patients could summon help if needed.

Maintenance, cleanliness and infection control

All wards appeared clean, had appropriate furnishings and were well maintained. We saw a dedicated team of staff cleaning the wards throughout the inspection. Cleaners worked flexibly over the seven day period and worked to a schedule to ensure all ward areas were cleaned. Patients were encouraged to keep their bedrooms clean and tidy.

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. Protective clothing such as aprons and gloves were available. Staff had adequate hand washing facilities and hand gel on each ward. The service completed infection control audits and any associated actions were completed.

For the most recent Patient-led assessments of the care environment (PLACE) assessment (2017) the locations scored higher than the similar trusts for all four aspects overall.

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
Berrywood Hospital	MH - Acute wards for adults of working age and psychiatric intensive care units MH - Child and adolescent mental health wards MH - Forensic inpatient MH - Long stay/rehabilitation mental health wards for working age adults MH - Mental health crisis services and health-based places of safety MH - Wards for older people with mental health problems	100%	98.3%	96.6%	93.3%
St Mary's Hospital	MH - Acute wards for adults of working age and psychiatric intensive care units MH - Mental health crisis services and	100%	98.9%	99.3%	97.5%

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
	health-based places of safety MH - Wards for older people with mental health problems				
Trust overall		99.9%	98.2%	96.6%	95.2%
England average (Mental health and learning disabilities)		98%	95.2%	84.8%	86.3%

Seclusion room

The service had four seclusion rooms in total across the two sites. Two were located at Berrywood hospital (Marina ward, and Bay and Cove ward shared a second). Two further seclusion rooms were located on Shearwater and Kingfisher wards. All seclusion rooms were compliant with the Mental Health Code of Practice, in terms of having clear observation; two-way communication, had toilet facilities and a clock. However, we observed that on the day of our visit, the two-way communication on Marina ward was not working. The trust fixed this on the day it was highlighted. On Shearwater ward, we observed a broken tap in the bathroom. The trust assured us that this had been scheduled to be fixed. There was also some sharp metal edging on the en-suite doorframe. However, the Trust dealt with this immediately.

Staff confirmed that Avocet ward accessed the seclusion room on Kingfisher, if a patient required seclusion. Patients requiring this would have to be moved from the first, to the ground floor. However, we were told that this rarely occurred, and when it did, it was well planned with additional staff support.

As Cove and Bay wards shared a seclusion room, we were concerned this could compromise the safety and dignity of a patient being taken into seclusion, due to walking past communal areas and through corridors. Ward managers confirmed that arrangements were risk assessed, and additional staff would be provided to ensure this was completed safely, with minimal compromising of patient dignity.

Clinic room and equipment

Clinic rooms were fully equipped with accessible resuscitation equipment. Emergency medicines were readily available apart from naloxone (required for the emergency treatment of opioid overdose). However, before the inspection had completed we received assurance that it had been made available across every ward. Nursing staff checked medical equipment and emergency medicines regularly. Staff maintained equipment well and replaced as required.

Safe staffing

Nursing staff

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			Trust target
Total number of substantive staff	31 January 2018	213.35	N/A
Total number of substantive staff leavers	1 February – 31 January 2018	16.47	N/A
Average WTE* leavers over 12 months (%)	1 February 2017 – 31 January 2018	8%	8-12%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	31 January 2018	38.5	N/A
Total vacancies overall (%)	31 January 2018	15%	10%
Total permanent staff sickness overall (%)	Most recent month (31 January 2018)	6%	4.2%
	1 February 2017 – 31 January 2018	6%	4.2%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	31 January 2018	102.58	N/A
Establishment levels nursing assistants (WTE*)	31 January 2018	111.21	N/A
Number of vacancies, qualified nurses (WTE*)	31 January 2018	23.1	N/A
Number of WTE vacancies nursing assistants	31 January 2018	11.94	N/A
Qualified nurse vacancy rate	31 January 2018	23%	10%
Nursing assistant vacancy rate	31 January 2018	11%	10%
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 February 2017 – 31 January 2018	2330	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 February 2017 – 31 January 2018	1218	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 February 2017 – 31 January 2018	326	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 February 2017 – 31 January 2018	4244	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 February 2017 – 31 January 2018	135	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 February 2017 – 31 January 2018	495	N/A

*Whole-time Equivalent

This core service reported an overall vacancy rate of 23% for registered nurses at 31 January 2018.

This core service reported an overall vacancy rate of 11% for registered nursing assistants.

This core service has reported a vacancy rate for all staff of 15% as of 31 January 2018.

During inspection, we were told that staff recruitment had been an ongoing priority. Some vacancies had been recruited into, and staff had start dates. We were told that each ward had the following vacancies outstanding: Harbour ward – one qualified nurse and one part- time nursing assistant; Avocet – awaiting four qualified nurses to commence; Kingfisher ward – two qualified

nurse vacancies, and were awaiting one to commence, and one nursing assistant post; Cove ward reported three qualified vacancies and one-part time nursing assistant. Marina had two qualified nurse vacancies; and Bay ward had four qualified vacant posts.

	Registered nurses			Health care assistants			Overall staff figures		
Ward/Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Sandpiper Treatment Ward	3.7	13.3	28%	2.3	11.5	20%	6	24.8	24%
AMH Inpatients - Psychosis	-	-	-	1	1	100%	1	4.3	23%
Avocet Treatment Ward	5.5	13.3	42%	-0.3	10.5	-2%	5.3	23.8	22%
Kingfisher Assessment Ward	2	8	26%	2.7	13.3	20%	4.8	21..4	22%
Bay Admissions (Female)	2.5	13.3	19%	2.3	10.5	22%	4.7	24.7	19%
Cove Admissions (Male)	3.3	13.3	25%	1.3	10.5	12%	4.6	25.7	18%
Welland Centre	0	4	0%	2.3	9	26%	2.3	14	17%
Harbour Acute	1.1	8	13%	1.7	13.3	13%	2.8	21.4	13%
Shearwater PICU	3	11.6	27%	-2.5	14.5	-17%	3.4	29.9	11%
Marina ICU	1.6	10.5	15%	1.2	13.3	9%	2.6	25.6	10%
AMH Nurse Management Acute Care	0.2	7	3%	-0.2	3.8	-5%	0	10.8	0%
Core service total	23.15	102.58	23%	11.94	111.21	11%	38.5	252.85	15%
Trust total	141.2	1260.38	11%	123.67	990.5	12%	279	2560.1	11%

NB: All figures displayed are whole-time equivalents

Between 1 February 2017 and 31 January 2018, bank staff filled 2330 shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 1218 shifts for qualified nurses and 326 shifts were unable to be filled by either bank or agency staff.

Ward/Team	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Adult Inpatients - Marina ICU	262	104	21
Adult Inpatients - Shearwater ICU	103	153	3
Adult Inpatients Acute - Avocet Ward	276	276	46
Adult Inpatients Acute - Bay Ward	355	129	31
Adult Inpatients Acute - Cove Ward	474	118	81
Adult Inpatients Acute - Harbour Ward	266	107	58
Adult Inpatients Acute - Kingfisher Ward	178	95	38
Adult Inpatients Acute - Sandpiper Ward	416	236	48
Core service total	2330	1218	326
Trust Total	14171	10118	1440

Between 1 February 2017 and 31 January 2018, 4244 shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same time period, agency staff covered 135 shifts and 495 shifts were unable to be filled by either bank or agency staff.

Ward/Team	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Adult Inpatients - Marina ICU	589	26	46
Adult Inpatients - Shearwater ICU	88	13	1
Adult Inpatients Acute - Avocet Ward	398	13	64
Adult Inpatients Acute - Bay Ward	586	27	56
Adult Inpatients Acute - Cove Ward	680	6	65
Adult Inpatients Acute - Harbour Ward	829	7	95
Adult Inpatients Acute - Kingfisher Ward	592	36	107
Adult Inpatients Acute - Sandpiper Ward	482	7	61

Ward/Team	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Core service total	4244	135	495
Trust Total	16465	1034	1456

Managers had calculated the number and grade of nurses and nursing assistants required per ward. We examined staffing rotas and found that the number of nurses and nursing assistants matched this number on most of the shifts.

Each ward manager adjusted staffing levels daily as required, to meet patient needs. When necessary, bank and agency staff were sought to maintain safe staffing levels. Staff could be deployed from other acute wards within the service on occasions to cover safe staffing numbers at short notice. The service used bank staff where possible, and agency staff who were familiar with the service. Bank and agency staff who were unfamiliar with the service received a ward induction.

Both Berrywood hospital and St Mary's had a Section 136 suite. Staff from different wards would be allocated to care for patients admitted. However, additional staff were provided to meet this need, and so this did not impact upon staffing of the wards.

We observed staff in communal areas of the wards at all times during inspection. Staff and patients confirmed that staffing levels enabled one to one time to be facilitated with their named nurse.

Staff shortages rarely resulted in staff cancelling escorted leave. If this occurred, staff re-arranged at the earliest opportunity. Activities were available throughout the seven-day period, facilitated by both occupational therapy and nursing staff.

The service had enough staff to carry out physical interventions, such as restraint, or seclusion safely. Each ward had a designated "responder", who attended wards when the alarm sounded to offer support. Staff received training before they used any physical interventions, and were updated regularly.

This core service had 16.5 (8%) staff leavers between 1 February 2017 and 31 January 2018.

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Bay Admissions (Female)	21	4	19%
Cove Admissions (Male)	21.2	2.7	13%
Sandpiper Treatment Ward	17.8	2	12%
Kingfisher Assessment Ward	18.7	1.8	10%
Welland Centre	10.6	1	10%
Marina ICU	23	2	9%
Mental Health in-patient OT/Physio Service	24.3	2	8%

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Harbour Acute	18.6	1	5%
MH Inpatients – Psychosis	3.3	0	0%
AMH Nurse Management Acute Care	10.8	0	0%
Avocet Treatment Ward	18.5	0	0%
Shearwater PICU	25.5	0	0%
Welland Centre In-Patients	2	0	0%
Core service total	213.3	16.5	8%
Trust Total	3011.4	288.2	9%

The sickness rate for this core service was 6% between 1 February 2017 and 31 January 2018. The most recent month's data [31 January 2018] showed a sickness rate of 6%.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Avocet Treatment Ward	11%	8%
Bay Admissions (Female)	5%	8%
Harbour Acute	8%	8%
Kingfisher Assessment Ward	9%	6%
Welland Centre	12%	6%
Cove Admissions (Male)	2%	5%
Sandpiper Treatment Ward	9%	5%
Shearwater PICU	9%	5%
Marina ICU	0%	4%
AMH Nurse Management Acute Care	2%	3%
AMH Inpatients – Psychosis	1%	1%
Core service total	6%	6%
Trust Total	6%	5%

The below table covers staff fill rates for registered nurses and care staff during October, November and December 2017.

Avocet Ward was above the planned fill rate for care staff for day shifts for all months reported.

Bay Ward was above the planned fill rate for care staff for day and night shifts in December 2017.

Sandpiper Ward was above the planned fill rate for care staff for night shifts in October and December 2017.

Shearwater Ward was above the planned fill rate for care staff for night shift in November and December 2017 and also for day shifts in October and December 2017.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses %	Care staff %	Nurses %	Care staff %	Nurses %	Care staff %	Nurses %	Care staff %	Nurses %	Care staff %	Nurses %	Care staff %
	October 2017				November 2017				December 2017			
Kingfisher	105.5	101.8	98.0	105.5	103.0	103.6	112.2	105.4	97.9	110.4	106.8	106.2
Avocet	91.2	140.7	98.9	121.3	98.1	147.0	99.0	150.3	98.2	158.8	95.4	157.8
Sandpiper	99.2	142.6	98.4	137.3	102.3	118.3	100.5	120.3	101.5	122.1	99.5	130.3
Harbour	101.1	97.2	100.1	96.9	101.0	96.8	100.3	105.2	97.0	112.6	101.1	134.8
Cove	92.0	129.8	101.3	110.0	96.6	110.7	100.4	98.5	95.0	93.2	98.9	101.4
Bay	96.8	105.1	101.7	101.6	95.9	109.2	101.9	105.2	93.4	167.8	99.3	147.1
Marina PICU	97.4	113.8	98.4	132.7	98.7	118.0	98.3	129.6	102.1	130.8	99.5	117.0
Shearwater	92.4	172.6	102.1	114.9	110.3	117.3	100.0	136.1	107.2	162.3	99.4	132.3

Medical staff

All wards had access to medical staff when required.

There was adequate medical cover throughout the day, and an on-call rota in place throughout the night. Doctors could usually attend the ward quickly in the event of an emergency.

Between 1 February 2017 and 31 January 2018, 1% of shifts were filled by bank staff to cover sickness, absence or vacancy for medical locums.

In the same time period, agency staff covered 16% of shifts. 0% of shifts were unable to be filled by either bank or agency staff.

The trust was unable to break this information down by ward and team.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff

Core service total	3600	29 (1%)	567 (16%)	0 (0%)
Trust Total	26472	173 (1%)	3508 (13%)	0 (0%)

***** Percentage of total shifts

Mandatory training

The compliance for mandatory and statutory training courses at 31 January 2018 was 54%. Of the training courses listed all failed to achieve the trust target and of those, 20 failed to score above 75%.

However, the trust had been changed the way their recorded their compliance with mandatory training and data provided in January was not an accurate reflection of staff compliance. As of 31 May, the overall compliance with mandatory training for this core service was 92%. The only one training which achieved less than the trust target of 90% compliance, was intermediate life support, which was reported to be at 59%.

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	This core service %	Trust target %	Trust wide mandatory/ statutory training total %
Falls Prevention Training - Level 2	85%	90%	93%
Infection Prevention (Level 2)	79%	90%	74%
Mental Health Act	78%	90%	72%
Mental Capacity Act DoLS	75%	90%	43%
Fire Safety	74%	90%	72%
Information Governance	71%	90%	67%
Resuscitation Level 3 - Immediate Life Support	70%	90%	62%
Resuscitation Level 2 - Adult & Paediatric	63%	90%	62%
Falls Prevention Training - Level 1	59%	90%	81%
Duty of Candour	55%	90%	54%
Moving and Handling	50%	90%	29%
Staff and Pt. Safety (Quality & Safety)	48%	90%	39%
Safeguarding Adults (Level 2)	47%	90%	41%
Safeguarding Children (Level 2)	47%	90%	32%
Raising concerns and whistleblowing	37%	90%	24%
Venous Thromboembolisn	35%	90%	31%
Making Every Contact Count	34%	90%	26%
Learning Disability Awareness	32%	90%	31%
Conflict Resolution	20%	90%	39%
Resuscitation Level 1	19%	90%	16%
Equality and Diversity	18%	90%	23%
Health, Safety and Welfare	18%	90%	19%
Safeguarding Prevent Health WRAP	17%	90%	32%
Core Service Total %	54%	90%	47%

Assessing and managing risk to patients and staff

Assessment of patient risk

We examined 35 care records. Staff completed a risk assessment of every patient upon admission to the wards. These included the patients historical and current risks. Nursing staff updated these regularly, including following incidents. The trust used their own risk assessment tool.

Management of patient risk

Staff were aware of any specific physical risk issues for individual patients and managed these effectively. For example, at Berrywood hospital, we saw that one patient was at risk of developing pressure sores. Staff had completed a relevant risk assessment and had put measures in place to minimise the risk. A further example seen, was in relation to a patient who had epilepsy and had experienced seizures. Staff had implemented a care plan specifically around this, which was reflected in the risk assessment.

We observed that one patient at St Mary's hospital had expressed their intention to self-harm around a particular date. The staff had recorded this in the care records. The patient went out and engaged in self-harm, as previously voiced. The nursing staff on duty had not put any safety measures or support in place to minimise the risk of this happening.

The trust had a policy in place for the use of observations which staff were aware of, and adhered too. We examined a sample of observation documentation, and found that staff undertaking patient observations completed documentation as expected, and in a timely way.

The searching of patients and property was undertaken by staff in line with the trust policy. Staff undertook searches of patients based upon individual risk assessments.

The acute wards at Berrywood hospital took part in a pilot scheme, using body cameras across five acute wards. The pilot commenced in December 2016, and the aim was to examine the feasibility of using these cameras in a mental health setting. The response team wore the cameras and only turned them on during incidents of aggression. Staff explained that data collected showed that there was some decrease in violence on aggression. Staff told us that patients generally had been positive about this.

Staff had actively looked to reduce any blanket restrictions upon patient's freedom. Any restrictions were justified, incorporated into care plans, and based upon risk. Staff discussed any restrictions with the patients, and imposed these for the shortest time possible.

The trust adhered to best practice in having a smoke free policy. Nicotine replacement therapy was offered where applicable. The staff and patients reported some difficulties around not all patients' being able to go outside to have a cigarette. However, patients could use e-cigarettes and vapes in outside areas.

Staff regularly explained to informal patients their rights, which included being able to leave the ward. Every informal patient on every acute ward had to complete a "self-assessment form" prior to being able to leave the ward. The nurse in charge then reviewed this, and either agreed that the patient could go out; or expressed any concerns in relation to this. The patients could indicate if they felt low in mood, for example, within the form, which would generate a discussion with the nurse. If a nurse felt that it was unsafe for the patient to go out on unescorted leave; several staff and patients told us that they would talk to them and advise that they go out escorted with a staff member. If the patient still wanted to go out unescorted, the nurse would call the doctor. As a last resort, senior staff told us that the Mental Health Act would be applied, which would legally enable staff preventing the patient from leaving the ward, pending further assessment. We found that between 31 December 2017 and 31 May 2018, the nurses used these powers (Section 5 (4) on 26

occasions across the wards. During that same time frame, doctors had applied their powers (Section 5 (2) on 53 occasions. Of these, a total of 29 had been converted to either a Section 2, or a Section 3 following further assessment. This equated to 36% of patients.

Nursing and medical staff had applied these holding powers to eight patients, on more than one occasion, during a single admission episode. Of these, four were later placed on a Section 2 or a Section 3, and four patients remained informal.

Use of restrictive interventions

This core service had 512 incidents of restraint (on 127 different service users) and 206 incidents of seclusion between 1 February 2017 and 31 January 2018.

Over the 12 months, there was an increase in the incidence of both restraint and seclusion in December 2017.

The below table focuses on the last 12 months' worth of data: 1 February 2017 and 31 January 2018.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Avocet	21	20	13	3 (15%)	0 (0%)
Bay	0	69	27	40 (58%)	14 (20%)
Cove	11	32	21	16 (50%)	1 (3%)
Harbour	11	32	15	21 (66%)	2 (6%)
Kingfisher	135	18	12	5 (28%)	0 (0%)
Marina	1	179	13	125 (70%)	27 (15%)
Sandpiper	27	43	17	9 (21%)	2 (5%)
Shearwater	0	119	9	69 (58%)	24 (20%)
Core service total	206	512	127	288 (56%)	70 (14%)

There were 288 incidents of prone restraint which accounted for 56% of the restraint incidents.

We were concerned about restrictive practices across the acute pathway. The trust reported an increase in the use physical interventions (restraint) including prone restraint and seclusion, since the last inspection. However, the trust had a new psychiatric intensive care unit, not inspected previously, which accounted for much of this increase. Senior managers and staff reported that prone restraint was predominantly used to administer medication, and to exit seclusion safely. Data provided from February 2017 to January 2018 showed, across all acute wards and psychiatric intensive care units, there were 288 incidents of prone restraint and 276 incidents of seclusion or administration of rapid tranquilisation, equating to 96%. However, information provided by the trust did not indicate that staff were encouraged to consider alternate sites for administration of rapid tranquilisation. Prone restraint accounted for 56% of all the restraint incidents across this service between February 2017 and January 2018. Further data from the trust showed some decrease in prone restraint between February and June 2018. However, this still equated to 38%. We considered the trust should review its practice around the use of prone restraint, in accordance with the Mental Health Act Code of Practice guidelines.

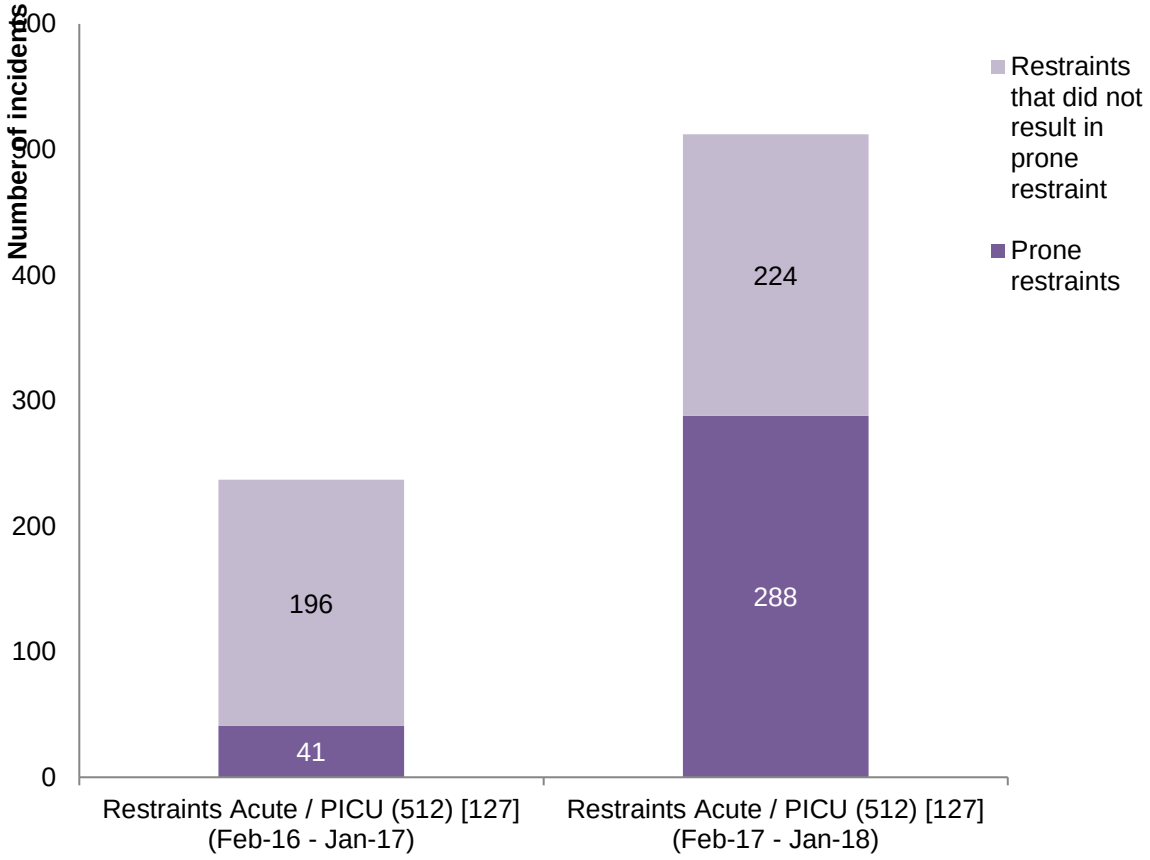
Staff were aware that prone restraint should be avoided where possible. Staff were trained to turn a patient over at the earliest opportunity when prone restraint did occur. Updated data showed us that prone restraint was used more on Avocet, Bay, Marina and Shearwater wards, between December and May 2018. Staff recorded every episode of restraint on an incident form.

Over the 12 months, there were peaks in the use of restraint in November and December 2017, where there were a total of 92 and 100 incidents respectively.

Incidents resulting in rapid tranquilisation for this core services seem to have been increasing, with the highest numbers in October 2017 and December 2017. We reviewed 99 medication charts. Only two patients had received recent rapid tranquilisation recently. Initially, one record of observation monitoring could not be found, but was later located by a nurse. However, a patient on Shearwater ward had no evidence that nurses monitored their physical health following administration of rapid tranquilisation medication.

There have been no instances of mechanical restraint over the reporting period.

Number of incidents of restraint and prone restraint for this core service over the 12 months



Please note the figures in square brackets ,after the total number of restraints, are the number ofdifferent service users restraint was used on during this time period.

Over the 12 months, there was an increase in the use of seclusion in December 2017, where there were a total of 43 instances.

The number of seclusion incidents reported during this inspection was higher than the 92 reported at the time of the last inspection.

We reviewed 46 seclusion records across seven wards; Shearwater; Bay; Cove; Marina; Avocet; Sandpiper and Kingfisher. We found that seclusion documentation was not always fully completed.

Of the 46 records examined, 63% had no indication of what the patient took into the seclusion room. This was significant, as there had been reported incidents in seclusion, where patients had engaged in self-harm, with items they had taken in with them.

Staff were not recording if and when a family member, carer, or advocate had been informed of the use of seclusion. Staff failed to record this in 89% of records seen.

Care plans were not always sufficiently detailed. Of those examined, 47% did not detail how patients' needs were to be met, or how risks would be managed. Furthermore, 78% contained no details with regards to what bedding and clothing was to be provided.

Four hourly medical reviews had missing documentation in 23% of records viewed.

There have been no instances of long term segregation over the 12 month reporting period.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made 43 safeguarding referrals between 1 January 2017 and 31 December 2017, of which 43 concerned adults and zero children.

Referrals		
Adults	Children	Total referrals
43	0	43

There were two peaks identified in adult referrals across the period in March 2017 and July 2017 with seven and eight respectively.

Staff were trained in safeguarding and knew how to make a referral. We saw that nursing staff had raised safeguarding concerns appropriately, and in a timely way. Care plans included protection plans and vulnerabilities where applicable. Staff could give examples of how to protect patients from harassment or discrimination; including protected characteristics under the Equality Act. Staff worked with other agencies where appropriate to keep patients safe. We saw an example of this when staff had made a children's safeguarding referral, due to concerns around their parents who were receiving treatment.

The service followed safe procedures for children visiting patients. Each ward had a designated room off the ward for this purpose. Staff did not permit visitors under 18 years on the wards.

Northamptonshire Healthcare NHS Foundation Trust has submitted details of zero serious case reviews commenced or published in the last 12 months (1 February 2017 to 31 January 2018) that relate to this core service.

Staff access to essential information

The trust used an electronic patient record system. Some documentation was initially hand written, with staff later scanning on to the electronic system. All patient information was accessible to all staff working on the wards, as and when they needed it. This included when patients transferred between wards.

Medicines management

Medicines were stored safely and securely and were only accessible by authorised staff. Controlled drugs were appropriately stored and managed. Refrigerator and room temperatures were monitored and were maintained within the recommended limits. All medications were available, within date, and suitable for use. Following issues at our previous inspection, double checks had been put in place and any gaps in the records were reported and investigated.

We saw that on three wards, Cove, Bay and Kingfisher, that morning medication administration was continuing up until 11:30hrs. The administering nurses were signing that the medications were given at the time prescribed (08:00hrs), and not the actual time the patient received their medication. If a different nurse was administering medications later in the day, there could be the potential of medications prescribed more than once daily, being administered too early without sufficient gap between doses.

Staff reviewed the effects of patients' physical health regularly. We saw that, where required, patients received daily monitoring of blood pressure, pulse, temperature and blood glucose monitoring. Staff monitored physical health in line with the National Institute for Health and Care Excellence guidance in relation to high dose anti-psychotic medications and mood stabilisers. We saw that doctors had entered discussions with female patients about the risks of pregnancy whilst taking certain medications, and potential complications.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 January 2017 and 31 December 2017 there were five STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was apparent/actual/suspected self-inflicted harm with four. Three of the unexpected deaths were instances of apparent / actual / suspected self-inflicted harm meeting SI criteria.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.

Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no 'prevention of future death' reports sent to Northamptonshire Healthcare NHS Foundation Trust.

All staff knew what incidents to report, and how to report them. Staff reported incidents as expected, in line with Trust policy. Staff interviewed spoke about the importance of being open and transparent with patients. Staff had an awareness of the duty of candour. We saw a recent incident had occurred in relation to a medication error. The nurse who made the error spoke at length with the patient, and recorded this as part of a reflective account.

Two relatives we spoke with, told us that their relatives had been involved in incidents, and the staff had not informed them of these. One related to a patient who went missing, and another related to an incident of self-harm. These were different patients, on different wards (Avocet and Shearwater).

Staff received feedback from investigations of incidents, both internal and external to the service. Staff relayed examples of learning, and were aware of when incidents were discussed, and in what forum. The “self-assessment” leave forms, completed by informal patients prior to any leave, alongside the review of the informal patient policy, were examples of learning following a significant incident within this core service last year. Staff gave us examples of changes to practice following incidents specifically in the way patients would be managed, for example ensuring certain patients were never in the same space as each other following aggressive outbursts towards each other.

Systems in place for dissemination of information, included discussions at team meetings / team days; during individual supervision; during reflective practice meetings, through emails and alerts which were sent out centrally to staff, and during multi-disciplinary meetings.

Staff were supportive of one another following incidents. Most staff who had been involved in an incident had received a de-brief and support.

Is the service effective?

Assessment of needs and planning of care

We examined 35 care records. Staff completed a mental health assessment of patients upon, or shortly after admission. This included, where possible an assessment of the patients’ physical health needs. Staff implemented care plans which reflected the patient’s needs following initial assessment. Most care plans were personalised, holistic and recovery orientated. Nursing staff updated care plans when necessary and following multidisciplinary discussions.

We observed that language used by staff in care plans for informal patients, could be misinterpreted as the patient being detained. For example, we saw several references to “Section 17 leave being suspended”; patients were referred to as having “unescorted leave”, and “escorted leave with two staff”. One care plan stated, “unescorted leave but must take medications”.

Best practice in treatment and care

This core service participated in seven clinical audits as part of their clinical audit programme 2017 – 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Quarterly Audit of MUST	All Inpatient Services within the Trust participate in the audit	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	Quarterly	*After discussion with the Palliative Care Team, the audit tool was adapted to bring it in line with Trust policy. The results from Quarter 3 2017/18 highlight that where it was deemed clinically inappropriate to conduct a MUST assessment, the reason

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
					for this was recorded in 100% of the records audited Initially the audit was undertaken by the Quality team. This led to a disconnect between audit results and actions on the wards. Later, this was shared with key clinicians in areas and since then the MUST totals have improved as a result of ownership and greater understanding of MUST. All staff were offered MUST training to better understand the underlying key themes of malnutrition and the impact this can have on MH.
Quarterly Audit of NEWS	All Inpatient Services within the Trust participate in the audit	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	Quarterly	*Weekly audit outcomes to continue to be monitored by the Executive Team and Quality Forum with issues escalated to the Forum *For areas of non-compliance ward managers to discuss results with the staff responsible for completing the audit to ensure factual accuracy in reporting training on NEWS was delivered to all MH staff face to face and further on line learning would be completed if required.
Quarterly Record Keeping Audit	All clinical services both community and inpatient participate in the audit	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	Quarterly	All areas have specific designed questions for their areas.
Quarterly Photographic ID Audit	All Inpatient Services within the Trust participate in the audit	MH - Acute wards for adults of working age and psychiatric	Clinical	Quarterly	Since commencement of this audit, areas that were non- concordant have placed action plans on the units to ensure

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
		intensive care units			this protocol is followed and show improvement.
Re-audit of the quality of medical recommendations and medical scrutiny for detention of Patients under Section two and Section Three of the MHA 1983 (as amended in 2007) in Northamptonshire.	All Adult Mental Health Inpatient Services	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	n/a	n/a
Audit of Medicine Reconciliation Record Forms at St Mary's and Berrywood Adult Mental Health Inpatient Wards, Palliative Care Inpatient Wards and the Community Hospital Inpatient Wards	All Adult Mental Health Inpatient Services	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	Ongoing	n/a
Audit of compliance with the Policy for Primary Thromboprophylaxis at St Mary's and Berrywood Adult Mental Health Inpatient Wards and the Community Hospital Inpatient Wards	All Adult Mental Health Inpatient Services	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	Ongoing	n/a

Staff provided a range of care and treatment interventions which were suitable to the patient group. This included medication, activities, and psychological therapies. Staff provided psychological therapies across all wards. This included one to one assessments to develop psychological formulations, cognitive behavioural therapy, and psycho-educational sessions. These interventions were delivered in line with guidance from the National Institute for Health and Care Excellence.

Patients had access to physical healthcare, including specialists when needed. We saw examples of this, including input from a physiotherapist and appointments with specialist, physical health consultants.

Staff monitored the dietary and fluid intake of patients where it was necessary, due to concerns with physical health, or potential side effects of medications.

Staff encouraged patients to live healthier lives, and placed emphasis upon health education. The service had a range of leaflets around physical health available on each ward. Staff supported patients with smoking cessation. Information was given around healthy eating. Care plans included aspects of physical health, weight and general wellbeing.

Staff completed Health of the Nation Outcome Scales (HONOS) and assigned patients to specific mental health clusters. These are tools used to individualise patient care and record severity and outcomes.

Staff participated in clinical audits, to monitor quality. Examples of these included patient care record audits; physical health monitoring of patients and Mental Health Act documentation audits.

Skilled staff to deliver care

The teams included a range of specialists required to meet the needs of the patients. Teams included doctors; nurses; nursing assistants; occupational therapists; psychologists; social workers; bed managers and discharge facilitators. Other specialists, such as a speech and language therapist or dieticians, could be accessed via a referral.

Staff had various levels of experience and qualifications. Training given supported staff to meet the needs of the patients. Nursing assistants undertook care certificates and national vocational qualifications. These enabled them to develop professionally, with opportunity for promotions. Some nursing assistants were undertaking nurse training while working part time for the trust. Qualified nurses were encouraged to attend additional training and conferences. There were examples of nurses being promoted, over time, to the ward managers positions.

All new staff received an appropriate induction to the service. This consisted of a corporate induction, some mandatory training, and learning about the ward and trust policies and protocols. Staff then spent time orientating themselves to the ward allocated, alongside staff, before working as part of the team.

Staff had the opportunity to reflect and learn from practice; seek out personal and peer support; and discuss issues around work performance. Each ward held regular team meetings, or team days. Most staff received regular one to one supervision. Managers completed annual appraisals with all staff.

Ward managers dealt with poor staff performance promptly. Support from human resources was readily available, via telephone, or face to face.

The trust's target rate for appraisal compliance is 90%. As at 31 December 2017, the overall appraisal rates for non-medical staff within this core service was 93%.

The wards/teams failing to achieve the trust's appraisal target were AMH Inpatients - Psychosis (B275) with an appraisal rate of 60%, Avocet Treatment Ward (B711) with an appraisal rate of 85%, Harbour Acute (B260) with an appraisal rate of 85%, Kingfisher Assessment Ward (B710) with an appraisal rate of 88% and Sandpiper Treatment Ward (B712) with an appraisal rate of 88%.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
AMH Inpatients - Psychosis	5	3	60%
Avocet Treatment Ward	20	17	85%
Harbour Acute	20	17	85%
Kingfisher Assessment Ward	16	14	88%
Sandpiper Treatment Ward	17	15	88%
Welland Centre	11	10	91%
Marina ICU	22	21	95%
Mental Health in-patient OT/Physio Service	25	24	96%
AMH Nurse Management Acute Care	10	10	100%
Bay Admissions (Female)	20	20	100%
Cove Admissions (Male)	21	21	100%
Shearwater PICU	29	29	100%
Core service total	216	201	93%
Trust wide	3236	2934	91%

The trust's target rate for appraisal compliance is 90%. As at 31 December 2017 there is no data reported for permanent medical staff.

The trust's measure of clinical supervision data is sessions delivered, hours of supervision delivered etc.

Between 1 January 2017 and 31 December 2017 the average rate across all 10 teams in this core service was 149% of the trust's target.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Sandpiper Treatment Ward	30	20	67%
Shearwater PICU	48	36	75%
Kingfisher Assessment Ward	32	31	97%
Harbour Acute	48	52	108%
Marina ICU	50	56	112%
Bay Admissions (Female)	66	92	139%
Avocet Treatment Ward	60	87	145%

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Welland Centre	32	59	184%
AMH Nurse Management Acute Care	42	113	269%
Cove Admissions (Male)	44	127	289%
Core service total	452	673	149%
Trust Total	7604	9378	123%

Multidisciplinary and interagency team work

Each ward held regular ward rounds, where patient care and progress was discussed. One carer and two patients from Bay ward explained that the consultant for the ward did not have a fixed day or time for ward round. This meant that patients were not always given adequate time to prepare, and relatives had missed the opportunity to attend. Ward staff confirmed that the consultant offered more flexible time, and so patients did not necessarily have a set time or day. However, staff were mindful of needing to give an approximate appointment if external agencies were attending.

Nurses and nursing assistants attended handover meetings at the commencement of their shifts. Each patient was discussed, and any risks, plans for the day, any recent incidents, and anything else appropriate for staff to care for the patients on that shift was shared. The wards also had daily multidisciplinary handover meetings, for other professionals, to ensure that progress and recent incidents were discussed more widely. We observed a multi-disciplinary meeting, and found this to be very thorough, and included any potential leave or discharges.

Ward teams had good working relationships with other teams, such as the crisis team, community mental health teams, and the personality disorder hub. Ward staff maintained relationships with teams external to the Trust, such as the local authority and general practitioners.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

As of 31 January 2018, 72% of the workforce in this core service had received training in the Mental Health Act. This had increased to 96% by the end of May 2018. The trust stated that this training is mandatory for all core services for inpatient and all community staff.

Data was not provided for training compliance for the last inspection.

Staff understood their roles and responsibilities under the Mental Health Act 1983, Code of Practice and the guiding principles. The service had access to Mental Health Act administrators, who provided support and legal advice. Staff knew who they were and how to contact them.

As of 31 May 2018, 96% of staff had completed training in the Mental Health Act.

The trust had relevant policies and procedures in place relating to the Mental Health Act, and informal patients. Staff could access policies and procedures easily when required, and they incorporated the most recent guidance.

Staff displayed information around the ward about independent mental health advocacy. Staff assisted patients with accessing the service.

Nursing staff regularly explained patients' rights under the Mental Health Act to them. However. six patients we spoke with stated they were unaware of their rights.

Nursing staff accommodated patients escorted Section 17 leave, when granted. (Section 17 refers to detained patients having permission to leave the hospital for a specified length of time). Leave was rarely cancelled. Staff reported that on occasions, leave had been delayed slightly, due to the activity levels on the wards. However, this was not a regular occurrence. Section 17 leave forms clearly included terms and conditions for leave, including a risk assessment.

Doctors requested an opinion from a second opinion appointed doctor when necessary, when detained patients had not consented to medications, in line with the Mental Health Act.

Staff stored detention paperwork electronically so that all staff had access to them. Original paper copies were stored with the Mental Health Act administrator.

Each ward displayed notices to tell informal patients that they could leave the ward freely, and to discuss with nursing staff.

Care plans referred to patients where Section 117 aftercare was to be provided. (Section 117 refers to patients who have been detained under Section 3 or equivalent).

Staff completed audits of detention paperwork.

Good practice in applying the Mental Capacity Act

As of 31 January 2018, 43% of the workforce in this core service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

Data was not provided for training compliance for the last inspection.

Staff had a broad understanding of the Mental Capacity Act and knew where they could find relevant information including an up to date policy. Staff assumed patients had the capacity to make specific decisions.

Staff encouraged patients to make decisions for themselves where possible. Staff completed capacity assessments for specific decisions, if they believed a patient had impaired capacity. When a patient lacked capacity, staff made decisions in their best interests. One example we saw was around the management of money. Staff also considered and documented the patients' capacity to consent to care plans.

Staff had support from the Mental Health Act administrators, for guidance on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff worked within the Mental Capacity Act definition of restraint.

The trust told us that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this core service between 1 January 2017 and 31 December 2017.

There were no patients under a Deprivation of Liberty application at the time of inspection.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

The 2017 Patient-led assessments of the care environment (PLACE) score for privacy, dignity and wellbeing at two core service location(s) scored higher than similar organisations.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
St. Mary's Hospital	MH - Acute wards for adults of working age and psychiatric intensive care units MH - Mental health crisis services and health-based places of safety MH - Wards for older people with mental health problems	94.9%
Berrywood Hospital	MH - Acute wards for adults of working age and psychiatric intensive care units MH - Child and adolescent mental health wards MH - Forensic inpatient MH - Long stay/rehabilitation mental health wards for working age adults MH - Mental health crisis services and health-based places of safety MH - Wards for older people with mental health problems	93.3%
Trust overall		93.1%
England average (mental health and learning disabilities)		90.6%

We observed positive interactions between staff and patients. Staff were responsive to individual need during our inspection. Staff directed patients to other services when appropriate, such as local drug and alcohol support services. Staff understood individual needs of patients and knew the patients well. This included cultural, social and religious needs. Of the 31 patients we spoke with, 29 were positive about the staff. Patients felt that staff were kind and supportive, and treated them with dignity and respect.

Three out of the 31 patients we spoke with, were negative about the staff. One patient referred to staff as "a little heavy handed and sarcastic". Two patients told us that on occasions staff spoke about patients in a stigmatising or derogatory way. One relative, out of the six we spoke with, described the staff as "negligent", in relation to the care and treatment their relative received. In addition to this, the relative spoke about the staff "man-handling" their relative, and were "threatening".

Information from an external source told us that some patients from across the service reported that staff were "punitive", and would threaten to take away leave, or threaten them with detention under the Mental Health Act if they behaved in a certain way.

Staff said they could raise concerns about any discriminatory, disrespectful or abusive behaviour or attitudes towards patients, without fear of reprisal.

Staff maintained the confidentiality of patients. Sensitive conversations with patients took place in private. Staff were mindful of other patients being in communal areas, and ensured that any conversations about patients between staff could not be overheard by others.

Involvement in care

Patients were orientated to the ward upon admission. Staff showed patients around and introduced them to other staff and patients. Staff provided patients with welcome packs upon admission. This contained information about the ward generally and the patients' rights, whether detained or informal. One patient and carer told us that they sat in the lounge and were "ignored" by staff for about one hour, upon admission to Sandpiper ward.

Some patients were involved in care planning across the service, which was demonstrated in care records. However, nine patients (29%) told us they were not aware of their care plans, and two further patients told us that they knew a care plan existed, but did not know the content. Some other patients we spoke with had sat with a staff member and discussed. Staff offered patients a copy of their care plans, which was usually reflected in care records.

Staff communicated effectively with patients, and used language that they understood.

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Staff communicated effectively with patients, and used language that they understood.

Involvement of families and carers

Staff told us they informed and involved families and carers appropriately and provided them with support when needed, if the patient had consented to this. However, of the six relatives we spoke with, four told us of a lack of communication from the staff. Two carers had been informed of incidents, which they considered to be serious, by their family member themselves, and not ward staff.

Patients and carers could give immediate feedback about the service through the "Did you receive great care today" leaflets. These were readily available on all wards.

The trust also had a carers charter, and recognised that carers had a statutory right to an assessment of their own needs.

Carers, family and friends' events had been arranged at both St Marys and Berrywood hospital during the month of June 2018.

Staff ensured that patients could access advocacy and assisted with this when needed.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for eight wards in this core service between 1 February 2017 and 31 January 2018.

Seven of the wards within this core service reported average bed occupancies ranging above the provider benchmark of 85% over this period. Five of the eight wards reported average occupancy of over 100%.

We are unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

Ward name	**Average bed occupancy range (**1 February 2017 – 31 January 2018**) (current inspection)**
Avocet Ward	108.3% - 123.6%
Bay Ward	108.3% - 128.8%
Cove Ward	101.2% - 121.3%
Harbour Ward	99.5% - 132%
Kingfisher Ward	104.3% - 136.8%
Marina Ward PICU	77.4% - 114.3%
Sandpiper Ward	107.5% - 121.6%
Shearwater	29.5% - 68.7%

We found that there was overcapacity on most wards. Seven of the wards within this core service reported average bed occupancies ranging above the provider benchmark of 85%. Five of the eight wards reported average occupancy of over 100%.

Bed management processes were effective and included daily bed management meetings. Whilst staff could not guarantee that patients had access to a bed on the same ward upon return from leave, as the acute wards regularly admitted new patients into leave beds, to resolve this staff completed risks assessments for all patients on leave; should they return unexpectedly. On occasions staff had made other areas of the ward into temporary bedrooms for these patients for short periods. On return patients were asked if they would prefer to be placed out of area, or when appropriate provided alternative care, for example additional support from the home treatment team. We observed that 13 leave beds were in use across Avocet, Kingfisher, Harbour and Bay wards at the time of inspection. We found that between January and June 2018, 12 patients had slept in either a bed on an older adult ward; or a temporary bed within the acute wards. We were told that any patients sleeping in other areas then bedrooms, had to be authorised by a manager on call for the service. The number of nights these temporary sleeping arrangements continued for, varied between one, and ten nights; in the case of a person who was placed on another ward where it was assessed that they were appropriately placed. The consultant continued to oversee care. We noted the trust were lower bed weighted per population (14 beds per 100,000 against an average of 18 beds per 100,000). We considered the trust was managing these patients in a safe manner and the privacy and dignity of patients had not been compromised.

Patients were not moved between wards during an admission episode unless it was justified on clinical grounds, for example a transfer to the psychiatric intensive care ward.

When patients were transferred or discharged, this occurred at appropriate times of the day.

There were no patients awaiting a psychiatric intensive care bed. Ward managers told us that they had no waiting lists, and usually met patient need for beds.

Staff across the service worked on admissions and discharges. Bed managers, social workers and discharge co-ordinators all worked collaboratively to ensure appropriate flow of movement across the acute and psychiatric intensive care units. Out of hours, after 17:00hrs and over the weekends, referrals would go directly to the respective wards. Senior staff on duty at the time would manage these.

The trust provided information for average length of stay for the period 1 February 2017 to 31 January 2018.

We are unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

Ward name	**Average length of stay range (**1 February 2017 – 31 January 2018**) (current inspection)**
Avocet Ward	16-63
Bay Ward	12-62
Cove Ward	21-39
Harbour Ward	8-55
Kingfisher Ward	8-50
Marina Ward PICU	13-74
Sandpiper Ward	16-77
Shearwater	5-24

Out of Area Placements

This core service reported 274 out area placements between 1 February 2017 and 31 January 2018.

As of 31 January 2018 this core service had three ongoing out of area placements. There was one placement that lasted less than one day, and the placement that lasted the longest amounted to 231 days.

This was a significant increase in out of area placements, compared to the previous inspection, over a twelve-month period. Between October 2015 and September 2016, the service had 133 patients placed elsewhere. Between February 2017 and January 2018, 274 patients had been placed out of area. Of the out of area beds used, 40 were for PICU beds, and all patients were transferred to other units due to safeguarding issues. The remaining patients were transferred to acute beds elsewhere due to the trust having no available beds. Every patient who was transferred had been detained under the Mental Health Act.

We found that patients had been transferred to 25 different hospitals across England. Some of which were miles from their homes. Of the different hospitals used, 18 were over 50 miles away from Northampton, and 12 were over 100 miles. This would make it difficult for some family members to visit. We spoke with one family member who had experienced a lack of local beds. Their relative had to receive care in another hospital over 100 miles away. The family member was unhappy, as for the length of the admission (approximately three weeks), they had been unable to speak with a doctor, and did not have any involvement with their care.

Data showed 264 out of 274 out of area placements were due to patients being placed with another provider due to capacity issues. The number of days spent out of area varied considerably, between just one night, and one patient being elsewhere for 231 nights. At the time

of transfer to other hospitals, 80% of patients were informal and 20% had been detained. The majority of patients were discharged to their home address, or temporary accommodation (76%); 22% were transferred back to NHFT, and the remaining 2% were transferred elsewhere. During this inspection, we were told that there were five out of area placements from Northampton, and three from Kettering, due to lack of beds available. However, all beds were filled on the wards, and an additional 13 patients were on leave.

Number of out of area placements	Number due to specialist needs	Number due to capacity	Range of lengths (completed placements)	Number of ongoing placements
274	2	264	0-231	3

This core service reported 47 readmissions within 28 days between 1 February 2017 and 31 January 2018. 29 of readmissions (62%) were readmissions to the same ward as discharge.

This has increased significantly since the last inspection, where there was no re-admission of patients within 28 days of discharge.

The average of days between discharge and readmission was 11 days. There was one instance whereby patients were readmitted on the same day as being discharged but there were no instances where patients were readmitted the day after being discharged.

At the time of the last inspection, for the period 1 October 2015 to 30 September 2016, there were no readmissions within 28 days. Therefore, the number of readmissions within 28 days has increased between the two periods and the average time between discharge and readmission has increased.

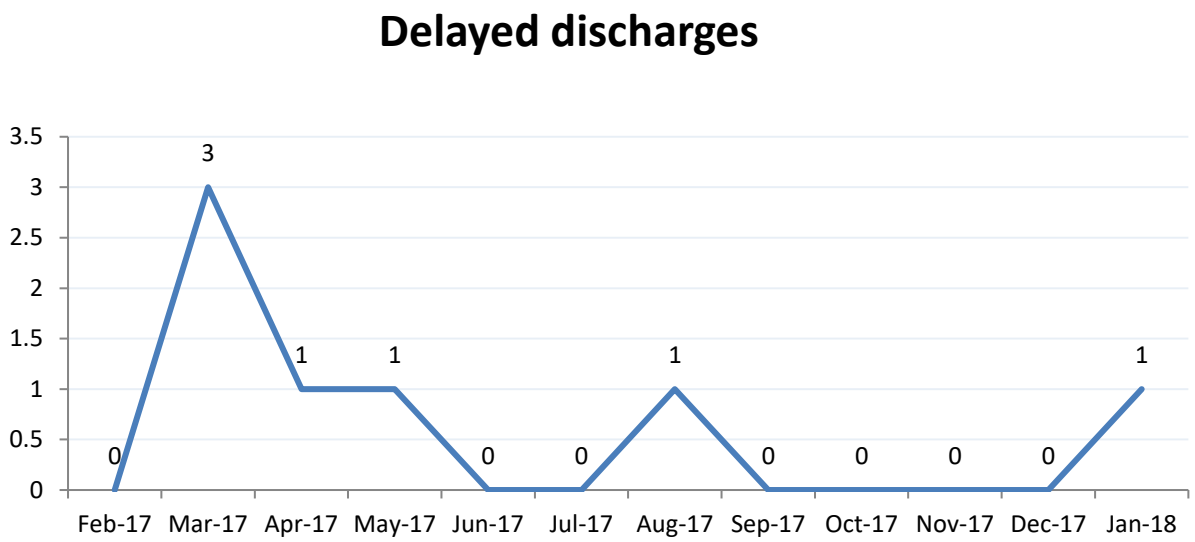
Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
47	29	62%	0-28	11

Discharge and transfers of care

Between 1 February 2017 and 1 January 2018 there were 948 discharges within this core service. This amounts to 15% of the total discharges from the trust overall (6497).

The graph below shows the trend of delayed discharges across the 12 month period.

The graph suggests a spike in March 2017 with three delayed discharges.



Staff teams planned for patients discharges, with liaison with community teams and care co-ordinators.

There had been occasions when there had been delayed discharges. This was attributed to finding a suitable placement, or an issue of awaiting funding. The service did have a local provider whereby patients who were clinically fit for discharge, but did not have accommodation to go to, could be transferred, if there were beds available.

The trust has reported that the target for 'referral to initial assessment' and 'assessment to treatment' is 18 weeks and that this has been achieved as treatment begins at the first face to face contact (where advice and support is given to the service user directly), so there is no difference between the two measures.

Facilities that promote comfort, dignity and privacy

The 2017 Patient-led assessments of the care environment (PLACE) score for ward food at the locations was comparable to similar trusts. There was one location, St Mary's Hospital (90.4%) that scored lower than other similar trusts for ward food. Patients we spoke with had varying opinions of the food offered. Some patients reported that there was adequate choice and enough food; whereas other patients reported that there was not always enough choice.

Site name	Core service(s) provided	Ward food
St Mary's Hospital	MH - Acute wards for adults of working age and psychiatric intensive care units MH - Mental health crisis services and health-based places of safety MH - Wards for older people with mental health problems	90.4%
Berrywood Hospital	MH - Acute wards for adults of working age and psychiatric intensive care units MH - Child and adolescent mental health wards MH - Forensic inpatient MH - Long stay/rehabilitation mental health wards for working age adults MH - Mental health crisis services and health-based places of safety	100%

Site name	Core service(s) provided	Ward food
	MH - Wards for older people with mental health problems	
Trust overall		97.7%
England average (mental health and learning disabilities)		91.5%

We saw a range of foods available to cater for different diets, to include vegetarian options and halal meats.

All wards had single bedrooms for patients. There were no shared bedrooms or dormitories.

We saw that some patients who had been on the wards for some time, had personalised their bedrooms with photographs, pictures and personal items.

All patients had somewhere safe to store their possessions. There were lockable cupboards or drawers in bedrooms, and patients could store items in a separate locked area, if needed.

Staff and patients had access to a full range of rooms and equipment to support treatment and care. Each ward had space utilised for activities, clinic rooms and de-escalation rooms. In addition to this, outside space was available for fresh air. The service also had gyms for patient use, following an appropriate induction. Sensory modulation rooms were being developed at the time of inspection, and were planned for four of the eight wards. These will become designated rooms, where patients could be directed too, to gain skills in self-management and changing emotional states by using sight, sounds, smells, movement and items such as weighted blankets.

Each ward had quieter areas where patients could receive visitors. Each ward had an area where patients could make phone calls in private, if they required a ward telephone. Staff undertook risk assessments for the use of mobile phones on the ward. We saw many patients throughout the inspection using their own mobile phones.

Each ward had access to outside space, although staff had to supervise the use of outdoor areas, due to risks, including blind spots.

Patients could make hot drinks and snacks throughout the 24-hour period. Generally, the kitchen areas were locked by staff throughout the night. However, if patients requested something to eat or drink, this was facilitated by staff.

Patients' engagement with the wider community

Staff supported patients to maintain contact with friends and family members where appropriate. If patients wanted families or carers involved in their care, this was encouraged. Patients told us that family members had been into ward rounds when requested.

Meeting the needs of all people who use the service

The service made adjustments for disabled patients. Each hospital had appropriate access to premises for patients who may require a wheelchair, or who had limited mobility. We saw that special beds and mattresses, and hoists had been sourced as and when required for patients.

Patients had access to a wide range of information through leaflets displayed on each ward. This included information on treatments, patients' rights, how to complain, how to contact advocacy, as well as information about local services, for example housing or drug and alcohol support groups.

Information provided was in English. Staff could obtain information in different languages spoken by patients. Easy read versions of leaflets could also be sourced for those patients who had a learning disability.

Ward staff had access to interpreters and signers. We spoke with some staff who spoke different languages, and who had helped patients interpret during multi-disciplinary meetings.

Patients were given a choice of foods to meet individual dietary requirements of religious and ethnic groups.

The trust provided a chaplaincy service that provided patients with access to support from a variety of religions and faiths.

Listening to and learning from concerns and complaints

This core service received 22 complaints between 1 January 2017 and 31 December 2017. One of these was upheld, 13 were partially upheld and six were not upheld. No complaints were referred to the Ombudsman. Most complaints were around care and treatment. Ward staff attempted to resolve most complaints where possible. If a patient wanted their complaint put into writing, staff assisted them with this. We spoke with a patient who had previously made a complaint. They did not feel that they were treated any differently during this time.

Total Complaints	Fully upheld	Partially upheld	Not upheld	Withdrawn	Referred to Ombudsman
22	1	13	6	2	0

This core service received 206 compliments during the last 12 months from 1 January 2017 and 31 December 2017 which accounted for 16% of all compliments received by the trust as a whole.

We saw some cards of thanks from patients during inspection.

Patients we spoke with were aware of how to make a complaint, and who to approach in the first instance.

Staff managing the complaint usually fed back the findings to the patients. This could be face to face, if the patient was on the ward, or through a letter.

Staff knew how to handle complaints appropriately, and knew how to escalate, where to record, and who to report too.

Staff received feedback on the outcome of the investigation of complaints during team meetings and in supervision. One example of learning from a complaint, resulted in staff having some training about breaking bad news to relatives.

Is the service well-led?

Leadership

Managers had the skills, knowledge and experience to perform their roles. Ward managers had a good understanding of the wards they managed, and were aware of how well the team was performing.

We saw that ward managers were visible throughout the inspection, attended multidisciplinary meetings, patient meetings, and were available generally for staff and patients. Staff reported that

they could approach the ward managers, who would make time to speak with them as required. Staff on the wards knew who the service managers were.

Ward managers and senior nurses had been given the opportunity to undertake leadership development.

Vision and strategy

Staff could tell us the vision and values of the trust. The trusts vision and values were dedicated to making a positive difference, and aimed to provide care with compassion. Throughout the inspection, we saw staff demonstrate these values in their day to day work with patients.

There was evidence that ward managers contributed to discussions about strategy of the service and new initiatives and different ways of working. We heard from staff that there had been lots of discussions around the sensory modulation rooms and the use of body cameras across the service.

Staff interviewed were keen to give all patients a positive experience of being in hospital, with emphasis upon recovery and returning to the community.

Culture

During the reporting period there were three cases where staff have been either suspended, placed under supervision or were moved to a different ward. Three staff have been suspended, zero were placed under supervision and zero were moved ward.

Of the three cases, one involved Band seven staff group, one involved Band 6 staff group and one involved an apprentice. Two staff resigned from post and one staff was redeployed.

Caveat: Investigations into suspensions may be ongoing, or staff may be suspended, these should be noted.

Ward name	Suspended	Under supervision	Ward move	Total
Sandpiper	1	0	0	1
Cove	2	0	0	2
Core service total	3	0	0	3

Staff felt respected, supported and valued by team members and senior staff. Staff were proud to be working for the trust, and enjoyed their roles on the wards.

Staff felt able to raise any concerns about patient care and treatment without any fear of retribution. Staff were familiar with the whistle blowing process and the role of the Speak up Guardian.

Ward managers dealt with poor staff performance when needed. Managers were supported by senior staff and the human resource department when required. Staff followed the trust policy for any misconduct to ensure a fair process for staff.

Ward teams worked well together and provided mutual support. Staff felt able to speak with the ward managers or service director if there were any difficulties within the teams.

Staff appraisals included conversations about career development, and how this could be supported.

Staff were supported with wellbeing, and were encouraged to look after both their physical and emotional health needs. Additional support was available through the occupational health service, if appropriate.

The Trust recognised staff and team success within the service. We saw individual staff had received staff awards, which were displayed.

Staff sickness rate across this service was 6% between 1 February 2017 and 31 January 2018. This was higher than the national average, which was 4%.

Governance

The trust have provided their board assurance framework, which details any risk scoring 27 or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. The four strategic ambitions outlined by the trust relating to this core service are as follows:

1 – Develop in partnership

2 - Innovate

3 – Build a sustainable organisation

4 - Quality

5 – Grow our staff capability

The trust has provided a document detailing their nine highest profile risks. Each of these has a current risk score of 15 or higher. None relate to this core service.

There were effective governance processes in place. Managers attended monthly quality meetings. Ward issues, such as incidents, safeguarding and staffing concerns were discussed with other managers across the service. Ward managers participated in daily meetings to review patient admissions, leave and discharges.

Wards had set agendas of what needed to be discussed at team level, in team meetings. This included learning from incidents, ward issues, security and environmental issues, and documentation. Staff took minutes of meetings so that those who could not attend knew what was discussed. Minutes were emailed to staff, and were available on the trust shared drive.

We saw that staff had implemented recommendations from the learning of incidents and complaints. Information had been successfully cascaded to staff at ward level.

Staff undertook clinical audits on the wards. We saw that the seclusion audits were not robust.

The way in which the questions were phrased within the audit tool, indicated staff were auditing whether the forms had been checked, rather than if the forms had been completed accurately. We found that some audits completed, stated records were complete, when in fact, they were not. This questioned the effectiveness of the tool, which could affect the oversight of seclusion practice across the service.

We also found that staff were completing paperwork which was not in line with the most up to date trust policy.

Staff understood the importance of working with external teams and individuals, to meet the needs of the patients. Care records demonstrated effective joint working with others.

Management of risk, issues and performance

Staff had access to the risk register at ward level. Senior staff regularly reviewed this. Staff at ward level could escalate any concerns through the ward manager.

The service had plans for emergencies, such as a flu outbreak, information technology failure or adverse weather.

Ward managers were aware of budget restraints, and for example, were looking to reduce the number of agency staff used. However, this did not compromise patient care, as agency was used when necessary.

Information management

Systems were in place to manage information. The trust used electronic systems to collect data from wards. These included an electronic system to record incidents and risks, and a system to record staff training, sickness, supervision and appraisals. The trust used this data to provide monthly compliance reports, which enabled managers to review and act.

Staff had access to information technology needed to complete their work. Staff reported that generally the electronic recording system worked well and was not difficult to navigate.

Staff adhered to confidentiality of patient records.

Staff made notifications to external bodies when appropriate, such as the local authority and the Care Quality Commission.

Engagement

Patients and carers could give immediate feedback about the service through the “Did you receive great care today” leaflets. These were readily available on all wards.

The trust also had a carers charter, and recognised that carers had a statutory right to an assessment of their own needs.

Carers, families and friends’ events had been arranged at both St Marys and Berrywood hospital during the month of June 2018.

Staff were proactively engaging with patients in co-production work around some aspects of staff training. In addition to this, Berrywood hospital provided some patients volunteering opportunities. Examples of volunteers used was for art work displayed within the hospital, and an allotment on site.

Learning, continuous improvement and innovation

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services within this core service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Service accredited	Comments and date of accreditation / review
Accreditation for Inpatient Mental Health Services (AIMS)	Cove	AIMS peer review on the 11th September 2017 – waiting for report
Accreditation for Inpatient Mental Health Services (AIMS)	Bay	AIMS peer review took place 21 September 2017 - waiting for report
Accreditation for Inpatient Mental Health Services (AIMS)	Harbour	AIMS Peer review took place 20th September 2017 waiting for report

Accreditation scheme	Service accredited	Comments and date of accreditation / review
Accreditation for Inpatient Mental Health Services (AIMS)	Marina ICU	Accredited November 2017

Staff were supported to consider improvement opportunities and innovation. One recent example of this, was the sensory modulation rooms which were in progress across the service. Bay, Shearwater, Sandpiper and Marina wards were having these fitted. There is little research in England which refers to the effectiveness of sensory modulation rooms within acute, mental health settings. Research in Scandinavia and Australia indicates this could be an effective way to help patients. The two hospitals will be trialling this, and aim to complete an evaluation following their use after approximately six months.

A further example, was the controlled use of body camera's, as mentioned earlier in this report. The trust had been nominated for a RCNI award for patient safety, in relation to this work. (An RCNI award recognises nurse innovators). The trust was also nominated and was successful in winning the Health Service Journal patient safety award for body worn cameras.

All wards were actively working towards achieving AIMS accreditation.

Community-based mental health services for adults of working age

Facts and data about this service

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Trust Headquarters	Early Intervention Service	n/a	Mixed
Trust Headquarters	Personality Disorders Team	n/a	Mixed
Trust Headquarters	Planned Care and Recovery Treatment Service	n/a	Mixed

Is the service safe?

Safe and clean environment

The trust had reviewed its health and safety arrangements at Campbell House after our last inspection, to ensure they accounted for visitors entering the building. Patients visited all the team's office sites for care and treatment. The trust had extended the close circuit television of areas where patients might be and staff escorted patients to rooms on the first floor. They had introduced a log for visitors to sign when entering and leaving the premises. However, managers had removed this following a complaint and consideration of the General Data Protection Regulation. Other sites still had these books when we visited. An information governance manager said that they were changing systems to account for patients in buildings across all their sites.

Trust staff had implemented environmental ligature risk audits for all community buildings accessed by patients, after our last inspection. However, staff had not identified all ligature risks in the audits, for example the one for Campbell House, did not capture interview room risks. The trust had not identified actions to reduce risks of emergency call alarms in toilets at Danetre and Isebrook offices. Staff said they would not leave patients alone in interview rooms. The trust had not updated their 'Ligature risk reduction' policy to reflect they were now completing these audits.

The trust had completed other assessments of the care environment relating to health and fire safety. Staff gave fire safety information to us when we visited each site. The trust had security systems in place, such as swipe card access points to restrict visitors access to staff's individual offices for staff's safety and privacy.

The trust had ensured that most interview rooms had alarms. Campbell House did not have any and staff said they used personal alarms where they had identified a potential risk with patients. There were staff on site to respond to alarms. Northamptonshire Service for the Treatment of Early Psychosis (N-STEP) team at St Marys hospital site had plans to implement alarms in rooms. The trust had systems to check alarms worked.

The trust had ensured that clinic rooms were well-equipped with the necessary equipment to carry out physical examinations. For example, N-STEP staff had portable electrocardiogram machines to use with patients at their homes. Staff at the planned care and recovery team (PCART) St

Mary's hospital had limited surface area to prepare medication for depot injections. There was insufficient electrical socket access and staff had put electrical extension leads over cabinets to use.

Staff maintained equipment and kept it clean. Staff ensured that office sites were clean, had good furnishings and were well kept. Cleaning staff had checklists for daily tasks that showed they cleaned the environment regularly. Staff adhered to infection control principles including handwashing. N-STEP team had achieved 100% compliance in a hand hygiene audit 24 May 2018. However, staff at PCART St Mary's did not have access to a pedal bin in the clinic, and staff opened the bin with their hands, which posed a risk of contamination.

Safe staffing

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	At 31 January 2018	154.5	N/A
Total number of substantive staff leavers	1 February 2017 – 31 January 2018	9	N/A
Average WTE* leavers over 12 months (%)	1 February 2017 – 31 January 2018	6%	8-12%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 31 January 2018	11.7	N/A
Total vacancies overall (%)	At 31 January 2018	8%	10%
Total permanent staff sickness overall (%)	At 31 January 2018	4%	4.2%
	1 February 2017 – 31 January 2018	4%	4.2%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 31 January 2018	47.2	N/A
Establishment levels nursing assistants (WTE*)	At 31 January 2018	52.2	N/A
Number of vacancies, qualified nurses (WTE*)	At 31 January 2018	-5.3	N/A
Number of vacancies nursing assistants (WTE*)	At 31 January 2018	6.6	N/A
Qualified nurse vacancy rate	At 31 January 2018	-11%	10%
Nursing assistant vacancy rate	At 31 January 2018	13%	10%
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 February 2017 – 31 January 2018	549	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 February 2017 – 31 January 2018	271	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 February 2017 – 31 January 2018	59	N/A

Substantive staff figures			Trust target
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 February 2017 – 31 January 2018	133	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 February 2017 – 31 January 2018	0	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 February 2017 – 31 January 2018	2	N/A

*Whole-time Equivalent

Establishment, Vacancy, Levels of Bank & Agency Usage

This core service reported an overall vacancy rate of -11% for registered nurses at 31 January 2018.

This core service reported an overall vacancy rate of 13% for registered nursing assistants.

This core service has reported a vacancy rate for all staff of 8% as of 31 January 2018.

As of 21 June 2018, the trust's staffing establishment for PCARTs was 105.93 whole time equivalent (wte) and 95.74 staff were in post.

The trust had an establishment of 31.22 registered nurses whole time equivalent (wte) with 28.18 in post.

The trust had an establishment of 11.6 healthcare assistants whole time equivalent (wte) with 11.9 in post.

The trust had an establishment of nine clinical psychologists whole time equivalent (wte) with 9.15 in post.

The trust had an establishment of 9.49 occupational therapy staff whole time equivalent (wte) with 8.83 in post.

The trust had an establishment of 7.96 doctors whole time equivalent (wte) with 7.8 in post.

As of May 2018, the overall staff completion of mandatory training was 90%.

	Registered nurses			Health care assistants			Overall staff figures		
Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Kettering CMHT (B383)	0	0	0%	0	0	0%	1	1	100%
Northampton West Manager (B841)	0	1	0%	1.5	2.5	60%	1.5	3.5	43%
General Psychiatry M/Health (B365)	n/a	n/a	n/a	0	0.6	0%	1	2.5	41%
Mental Health Community North	-1	0	0%	1	1	100%	1	4	25%

	Registered nurses			Health care assistants			Overall staff figures		
Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Management (B864)									
PCART South (B389)	2.2	19.6	11%	4.1	18.5	22%	10.4	49.3	21%
EIS North and South (B337)	-0.4	10.2	-4%	1.4	5.7	24%	1.8	20	9%
Corby CMHT (B384)	1.8	6.4	28%	-0.9	8	-12%	1	19.7	5%
Personality Disorder Team (B700)	n/a	n/a	n/a	0	0.8	0%	0.2	7	3%
Wellingborough CMHT (B385)	-0.3	5.4	-5%	0.3	5	7%	0.3	13.9	2%
C.P.N Daventry (B433)	0	0	0%	0	0	0%	-1	0	0%
Campbell House (B430)	0	1	0%	0	2.7	0%	0.1	4.7	0%
IPC Recovery Team (B870)	0	2.6	0%	0	3.8	0%	0	8.2	0%
West Community Mental Health Team (B388)	0	0	0%	-1.4	0	0%	-2.4	0	0%
Adult MH Management (B846)	-5.6	1	-560%	1	1	100%	-0.2	8	-2%
Management - Clinical Leads (B283)	0	0	0%	-0.2	0.8	-25%	-0.8	5.4	-15%
Psychotherapy Non-Medical (B297)	n/a	n/a	n/a	-0.2	0.8	-25%	-0.2	0.8	-25%
Northampton Management (B705)	-2	0	0%	0	1	0%	-2	5	-40%
Core service total	-5.3	47.2	-11%	6.6	52.2	13%	11.7	153	8%

	Registered nurses			Health care assistants			Overall staff figures		
Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Trust total	141.2	1260.4	11%	123.7	990.5	12%	279	2560.1	11%

NB: All figures displayed are whole-time equivalents

Between 1 February 2017 and 31 January 2018, bank staff filled 549 shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 271 shifts for qualified nurses and 59 shifts were unable to be filled by either bank or agency staff.

Team	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Early Intervention Team	525	0	42
Personality Disorders Team 63	0	0	0
Planned Care and Recovery Treatment Service	24	271	17
Core service total	549	271	59
Trust Total	14171	10118	1440

Between 1 February 2017 and 31 January 2018, bank staff to cover sickness, absence or vacancy for nursing assistants filled 133 shifts.

In the same period, agency staff covered zero shifts. Of the shifts and two unable to be filled by either bank or agency staff.

Team	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Early Intervention Team	130	0	2
Personality Disorders Team 63	0	0	0
Planned Care and Recovery Treatment Service	3	0	0
Core service total	133	0	2
Trust Total	6465	1034	1456

Turnover

This core service had nine (6%) staff leavers between 1 February 2017 and 31 January 2018.

Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Medical: South Borough (B371)	0	1	100%
Personality Disorder Team (B700)	6.8	1	15%
C.P.N Daventry (B433)	1	1.8	14%
Management - Clinical Leads (B283)	6.2	0.8	12%
Adult MH Management (B846)	8.2	1	11%
Wellingborough CMHT (B385)	13.6	1	9%
Corby CMHT (B384)	17.9	1	5%
EIS North and South (B337)	17.2	1	5%
PCART South (B389)	37.2	0.4	2%
Campbell House (B430)	4.7	0	0%
CMHT Psychology - Heartlands (B279)	3.7	0	0%
CMHT Psychology - Npton (B273)	2.1	0	0%
CMHTs Daventry (B271)	3.3	0	0%
Corby CMHT Medical (B362)	0	0	0%
East Northants Medical (B363)	0	0	0%
General Psychiatry M/Health (B365)	1.5	0	0%
IPC Recovery Team (B870)	8.2	0	0%
Kettering CMHT (B383)	0	0	0%
Kettering CMHT Medical (B295)	0	0	0%
Medical: Daventry (B373)	1	0	0%
Medical: East Sector Community (B370)	0	0	0%
Mental Health Community North Management (B864)	3	0	0%
Mental Health Individual Packages of Care (B343)	6.5	0	0%
Northampton Management (B705)	7	0	0%

Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Northampton West Manager (B841)	2	0	0%
N-Step Medical (B339)	0	0	0%
Psychotherapy Non-Medical (B297)	1	0	0%
Wellingborough CMHT Medical (B296)	0	0	0%
West Community Mental Health Team (B388)	2.4	0	0%
Core service total	**154.5**	**9**	**6%**
Trust Total	**3011.4**	**288.2**	**9%**

The trust had ensured there was enough staff. They identified staffing levels by calculating the number and grade of members of the multidisciplinary team needed using a systematic approach. Team managers had systems for monitoring staff's caseloads to ensure staff did not have an unmanageable caseload, for example PCART managers used a caseload weighting tool.

As of 31 January 2018, the PCART south team had a 49.3 whole time equivalent (wte) staff establishment. There were no vacancies. Nursing staff included three band seven staff, 9.4 wte band five staff; two new band six nurse prescribers and 7.6 wte band four staff. Occupational therapy staff included 3.06 wte band six staff; one band five staff and 0.67 wte band four staff. There was 2.56 wte band four; 4.47 band three staff and 3.1 wte band two administration staff. Managers used more staffing to cover staffing shortfalls. This included a 0.6 wte bank (employed by the trust on an as needed basis) occupational therapist leading on groups and a 0.8 wte nurse. There were also three consultant psychiatrists one was a locum (not permanently employed by the trust) at the team for a year. There were 2.2 wte psychologists; one was on parental leave and one was a locum agency staff.

The average caseload per staff member was 25 patients. Three patients said staff cancelled appointments due to insufficient staffing, usually for psychiatrist appointments. Another patient said it was difficult to get an appointment with a doctor. One patient said they did not have a care co-ordinator for three months, another patient said they had difficulties seeing their care coordinator unless they went to a group. Other patients mentioned there had been a high turnover of staff, particularly psychiatrists and some were unhappy about the lack of consistency in their care.

The PCART north team had a 33.6 whole time equivalent (wte) staff establishment. There were no vacancies. They had a full-time bank worker covering staff sickness. The manager used agency and bank staff to cover previously vacant posts. The average caseload per staff member was 20 patients. However, two PCART north patients said staff had cancelled appointments due to staffing difficulties. One said this happened a lot but it had reduced recently.

The N-STEP had a 20 wte staff establishment. There was one nurse vacancy, which managers were trying to recruit to. Nursing staff included one band seven staff;10.2 wte band six staff; 2.67 wte band four and one band three staff. There was a consultant psychiatrist and a 0.5 wte staff grade doctor. There was 0.8 wte band six occupational therapy staff. There was 0.5 wte band four and 1.09 wte band three administration staff. Managers used more staffing was to cover staffing shortfalls. They had a bank band four nursing post to cover staff training. They were also using

bank administration staff. At the time of our visit the team had 145 patients on their caseload. The average caseload per staff member was 15 patients.

The personality disorder hub had a nine wte staff establishment. There were no vacancies. There were two band eight clinical psychologists; 0.8 wte band seven link worker to liaise with inpatient wards and patients, 4.7 wte band seven senior practitioners (nurse and occupational therapist); 0.8 wte band three administrative staff and a 0.2 wte psychology assistant. The average caseload per staff member was 30 patients.

Sickness

The sickness rate for this core service was 4% between 1 February 2017 and 31 January 2018. The most recent month's data (31 January 2018) showed a sickness rate of 4%.

The trust was managing staff sickness levels. The overall staff sickness rate when we visited was 4.4% for PCART south team slightly above the national average for trusts (4.2%) and below 4% in the personality disorder hub team. Managers at other sites did not give sickness figures.

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
CMHT Psychology - Npton (B273)	48%	31%
CMHTs Daventry (B271)	0%	11%
Kettering CMHT (B383)	0%	6%
Wellingborough CMHT (B385)	6%	6%
Corby CMHT (B384)	3%	5%
Custody Healthcare (B855)	10%	5%
EIS North and South (B337)	4%	4%
Mental Health in-patient OT/Physio Service (B294)	2%	4%
PCART South (B389)	7%	4%
C.P.N Daventry (B433)	0%	3%
Campbell House (B430)	0%	3%
Management - Clinical Leads (B283)	1%	3%
Mental Health Community North Management (B864)	15%	3%
West Community Mental Health Team (B388)	0%	3%
IPC Recovery Team (B870)	6%	2%
Psychotherapy Non-Medical (B297)	13%	2%

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
CMHT Psychology - Heartlands (B279)	2%	1%
Medical: East Sector Community (B370)	0%	1%
Mental Health Individual Packages of Care (B343)	1%	1%
Personality Disorder Team (B700)	2%	1%
Wellingborough CMHT Medical (B296)	n/a	1%
Adult MH Management (B846)	0%	0%
Changing Minds - Diabetes (B830)	0%	0%
Corby CMHT Medical (B362)	0%	0%
Kettering CMHT Medical (B295)	0%	0%
MHTR Pilot (B871)	0%	0%
Medical: South Borough (B371)	0%	0%
Medical: South Northants (B372)	0%	0%
N-Step Medical (B339)	0%	0%
Northampton Management (B705)	0%	0%
Northampton West Manager (B841)	0%	0%
Core service total	**4%**	**4%**
Trust Total	**6%**	**5%**

Medical staff

Between 1 February 2017 and 31 January 2018, 67 shifts were filled by bank staff to cover sickness, absence or vacancy for medical locums. Of these, four were consultant shifts, 55 were middle grade doctor shifts and eight were doctor in training shifts.

In the same time period, 710 agency staff covered shifts. Of these, 540 were consultant shifts, 153 were middle grade doctor shifts and 53 were doctor in training shifts.

In the same period, zero of shifts were unable to be filled by either bank or agency staff.

The trust was unable to provide this information at team level.

Core service total	**67**	**710**	**0**
Trust Total	173	3508	0

Mandatory training

The compliance for mandatory and statutory training courses at 31 January 2018 was 45%. Of the training courses listed 21 failed to achieve the trust target and of those, 21 failed to score above 75%.

Key:

Below CQC 75%	Between 75% & trust target	Trust target and above

Training course	This core service %	Trust target %	Trust wide mandatory/ statutory training total %
Staff and Pt. Safety (Quality & Safety)	100%	90%	39%
Venous Thromboembolism	100%	90%	31%
Falls Prevention Training - Level 2	97%	90%	93%
Information Governance	68%	90%	67%
Falls Prevention Training - Level 1	67%	90%	81%
Infection Prevention (Level 2)	62%	90%	74%
Fire Safety	62%	90%	72%
Resuscitation Level 2 - Adult & Paediatric	54%	90%	62%
Duty of Candour	53%	90%	54%
Infection Prevention (Level 1)	50%	90%	37%
Mental Capacity Act DoLS	43%	90%	43%
Safeguarding Adults Level 1	38%	90%	43%
Safeguarding Children (Level 1	38%	90%	43%
Learning Disability Awareness	38%	90%	31%
Safeguarding Prevent Health WRAP	34%	90%	32%
Dementia Awareness (inc Privacy and Dignity Standards)	31%	90%	28%
Moving and Handling	31%	90%	29%
Safeguarding Adults (Level 2)	31%	90%	41%
Conflict Resolution	30%	90%	39%
Safeguarding Children (Level 2)	30%	90%	32%
Health, Safety and Welfare	30%	90%	19%
Equality and Diversity	28%	90%	23%
Raising concerns and whistleblowing	26%	90%	24%
Resuscitation Level 1	20%	90%	16%
Core Service Total %	45%	90%	47%

The trust had ensured most staff had adequate training for their role. At our visit, 90% of PCART south team; 95% of PCART north team; 100% of the N-STEP team and 97% of the personality disorder team had completed the trust's mandatory training.

Assessing and managing risk to patients and staff

Assessment of patient risk

We checked 38 patients records and examined staff's risk assessments. Staff recorded their assessment on trust documentation. Staff used the nationally recognised 'the 'Historical clinical risk management-20' tool where relevant. Staff had comprehensively completed 33 risk

assessments and updated them regularly after incidents. Staff also completed crisis plans with patients, which they referred to as 'safety plans'. These held information about local crisis services including help lines. Staff from the personality disorder hub had input into plans, where appropriate. Doctors' letters to GPs following outpatient appointments with patients detailed risk assessment, management and crisis plan information.

However, Danetre staff had not completed three risk assessments for PCART south patients and staff confirmed these were not available. PCART north, Corby staff had completed two risk assessments for patients with basic information. Whilst staff had a good understanding of patients' needs, this posed a risk that staff would not know what action to take to reduce risks to patients.

Management of patient risk

Staff had various systems in place to manage patients' risks. For example, staff across teams gave examples of how they responded promptly to a sudden deterioration in a patient's health. PCART staff assessed and monitored risk to patients in weekday morning meetings. They used a live monitoring tool to detect and respond to increases in level of risk and potential deterioration of patient's mental health. Managers identified staff to work in a 'hub' that covered duty. These staff dealt with urgent referrals for patients where there were concerns about a deterioration in their mental health and covered staff absence. Doctors allocated appointment times each day for staff to arrange for patients to see them if urgent.

The N-STEP team held weekly multidisciplinary clinical meetings to review the management of significant risk issues for patients including contingency plans. Personality disorder hub staff completes a 'chain analysis' to identify signs and triggers for patients' risky behaviour.

The trust had a protocol for staff to follow when patients did not attend appointments. We saw examples where staff had needed to follow this. PCART north staff had updated their welcome letter they sent to referred patients to explain the actions staff would take if they did not attend appointments.

The trust had effective personal safety protocols for staff, such as lone working practices. Eighty two percent of staff in this core service had completed resuscitation level one training; 75% of staff had completed level two and 100% of staff had completed level three training. At PCART north St Mary's site there were no identifiable first aiders in the team. However, there were doctors on site and other staff available in the hospital to contact if needed. PCART north staff worked across a large geographical area and spent a lot of time driving between appointments. Staff could not always quickly visit patients if they needed urgent help.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made 35 safeguarding referrals between 1 January 2017 and 31 December 2018, of which 35 concerned adults and zero children.

Referrals		
Adults	Children	Total referrals
35	0	35

Ninety four percent of staff received safeguarding training and knew to contact the trust safeguarding team to make a safeguarding alert. The centralised safeguarding team held this information. Staff recorded safeguarding risk information in their risk assessments for patients and as an alert for staff if they accessed patients' records.

Staff gave examples of how they had protected patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm. That included working in partnership with other agencies. Examples included, staff alerting safeguarding teams where patients were vulnerable to 'cuckooing'. This involved gangs befriending vulnerable people who usually lived alone and using their home to sell drugs or carry out other criminal activity.

Fifty percent of staff had completed level three safeguarding children training. Staff had not made any safeguarding referrals for children. Staff explained they were often working in partnership with other agencies who then made the referral. We observed a morning meeting where staff discussed a child at risk referral that another agency working with the patient had made.

The trust had ensured that safeguarding was a standard agenda item for discussion in staff supervision and team meetings. PCART staff also discussed safeguarding concerns and reviewed staff actions in daily morning meetings.

Serious case reviews/external reviews

Northamptonshire Healthcare NHS Foundation Trust has submitted details of zero serious case reviews commenced or published in the last 12 months (February 2017 to 31 January 2018) that relate to this core service.

Staff access to essential information

The trust ensured staff had access to information they needed for their work. Staff documented patients' assessments, care plans and notes in electronic patient records. Staff had access to mobile telephones and laptops. Staff could access relevant policies, procedures and information for their role on the trust intranet. The trust had systems in place to ensure staff could access records remotely and securely away from their office.

Information needed to deliver patient care was available to relevant staff (including agency staff) when they needed it and in an accessible form. That included when patients moved between teams. The trust had arranged for PCART doctors to use an electronic system to dictate notes into text for letters following appointments. This avoided delays with staff sending letters to patients and professionals. Most GPs used the same electronic patient record system as the teams which helped staff communicate with them. Staff also used email to communicate information within the trust.

Staff recorded information in electronic and paper format. Staff described some difficulties because people often recorded information in different places.

Medicines management

The trust ensured staff had access to adrenaline kits at Campbell House, Isebrook and St Mary's hospital. The trust has updated anaphylaxis training for staff, following our last inspection.

When staff administered medicines on site or in patients' own homes, they followed good practice in medicines management (relating to transport, storage, dispensing, administration, recording and disposal). This was in line with national guidance. Pharmacy staff attended monthly meetings to give feedback on issues for teams. PCART's had nurse prescribers and held weekly patient clinics under a consultant psychiatrist's supervision. However, at PCART north Isebrook, there was not a list of nurse's signatures for audit reference purposes. PCART south staff at Campbell house clinic had overstocked depot medication which was soon due to expire in June 2018.

Staff reviewed regularly (or ensured that other healthcare professionals reviewed) the effects of medication on patients' physical health. This included a review of patients where doctors had prescribed antipsychotic medication or lithium. These reviews were line with guidance from the National Institute for Health and Care Excellence. We observed PCART staff completing annual physical health checks of patients. Staff used various tools when checking on patient's physical health, such as the 'Glasgow antipsychotic side-effect scale' and the 'Lester Tool' a guide for staff to assess patients cardiometabolic health.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 January 2017 and 31 December 2017 there were eight STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was category with apparent/actual/suspected self-inflicted harm meeting SI criteria.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.

	Number of incidents reported		
Type of incident reported on STEIS	Early Intervention Service	PCART	Total
Apparent/actual/suspected self-inflicted harm meeting SI criteria	0	7	7
Disruptive/ aggressive/ violent behaviour meeting SI criteria	1	0	1
Total	**1**	**7**	**8**

Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no 'prevention of future death' reports sent to the trust.

All staff knew what incidents to report and how to report them. We saw examples of this on the trust's electronic incident reporting system. Information from the trust, showed staff had reported 34 incidents from February to April 2018. The trust had identified the highest number of incidents were, eight for patients self-harming and seven for ill health PCART south Campbell House staff reported the highest amount with 16.

Staff understood the duty of candour and the trust gave training for staff about this. Staff were open and transparent, and gave patients and families an explanation if something went wrong. Managers had systems for checking this. They discussed feedback from serious incidents and duty of candour at team meetings, although minutes did not give much detail about the discussions. The PCART south team manager explained that if an incident did not meet the threshold for a serious incident investigation, managers assessed if it required a 'clinical review' to identify learning. We saw examples where staff had discussed these at team meetings.

The trust had systems for sharing information via emails and the intranet. Managers also gained feedback from trust quarterly morbidity and mortality meetings, where staff reviewed deaths. A personality disorder hub staff member attended the trust's suicide prevention committee and shared learning with colleagues as relevant. Staff received debriefs and received support after a serious incident, for example, from the trust's 'critical incident' psychology service.

Staff gave examples of making changes to their service following feedback from incidents. For example, personality disorder hub staff ensured they asked referrers for risk screening information and had reviewed their lone working protocol. Teams had exchanged learning following an incident with a patient using a weapon. N-STEP staff attended the East midlands regional early intervention meetings to share learning from other providers. However, teams had difficulty giving examples of learning relevant for their role from across the trust.

Following a medication incident in the N-STEP team, staff reviewed the information provided by the medication company. They contacted the manufacturer to make them aware of the potential for misinterpretation of the information within the package insert. The company then met with the team to discuss the issue but did not update their information. Staff had highlighted this potential risk to the trust on their local risk register.

Is the service effective?

Assessment of needs and planning of care

We examined 38 care and treatment records for patients. Staff completed 33 care plans that were comprehensive, holistic and patient centred, particularly in the N-STEP team. PCART staff used the wellness recovery action plan as part of ensuring person centred care. Staff completed mental health assessments for each patient and had a good understanding of their needs. Teams used the 'trusted assessor' system which meant that a team accepted the last staff assessment of patient when patients transferred to them. Therefore, staff did not unnecessarily reassess the patient unless their needs changed (for example when referred to the urgent care and assessment team and vice versa).

PCART teams had recently developed a 12-week assessment and care plan for patients with complex needs. Staff jointly assessed and care planned for patients with other teams for example, the personality hub team. However, PCART staff had not reviewed two care plans and staff had completed only basic information in three patient's plans.

Best practice in treatment and care

We examined 38 care and treatment records for patients, observed staff giving care to patients and gained feedback from patients, carers and staff.

Staff gave a range of care and treatment interventions suitable for the patient group. These interventions included those recommended by the National Institute for Health and Care

Excellence guidance. These included medication and psychological therapies and, when needed, support for employment, housing and benefits, and interventions that enabled patients acquire living skills.

Staff across teams referred to using cognitive behavioural, dialectical behavioural and cognitive analytical therapies. Some staff also provided eye movement desensitization and reprocessing (a psychotherapy treatment originally designed to alleviate the distress associated with traumatic memories) with patients. N-STEP staff worked with patients using the recovery 'strengths' model and interventions including brief family therapy.

The trust had reduced the amount of time patients waited by psychological assessment. Previously managers had closed the long term individual pathway temporarily as a psychologist was on parental leave. The trust had a target for patients receiving assessments within 13 weeks with staff giving appointments usually in eight weeks. Trust information showed PCART teams had 17 patients on their waiting list, with 11 patients from PCART north, Isebrook, waiting for up to 13 weeks. However, staff sickness, parental leave and agency staff cover affected this. PCART multi-disciplinary staff offered other psychological interventions and psychology staff gave them supervision. Psychologists were involved with working with staff at the early stage rather than waiting for staff to refer the patient for an individual assessment. Teams offered patients other services such as occupational therapy workshops on anxiety, depression, self-management, assertiveness, life skills, 'living life to the full' and relaxation.

The N-STEP team had three patients waiting for psychology assessment in the south and 16 in the north. Staff leave and sickness had affected this waiting time. Five patients were waiting for short term occupational therapy work.

The personality disorder hub team had a maximum wait of 13 weeks for patients to access groups. Trust information showed 23 patients from the urgent care and treatment (south) team waiting for the understanding and managing emotions group. However, there was some disparity as when we visited, the manager said patients in the south waited five months (20 weeks) and north patients waited two months (8 weeks) to attend this group. The urgent care and treatment team supported patients in the interim until they could attend. There was no waiting list for the structured clinical management group in the north. However, five patients in the south were on the waiting list. Staff had developed a contingency plan with other teams to support patients. There were no patients waiting for dialectical behavioural therapy.

Trust information showed 18 patients in PCART north team were waiting for individual occupational therapy work, up to 13 weeks.

Staff had ensured that 32 patients' (from the sample of records we checked) had physical healthcare assessments. The trust trained support workers to carry out checks, for example, blood pressure and we saw physical health check clinics taking place across PCART teams. If the GP had responsibility for these checks, staff had systems to check on this. Staff supported patients to live healthier lives, for example, through participation in smoking cessation schemes, acting on healthy eating advice, diabetes monitoring, managing cardiovascular risks and dealing with issues relating to substance misuse. However, we did find records for five PCART south Danetre patients. Two PCART south patients and a carer said staff could give more healthier living advice.

Staff used recognised rating scales and other approaches to rate severity and to monitor outcomes for example, the 'health of the nation outcome scales' and the 'model of creative ability'. PCART south occupational therapists used the 'Generalised anxiety disorder' tool and the 'Patient health questionnaire' to measure the effectiveness of their groups with patients. PCART and personality disorder hub staff gave patients self-rating questionnaires to measure any

improvements following the structured clinical management group (a collaborative formulation framework for patients with a personality disorder). Staff gave diary sheets to patients receiving dialectical behavioural therapy to check how they were managing.

The personality disorder hub team had completed a review of 12 patients between 2015 and 2018 which found that eight patients had reduced hospital admissions. Staff gained feedback from patients about the structured clinical managed group via 'I want great care' feedback forms. The average patient feedback (for the last six months as of April 2018), was 4.7 out of five stars. Patients had given 4.5 stars for the understanding and emotions group. The team had recently employed an assistant psychologist to help with audit and measuring outcomes for the service.

Staff used technology to support patients effectively, for example, access to blood test results. One patient said staff helped them find a relaxation application for their mobile telephone and two patients said staff gave them website details for information about their treatment.

Staff took part in clinical audit, benchmarking and quality improvement initiatives. For example, record keeping.

National and local audits

This core service took part in one clinical audit as part of their clinical audit programme 2017-18

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
Quarterly Record Keeping Audit	All clinical services both community and inpatient participate in the audit	Clinical	Not provided (carried out quarterly)	All areas have specific designed questions for their areas.

Skilled staff to deliver care

The trust's target rate for appraisal compliance is 90%. As at 31 December 2017, the overall appraisal rates for non-medical staff within this core service was 91%.

The teams failing to achieve the trust's appraisal target were Adult MH Management (B846) with an appraisal rate of 89%, CMHT Psychology - Heartlands (B279) with an appraisal rate of 80%, CMHT Psychology - Npton (B273) with an appraisal rate of 0%, Management - Clinical Leads (B283) with an appraisal rate of 75%, Mental Health Individual Packages of Care (B343) with an appraisal rate of 88%, Personality Disorder Team (B700) with an appraisal rate of 88%, Psychotherapy Medical (B714) with an appraisal rate of 0% and Psychotherapy Non-Medical (B297) with an appraisal rate of 0%.

Most teams included, or had access to, the full range of specialists required to meet the needs of patients. For example, doctors and nurses, support workers, occupational therapists, clinical psychologists, and pharmacists. N-STEP and PCARTs had peer support workers (people with experience of using mental health services).

The trust did not have any social workers in teams. There was not a partnership arrangement between the trust and local authority under section 75 of the NHS Act 2006 (as amended), to integrate social workers into teams. PCART managers told us they were keen to employ social workers but there was a low response rate to job advertisements. They told us they could access social workers in other teams as needed or made a referral to the local authority.

Staff had experience and had the right skills and knowledge to meet the needs of the patient group. Managers provided new staff with an appropriate induction.

Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance. The N-STEP and personality disorder hub managers said they had other supervision external to the trust. The disorder hub team offered weekly peer supervision to staff for the structured clinical management group. PCART south had achieved 217% compliance with supervision and N-STEP 100% compliance.

Managers completed appraisals of staff's work. When we visited, 93% of PCART south had an appraisal in the last 12 months and 100% of N-STEP staff had one. The percentage of staff that received regular supervision when we visited was 217% for PCART south and 100% for N-STEP teams. PCART north and PD Hub managers did not give us percentages but showed evidence of regularly carrying out supervision and appraisals with staff.

Managers arranged for staff to have regular team meetings. Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Managers ensured that staff received the necessary specialist training for their roles. Staff gave examples such as, suicide prevention training, brief family therapy, attention deficit hyperactivity disorder and cognitive behavioural therapy for psychosis. Psychologists gave training for support workers on problem solving. PCART managers had managers had introduced monthly staff development days. The personality disorder hub team gave training for staff across the trust to feel confident when dealing with challenging telephone calls. The N-STEP manager had identified wellbeing days for staff meetings, supervision and training. Managers gave examples of where they had dealt with poor staff performance promptly and effectively.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
CMHT Psychology - Npton (B273)	2	0	0%
Psychotherapy Medical (B714)	1	0	0%
Psychotherapy Non-Medical (B297)	1	0	0%
Management - Clinical Leads (B283)	8	6	75%
CMHT Psychology - Heartlands (B279)	5	4	80%
Personality Disorder Team (B700)	8	7	88%
Adult MH Management (B846)	9	8	89%
PCART South (B389)	42	39	93%
EIS North and South (B337)	19	18	95%
Campbell House (B430)	4	4	100%
CMHTs Daventry (B271)	1	1	100%
Corby CMHT (B384)	15	15	100%
General Psychiatry M/Health (B365)	2	2	100%
IPC Recovery Team (B870)	8	8	100%

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Mental Health Community North Management (B864)	4	4	100%
MHTR Pilot (B871)	1	1	100%
Northampton Management (B705)	5	5	100%
Northampton West Manager (B841)	1	1	100%
Wellingborough CMHT (B385)	12	12	100%
Core service total	148	135	91%
Trust wide	3236	2934	91%

The trust's target rate for appraisal compliance is 90%. As at 31 December 2017, the overall appraisal rates for medical staff within this core service was 82%.

The teams failing to achieve the trust's appraisal target were General Adult MH with an appraisal rate of 82%.

Team name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals
General Adult MH	11	9	82%
Core service total	11	9	82%
Trust wide	38	32	84%

The trust's measure of clinical supervision data is sessions delivered, hours of supervision delivered etc.

Between 1 January 2017 and 31 December 2017, the average rate across all 18 teams in this core service was 172%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
270 12 Northampton West Manager (B841)	8	4	50%
270 12 Mental Health Community North Management (B864)	16	13	81%
270 12 IPC Recovery Team (B870)	24	23	96%
270 12 EMAS Car (B862)	16	17	106%
270 12 PCART South (B389)	124	172	139%

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
270 12 Adult MH Management (B846)	54	80	148%
270 12 Mental Health Individual Packages of Care (B343)	28	44	157%
270 12 Corby CMHT (B384)	24	38	158%
270 12 EIS North and South (B337)	88	164	186%
270 12 Wellingborough CMHT (B385)	24	53	221%
270 12 C R H T Team - South (B435)	72	215	299%
Core service total	478	823	172%
Trust Total	7604	9378	123%

Multidisciplinary and interagency team work

Staff held regular and effective multidisciplinary team meetings. Staff shared information about patients at handover meetings within the team, for example, when staff were going on holiday.

The teams had effective working relationships, including thorough handovers, with other teams within the organisation, for example crisis team or inpatient services. PCART south and the personality disorder hub team had named staff to liaise with hospital ward staff. PCART south offered staff opportunities work alongside crisis team staff to develop greater understanding of their roles. Managers gave opportunities for staff to meet colleagues from other teams, for example, at senior staff and representatives from the crisis team had attended PCART morning meetings.

The teams had good working links, including effective handovers, with primary care, adult social care, and other teams external to the organisation. Staff gave examples of working with voluntary agencies, supported housing, substance misuse services and perinatal services. The PCART north manager had recently met with the A&E consultant to improve communication between their teams about patients often attending services. N-STEP and personality disorder hub staff had visited GPs to raised awareness about their services. PCART staff said there could be challenges accessing social care staff in the local authority. There could be delays in getting a response to their referral, which was beyond trust staff's control. Teams had named staff champions to improve liaison for this.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

As of 31 December 2017 there was no accurate data reported for workforce receiving training in the Mental Health Act.

Trust information for May 2018 showed 81% of staff in this core service had completed Mental Health Act training. Staff said they had received training and understood the Mental Health Act. Staff told us that this training was mandatory but we did not see information on site to confirm this.

The trust had ensured since our last inspection that staff documented the Mental Health Act status for patients in their records.

PCART south team had 26 and PCART north team had nine patients placed on a 'community treatment order' on their caseload when we visited. The N-STEP team had 11 patients. Staff explained rights to patients in a way that they could understand, repeated it as needed, and recorded that they had done it. Patients had easy access to information about independent mental health advocacy services. Staff had completed community treatment order paperwork correctly and it was up to date and stored appropriately. Staff had attached paperwork to patients' prescription charts. The personality disorder hub manager said staff did not usually work with patients under a community treatment order or section 41 Mental Health Act as staff expected that patients made a commitment to engage in their care and treatment.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were. The trust had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.

Staff's had ensured that care plans referred to section 117 aftercare services needed for those patients who had been subject to section three or equivalent Part II powers authorising admission to hospital for treatment.

Staff carried out joint assessments as relevant, of patients with the crisis team following their detention by the police under section 136 Mental Health Act. Staff gained patients' consent to treatment and care at appointments.

Good practice in applying the Mental Capacity Act

As of 31 December 2017, 43% of the workforce had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

Trust information for May 2018 showed 95% of staff in this core service had completed Mental Capacity Act training. Staff understood the Mental Capacity Act 2005. The trust had a policy on the Mental Capacity Act. Staff were aware of the policy and had access to it. Staff knew where to get advice from within the trust about the Mental Capacity Act. Staff gave patients help to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make it. For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis about significant decisions.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. PCART staff gave a leaflet to patients and carers with information about how to access independent mental capacity advocates.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Patients and carers had given positive feedback to teams about the care and treatment they received via 'I want great care' feedback forms and the trust shared this information with teams. The average patient feedback (for the last six months as of April 2018), was 4.9 out of five stars for PCART south Danetre and 4.4 for Northampton; 4.24 out of five stars for PCART north St Marys and Corby and 4.7 for Isebrook. Patient's rated the N-STEP team 4.9 out of five stars.

Patients gave the personality disorder hub team a rating of 4.7. The team had completed a 12 months review of patients' feedback in 2017 and had an overall average rating of 4.8 with 92% of patients recommending their service.

We observed and heard staff treating patients with kindness, privacy, dignity, respect, compassion and support. Thirty-eight patients and seven carers also confirmed that staff treated them kindness, dignity and respect.

Thirty-eight patients and six carers said staff were caring. However, two patients and a carer said that staff were not. They gave feedback that staff gave inconsistent care due to a change of workers and were not supportive. Another patient said a staff member kept them waiting for an hour for their appointment.

Involvement in care

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. Many patients commented on how flexible the staff at the service were at accommodating their needs.

Staff supported patients to understand and manage their care, treatment or condition. Staff directed patients to other services when appropriate and, if needed, supported them to access those services.

Patients said staff treated them well and behaved appropriately towards them. Staff understood the individual needs of patients, including their personal, cultural, social and religious needs.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. Staff kept patients' information confidential.

Involvement of patients

Staff involved patients in care planning and risk assessment. They had systems for recording when they offered them their care plan. However, six PCART patients we spoke said staff had they not offered them a copy of their care plan, two patients also said they did not want a copy. One patient said sometimes staff delayed their reviews. Staff gave patient's information about advance decisions (to refuse treatment, sometimes called a living will). Two patients commented that psychiatrists only seemed to want to prescribe medication rather than offer other treatment. One patient said they were not involved in care decisions. We observed a meeting with staff who were supporting a patient moving teams. Whilst staff involved the patient in the meeting, we observed that they did not formally discuss their care plan with them, which posed a risk that the patient might not be clear about the care the new team was providing.

Staff involved patients by recording their 'story' on 'My CPA care plan and information' documentation. This avoided the need for staff to ask patients for information about themselves at new appointments and when transferring between services.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. Staff gave patients advocacy service contact details. However, four PCART patients were not aware they could access advocacy services.

Staff involved patients when appropriate in decisions about the service. Staff enabled patients to give feedback on the service they received (for example, via surveys).

N-STEP patients and carers had reviewed and designed information packs to give to others. This included key contact information in an accessible and easy to find form such as banners on pens and fridge magnets. The information included crisis telephone support service, advocacy, family work and carers service information. Staff had involved patients and carers in developing a video which gave information to patients, carers and others about the service.

The personality disorder hub team had developed a 'lived experience and advisory panel', which involved patients in developing the service. Patients were involved in delivering training for staff and GPs. Staff had also involved patients and carers in developing a video on their website which gave information to patients and others about dialectical behavioural therapy. Patients were also involved at the first group session giving feedback about their experience.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. Staff offered carers an opportunity to give their view in a section of patients', 'My CPA care plan and information' documents.

Staff enabled families and carers to give feedback on the service they received (for example, via surveys or community meetings).

The trust had arranged for independent carers support workers at PCART offices to help carers access support. Staff gave carers information about how to access a carer's assessment.

The N-STEP team offered 'family and friends' sessions. Staff gave information about psychosis and gave an opportunity for carers, family and friends to ask any questions they might have. Staff gave carers questionnaires about the process of recovery. Additionally, they gave information about carers support groups.

The personality disorder hub team employed a carers consultant. They had developed a carers support service including expectations of the service, leaflets and programmes.

Six carers said staff gave enough information and support to them. However, one carer said PCART staff had not given any information about the patient's care or any updates or information on how to get a carer's assessment.

Is the service responsive?

Access and waiting times

Teams had clear criteria for which patients were eligible for their service. The criteria did not exclude patients who needed treatment and would benefit from it.

The trust had ensured that patients did not have to wait a long time for services. The trust had met commissioned timeframes as patients received an assessment with 18 weeks of referral to the service. Trust information 27 June 2018 showed there were no patients waiting for urgent or routine outpatient appointments. When we visited, N-STEP team had achieved 98% compliance with this, above the target set by their commissioners (50%). However, four patients at PCART south Campbell House were waiting for managers to give a care coordinator to them, with one patient waiting 21 days.

The trust had systems to monitor the length of time patients waited for services. PCART south had set up a hub team and PCART north had identified referral leads at each site to reduce waiting lists for assessments.

The PCART and the N-STEP team had ‘hub’s, with identified staff to see urgent referrals quickly and non-urgent referrals within an acceptable time. Managers and teams met regularly to review referrals and identify any staff actions. Teams had systems in place to contact patients within seven days of their discharge from hospital. Staff recorded any breaches of this on the trust incident form to highlight the risk. PCART south had achieved 100% of seven day follow ups for February; 94% for March and 100% in April 2018. PCART south had received 526 referrals and had discharged 545 patients from April 2017 to March 2018. The average length of time they worked with patients was 46 months for Campbell House staff and 28-64 months for Danetre staff.

If a patient needed an urgent response after 16:30 hours then staff referred patients to crisis services. Staff had given patients information on who to contact if they were in crisis outside of the team’s working hours (Monday to Friday 09:00 to 17:00 hours). Most patients said staff supported them to get help in a crisis. One patient said the crisis lines were not very helpful to them. The team responded promptly and adequately when patients telephoned the service. However, one patient said they had waited five weeks for their care coordinator to contact them for a routine issue.

The team tried to engage with people who found it difficult or were reluctant to engage with mental health services. The team tried to make follow-up contact with people who did not attend appointments. For example, by trying to build a therapeutic rapport with patients, or their carers, by visiting patients if they did not attend appointments, contacting other teams if involved and by arranging to meet patients outside of their home if they preferred.

PCART staff said they generally did not offer patients appointments outside of their working hours. N-STEP staff said their usual working hours were Monday to Friday 09:00 to 17:00 hours but they would offer appointments in the evening and at weekends as needed.

Staff cancelled appointments only when necessary and when they did, they explained why and helped patients to access treatment as soon as possible. Staff usually attended appointments on time and informed patients when this was not possible.

Staff supported patients during referrals and transfers between services, for example, if patients needed temporary treatment in an acute hospital.

Teams had processes to support patients when transferring their care to other teams. the trust had systems in place for supporting patients to move from child and adolescent mental health services to adult services. PCART north team had a staff champion to lead on this. PCART staff said they usually did not transfer patients aged 65 years or over to the older people’s community mental health, unless they developed an organic mental illness.

N-STEP staff accepted patients aged 14 to 16 years onto their caseload if there was an identified child and adolescent mental health service consultant in place. Staff had made a bid to increase their referral criteria (14 years to 35 years) to include patients aged 14 to 65 years which would mean a 33% increase of their caseload. They were liaising with commissioners about this and had identified the risk of not giving the service on their local risk register. Teams discharged most patients back to their GP’s care or primary medical services. Their remit was not to keep patients on their caseload beyond three years and they had developed a system to check this. The team were supporting some patients for over three years but there was a plan for their discharge. When we visited, staff had identified five patients for discharged to their GP and one patient was awaiting discharge to a PCART. Staff said there could be difficulties at times with PCART teams accepting patients.

The personality disorder hub team had discharged 96% of patients from of mental health services following intervention. One patient said they were anxious as staff had not given much information on what happened after group sessions finished.

The trust has identified the below services in the table as measured on ‘referral to initial assessment’ and ‘assessment to treatment’.

The core service met the referral to assessment target in four of the targets listed.

The core service met the assessment to treatment target in four of the targets listed.

Name of hospital site or location	Name of team	Service Type	Days from referral to initial assessment		Days from assessment to treatment		Comments, clarification
			Target	Actual (mean)	Target	Actual (mean)	
Trust Headquarters	Adult Community Mental Health Team (CMHT)	Adult Community Mental Health Team (CMHT)	18 Weeks	54 days	18 Weeks	54 days	Treatment begins at the first face to face contact (where advice and support is given to the service user directly), so there is no difference between the two measures.
Trust Headquarters	Early Intervention	Early Intervention	2 weeks	8 days	2 weeks	8 days	Treatment begins at the first face to face contact (where advice and support is given to the service user directly), so there is no difference between the two measures.
Trust Headquarters	Personality Disorders	Personality Disorders	18 Weeks	26 days	18 Weeks	26 days	Treatment begins at the first face to face contact (where

Name of hospital site or location	Name of team	Service Type	Days from referral to initial assessment		Days from assessment to treatment		Comments, clarification
			Target	Actual (mean)	Target	Actual (mean)	
							advice and support is given to the service user directly), so there is no difference between the two measures.
Trust Headquarters	Mental Health IPC	Mental Health IPC	18 Weeks	0 days	18 Weeks	0 days	Treatment begins at the first face to face contact (where advice and support is given to the service user directly), so there is no difference between the two measures.

Facilities that promote comfort, dignity and privacy

PCART and N-STEP staff had based themselves across different sites to increase patients' accessibility to their service.

Most teams had a range of rooms and equipment to support treatment and care. For example, they had a clinic room to examine patients, enough chairs in the waiting area and therapy rooms. Some of the N-STEP and PCART teams had displayed patient's artwork to make environments more welcoming. The trust had considered patient's privacy and dignity by ensuring interview rooms had adequate soundproofing. They had also placed spyholes or windows in interview room doors for staff to discreetly check if the room was in use.

However, most teams shared sites with other teams, this meant there could be challenges with staff competing with other teams to book interview rooms. The trust was piloting a room sensor checking system at Campbell House, to improve this. PCART staff at St Mary's hospital team had limited space as patients sometimes had to stand whilst waiting for appointments and doctors saw patients in their offices, due to a lack of interview rooms. Patients and others also had to stand waiting for various teams in a corridor outside the N-STEP office. PCART south St Mary's staff had ordered a room dividing curtain for their clinic room, to give a patient privacy whilst

undressing. Staff had to keep the window shut to prevent others walking past the office from viewing the room or hearing conversations, yet this sometimes made the clinic warm.

Patients' engagement with the wider community

Staff ensured that patients had access to education and work opportunities, as appropriate. For example, patients could attend the trust's recovery college, based at Campbell House. Staff gave examples of supporting patients to attend adult education, for example, N-STEP staff were supporting a patient to develop their art portfolio to enter college.

Staff gave patients the trust's leaflets 'want to work, were here to help' which held employment specialist information and contacts. The N-STEP team had a dedicated employment advisor attached to the team and PCART teams had plans to recruit advisors into their teams. They supported patients returning to work and with work placement opportunities. N-STEP staff monitored how many of their patients were working and 13 (9%) patients were when we visited (compared to 33% 26 April 2018). However, five PCART patients said staff had not supported them to access education or work.

Staff supported 34 patients to keep contact with their families and carers. Patients were encouraged to develop and keep relationships with people that mattered to them, both within the services and the wider community. However, six PCART patients said staff had not supported them to keep relationships with others.

Most patients said staff (particularly support workers) helped them with socialisation and activities of daily living such as shopping. Staff told us they sometimes met patients for appointments outside of their home or office at community venues such as cafes. This helped patients develop their social skills in the community. PCART teams arranged for housing benefit advisors to attend offices to give support to patients. They gave examples of working with patients and community services such as charity led crisis cafes, supported living schemes, homelessness and substance misuse services.

N-STEP and PCART staff gave examples of supporting patients to attend community groups to improve their wellbeing, such as yoga and gardening at allotments.

Meeting the needs of all people who use the service

The PCART operational policy referenced the trust's duty to consider patients protected characteristics in relation to section four of the Equality Act 2010. Staff had referred to this in their service information leaflet. The trust had identified equality and diversity training as mandatory for staff, and managers had ensured that 95% of staff completed this.

The trust made adjustments for disabled patients, for example, the trust had ensured that team offices were accessible for patients or others with mobility difficulties, for example they had designated disabled car parking areas and accessible meeting rooms and toilets.

Staff ensured that patients could obtain information on treatments, local services and patients' rights. However, one patient said some information given to them was out of date. Staff gave patients' information in an accessible form. The trust had information leaflets available in a variety of languages. Staff could access interpreting or signing services when needed.

Staff did not record much information in care and treatment records about the support they gave to patients about their diverse needs. One PCART patient said they would have liked some spiritual guidance but staff had not offered support with this. However, staff had identified patient's ethnicity, religion and gender on records. Staff referred to supporting transgender patients to access the trust's gender identity clinic as needed.

PCART south team had developed a group at Danetre to support men with mental and physical health issues in response to local needs. Campbell House staff had displayed information for patients including lesbian, gay, bisexual and transgender support services. A staff member had specialist training and skills to work with patients with a learning disability. Staff had displayed a range of information for patients with a learning disability at the office.

N-STEP staff had gained information about local population demographics from the trust and local government census to consider how to tailor their service for local needs. When we visited, the manager had given information to staff about Ramadan so that they could support patients, as needed during this spiritual time. Staff visited the local university and schools to meet staff and raise awareness of their role and service, to encourage earlier engagement with young people.

Personality disorder hub staff had reviewed how they were meeting the community's needs. They had changed their service from a consultation service to offering support to local teams to meet the needs of patients. They had identified that most patients using their services were white British women and the local population demographic was 86% (white) and 50% female (including 1% transgender). They were discussing with commissioners about extending their service therapy to include child and adolescent services.

Listening to and learning from concerns and complaints

The trust received 62 complaints between 1 January and 31 December 2017 for this core service. This was 52% of all complaints received by the trust. The trust had upheld five of these, they partially upheld 18 and did not uphold 30. Patients and others had not referred any complaints to the Ombudsman.

Patients knew how to complain or raise concerns. PCART and N-STEP staff gave patients service information leaflets which included how they could make a complaint. PCART Corby had a board for patients to write on and give comments Staff had displayed the trust leaflet, 'We listen, we respond, we improve' at their offices. However, a minority of patients (four out of 40) we spoke with were unsure of how to make a complaint.

Staff protected patients who raised concerns or complaints from discrimination and harassment Staff knew how to handle complaints appropriately and referred to being able to access the trust intranet for information. The trust had developed a complaints information sheet setting out the procedure. Teams gave information about how they had listened and learnt after receiving patients' or other's complaints or concerns. For example, staff displayed 'You said, we did' boards at offices giving feedback on changes they had made in response to feedback. We saw examples of manager's letters following complaints investigations. PCART south Campbell House staff had reviewed their care pathway following feedback. Managers met with staff in response to patients' feedback about a long wait for their first appointment and improvements needed with communication. PCART north team had reduced their waiting times and put a water dispenser in their Corby waiting room in response to patient feedback.

Managers gave staff feedback on the outcome of investigation of complaints at team meetings and acted on the findings. However, one patient and two carers said the trust had not satisfactorily resolved their concern, although were aware of how to appeal the decision.

This core service received 62 (52% of all complaints received by the trust) complaints between 1 January 2017 and 31 December 2017. Five of these were upheld, 18 were partially upheld and 30 were not upheld. No complaints were referred to the Ombudsman.
The category with the most complaints was 'All aspects of clinical treatment' with 43 (69% of all complaints within the core service)

Team name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Referred to Ombudsman	Upheld by Ombudsman
Beechwood (Isebrook)	1	0	1	0	0	0
Early Onset Dementia	1	0	0	1	0	0
PCART	59	5	16	29	0	0
Personality Disorders (Team 63)	1	0	1	0	0	0

This core service received six compliments during the last 12 months from 1 January 2017 and 31 December 2017 which accounted for <1% of all compliments received by the trust as a whole.

Is the service well-led?

Leadership

The trust had arranged for the director of adult mental health services to oversee this core service. The management structure between them and team managers varied slightly. The two PCART managers were accountable to different service managers. The trust had employed three senior staff to support managers, including two band seven clinical leads in PCART south and a business support manager in PCART north teams. NSTEP had the same service manager as the PCART north manager. The head of psychology supervised the personality disorder hub manager.

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed. They could explain clearly how the teams were working to give high quality care. Leaders were visible in the service and approachable for patients and staff. Staff said the director and associate director and other managers were accessible, supportive and had a good understanding of the work they did.

The trust offered leadership development opportunities, including opportunities for staff below team manager level.

Vision and strategy

Staff knew and understood the trust's vision and values and how their team applied this in their work. The trust's senior leadership team had successfully communicated the trust's vision and values to the frontline staff in this service, for example, via posters, emails and the 'staff room' on the trust intranet.

The trust had operational policies to set out the teams' purpose. Staff had the opportunity to contribute to discussions about the strategy and for their service, especially where the service was changing. Teams had staff awaydays, some with patients to review their service against these values.

The PCART team had developed their own mission statement, 'A Community mental health service with a committed approach working together to inspire hope to enhance and achieve your potential to recovery'. N-STEP had developed 'our vision board' with staff and patients. They had

identified objectives from their team development day. The personality disorder hub team held away days and strategy days to focus on reviewing their service and future planning.

Culture

Staff felt respected, supported and valued. Staff felt positive and proud about working for the trust and their team. An example of this was many staff said their team were willing to go “the extra mile” to support patients. PCART north staff completed a sponsored event and fundraised £2,000 for extra gardening group equipment for patients.

Staff felt able to raise concerns without fear of retribution. Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. The trust had given staff small information cards to carry in case they needed to make contact.

Teams worked well together and where there were difficulties managers dealt with them appropriately. Managers spoke to staff about their career development and the support they needed in staff appraisals. Managers dealt with poor staff performance when needed. Staff had access to support for their own physical and emotional health needs through an occupational health service. The service’s staff sickness and absence rates were less than the national average for NHS trusts (4.2%).

Staff said the trust promoted equality and diversity and gave opportunities for career progression. For example, support staff had the opportunity to complete nurse training or staff could apply for secondment roles to other teams. The trust had recruited some peer support workers to teams who were former patients. Managers encouraged staff to take on lead roles within the organisation for example, for recovery, infection control, perinatal and fire marshal to utilise their skills and encourage diversity of work. Managers had flexibility to authorise staff career breaks to give staff the opportunity to develop themselves away from work. The trust had a mentorship programme to give more support to staff outside their teams. The trust recognised staff success within the service, for example, through staff awards.

During the reporting period there were no cases where staff have been either suspended, placed under supervision or were moved to a different team.

Governance

The trust had systems and procedures to ensure that the premises were safe and clean; there were enough staff; staff had access to training and supervision; staff assessed patients and most patients said the service met their needs. Managers monitored referrals and waiting times were and there were systems to review incidents to reduce the risk of reoccurrence.

Managers had a clear framework of what they should discuss at a ward, team or directorate level in team meetings to ensure that they shared essential information, such as learning from incidents and complaints and discussed. However, we considered that the PCART south team minutes we saw did not fully capture staff’s discussion.

Staff gave examples where they had acted on recommendations from reviews of deaths, incidents, complaints and safeguarding concerns.

Staff undertook or took part in audits and staff made improvements where needed.

Staff understood arrangements for working with other teams, both within the trust and external, to meet the needs of patients.

The trust have provided their board assurance framework, which details any risk scoring 27 or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. The four strategic ambitions outlined by the trust relating to this core service are as follows:

1 – Develop in partnership
2 – Build a sustainable organisation
3 - Quality
4 – Grow our staff capability

The trust has provided a document detailing their nine highest profile risks. Each of these has a current risk score of 15 or higher. None relate to this core service.

Management of risk, issues and performance

Staff kept a risk register either at a team or directorate level and could escalate concerns when required from a team level. Staff concerns matched those on the risk register.

The service had plans for emergencies, for example, adverse weather or a flu outbreak.

Information management

The trust used systems to collect data from teams that were not over-burdensome for frontline staff. Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Trust information was in an accessible format, and was timely, accurate and identified areas for improvement.

Trust information governance systems included confidentiality of patient records. Staff made notifications to external bodies as needed.

Team managers had access to most information to support them with their management role. This included information on the performance of the service, staffing and patient care. However, staff did not have easy access to incident themes for their service. They could not easily access centralised safeguarding information for their team.

Engagement

Staff, had access to up-to-date information about the work of the trust for example, through the intranet, bulletins and newsletters. Patients and carers could access information via the trust website and updates from individual teams.

Managers and staff had access to feedback from patients, carers and staff and used it to make improvements. For example, the personality disorder hub team invited patients with experience of using the service to attend governance meetings to help in service development.

The trust gave patients and carers opportunities to give feedback on the service they received in a manner that reflected their individual needs. The trust held ‘community recovery and co-production’ groups to give community mental health patients, carers and staff opportunities to influence developments. They were finding staff to lead on promoting recovery in teams. Patients and staff could meet with members of the trust’s senior leadership team and governors to give feedback on their experience of services directly and tell ‘their story’ to influence care and treatment.

Directorate leaders and managers engaged with external stakeholders such as commissioners to gain feedback on the service.

Learning, continuous improvement and innovation

Managers gave staff the time and support to consider opportunities for improvements and Innovation and this led to changes. For example, staff and patients had devised a form for patients

and carers to complete and bring to new appointments so they did not have to keep repeating information.

This core service has not applied for any external accreditation. However, N-STEP staff had reviewed their service against the 'Early Intervention in Psychosis Network' accreditation standards in preparation for applying for accreditation. They had highlighted some areas for improvement. The team attended East Midlands regional network meetings to give information and gain feedback on other services to aid in the development of their service.

The personality disorder hub team had developed links with another trust to mutually develop and improve their services and share good practice.

The trust had gained electric cars that staff could request to take out on home visits to patients, so they did not have to always use their own cars.

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

This core service has not been awarded an accreditation.

Mental health crisis services and health-based places of safety

Facts and data about this service

Location site name	Team name	Number of beds	Patient group (male, female, mixed)
Berrywood Hospital	136 Suite	1	Mixed
Kent Close	The Warren Crisis House	7	Mixed
St Mary's Hospital	136 Suite	1	Mixed
Trust Headquarters	Acute Liaison Service and Liaison Psychiatry	N/A	Mixed
Trust Headquarters	Urgent Care Assessment Team (North)	N/A	Mixed

Is the service safe?

Safe and clean environment

Safety of the ward layout

Managers had carried out ligature audits but had not identified all ligature points or provided any mitigation plans to assist staff to reduce the risks across the services. For example, we saw that the ligature risk assessment at the crisis house lacked detail, the assessment was generic and there was little mitigation in place to assist staff to managed potential risks.

The acute liaison assessment room in Northampton did not meet the Psychiatric Liaison Accreditation Network (PLAN) standards; there were ligature points and equipment in the room that could be used to cause harm. Staff had access to second assessment room in another part of the service that could be used for higher risk patients. However, this room contained a hospital bed that posed a ligature risk, there was no safety furniture and there was an anchor point at the top of the shutter that was in place to restrict access to other items.

The acute liaison assessment room in Kettering had ligatures points that had not been identified on the ligature risk assessment. The chairs in the room were lightweight; we raised this during the inspection and staff placed suitable furniture in the room at the time of the inspection.

At the Health-Based Place of Safety in Kettering the radiator grills were not included on the ligature risk assessment, the room contained power sockets that could be used to cause harm. Two of the chairs in the room were lightweight, we raised this at the time of the inspection and staff immediately removed the furniture and replaced it with 'safe' furniture. Staff told us that one occasion the visitor's room in Kettering and a meeting room at Northampton were used to as additional space to accommodate patients bought in under S136 arrangements. These rooms did not have safe furniture and contained other equipment that could be used to cause harm.

Ligature risk assessments for both crisis resolution and home treatment team locations covered only public areas such as reception and toilets. Ligature risks in clinic and meetings rooms had not been identified. Staff told us that patients would not be left alone in these areas.

The crisis house complied with mixed sex accommodation guidance. There were three designated male bedrooms and three designated female bedrooms. There was an additional bedroom which could be used for male or female patients and a female only lounge.

Staff working within the crisis resolution and home treatment team in Northampton had access to personal alarms and when activated the alarms sounded and were visible on a board located in reception. Staff working within crisis resolution and home treatment team Kettering had access to two alarmed rooms on site or were able to use rooms within hubs across the county. There was no alarm in the treatment room that was isolated from the rest of the service and staff did not carry personal alarms.

Staff working at the crisis house did not have access to room alarms or personal alarms. Managers told us the risk was mitigated by carrying mobile phones and staff that had contact with patients had received breakaway training (breakaway training supports staff in developing the skills and techniques to and protect themselves in aggressive situations where they have been threatened or physically assaulted).

Maintenance, cleanliness and infection control

In the most recent Patient-led assessment for the care environment (PLACE) assessment the trust received a score of 99.9 % for cleanliness

At the time of inspection, ward and service areas were visibly clean, had good furnishings and were well maintained.

Clinic room and equipment

The crisis house did not have a dedicated clinic room. Patients kept their own medication in a locked cupboard in their bedrooms.

The acute liaison mental health services did not have dedicated clinic room.

Crisis and home resolution treatment teams did not have sole use of clinic rooms and shared clinic rooms with other areas.

The Health-Based Places of Safety did not have dedicated clinic rooms and utilised clinic equipment from the nearby wards.

Safe staffing

Nursing staff

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			Trust target
Total number of substantive staff	At 31 January 2018	100.8	N/A
Total number of substantive staff leavers	1 February 2017–31 January 2018	10.5	N/A
Average WTE* leavers over 12 months (%)	1 February 2017–31 January 2018	11%	8-12%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 31 January 2018	18.3	N/A
Total vacancies overall (%)	At 31 January 2018	15%	10%
Total permanent staff sickness overall (%)	Most recent month (At 31 January 2018)	8%	4.2%

Substantive staff figures			Trust target
	1 February 2017–31 January 2018	6%	4.2%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 31 January 2018	59.1	N/A
Establishment levels nursing assistants (WTE*)	At 31 January 2018	38.1	N/A
Number of vacancies, qualified nurses (WTE*)	At 31 January 2018	5	N/A
Number of vacancies nursing assistants (WTE*)	At 31 January 2018	8.6	N/A
Qualified nurse vacancy rate	At 31 January 2018	8%	11%
Nursing assistant vacancy rate	At 31 January 2018	23%	12%
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 February 2017-31 January 2018	723	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 February 2017-31 January 2018	409	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 February 2017-31 January 2018	40	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 February 2017-31 January 2018	1069	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 February 2017-31 January 2018	0	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 February 2017-31 January 2018	61	N/A

*Whole-time Equivalent

This core service reported an overall vacancy rate of 8% for registered nurses at 31 January 2018.

Across the 12 months, there has been a steady decline in vacancy rates for registered nurses.

This core service reported an overall vacancy rate of 23% for registered nursing assistants.

Across the 12 months, vacancy rates for registered nursing assistants have fluctuated.

This core service has reported a vacancy rate for all staff of 15% as of 31 January 2018.

At the time of inspection managers told us that vacancy rates had improved due to recent recruitment.

	Registered nurses			Health care assistants			Overall staff figures		
Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
270 12 Acute Hospital Liaison Service	1.0	17.7	6%	4.0	6.0	67%	9.7	35.4	27%

	Registered nurses			Health care assistants			Overall staff figures		
270 12 C R H T Team - North	-1.1	21.2	-5%	0.3	7.5	4%	0.0	31.2	0%
270 12 C R H T Team - South	3.5	15.6	23%	1.6	5.5	30%	5.3	29.3	18%
270 12 Crisis Helpline	1.6	3.6	44%	1.2	3.0	39%	2.8	6.6	42%
270 12 Rapid Resolution Medical	0.0	0.0	0%	0	0	0%	-1.0	0.6	-173%
Section 136 Suite	0	0	0%	1.3	5.3	25%	1.3	5.3	25%
270 12 The Warren	0.0	1	0%	0.2	10.8	2%	0.2	11.8	2%
Core service total	5.0	59.1	8%	8.6	38.1	23%	18.3	120.1	15%
Trust total	141.2	1260.4	11%	123.7	990.5	12%	279.0	2560.1	11%

NB: All figures displayed are whole-time equivalents

Between 1 February 2017 and 31 January 2018, bank staff filled 723 shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 409 shifts for qualified nurses and 40 shifts were unable to be filled by either bank or agency staff.

Team	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
136 Suite	0	0	0
Acute Liaison Service and Liaison Psychiatry	391	76	17
The Warren Crisis House	1	0	0
Urgent Care Assessment Team (North)	331	333	23
Core service total	723	409	40
Trust Total	14171	10118	1440 (6%)

Between 1 February 2017 and 31 January 2018, bank staff to cover sickness, absence or vacancy for nursing assistants filled 1069 shifts.

In the same period, agency staff covered zero shifts and 61 shifts were unable to be filled by either bank or agency staff.

Team	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
136 Suite	252	0	44
Acute Liaison Service and Liaison Psychiatry	1	0	1
The Warren Crisis House	438	0	13

Team	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Urgent Care Assessment Team (North)	378	0	3
Core service total	1069	0	61
Trust Total	16465	1034	1456

Staffing rotas showed that managers were usually able to fill gaps on shifts by using bank staff.

When bank staff were used, managers tried to ensure that these staff were familiar with the ward areas. Additional shifts were also covered by permanent staff working additional hours.

Managers reported that they were able to adjust staffing levels to take account of patient presentation at the crisis house, acute liaison and the Health-Based Places of Safety. Staff that we spoke with on inspection told us that there was adequate staffing in place to ensure that patients had access to staff when needed and that activities and sessions took place.

This core service had 10.5 (11%) staff leavers between 1 February 2017 and 31 January 2018.

Across the 12 months, the core service turnover has remained below the trust target of 8-12%, their highest turnover occurred in February 2017 with 2.3%.

Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
270 12 Acute Hospital Liaison Service (B845)	25.7	6.27	24%
270 12 C R H T Team - North (B436)	31.2	1.6	6%
270 12 C R H T Team - South (B435)	24.0	2.61	10%
270 12 Crisis Helpline (B737)	3.8	0	0%
270 12 Rapid Resolution Medical (B340)	0.5	0	0%
270 12 Section 136 Suite (C694)	4.0	0	0%
270 12 The Warren (B861)	11.6	0	0%
Core service total	100.8	10.5	11%
Trust Total	3011.4	288.2	9%

The sickness rate for this core service was 6% between 1 February 2018 and 31 January 2018. The most recent month's data (31 January 2018) showed a sickness rate of 8%.

Across the 12 months, the sickness rates have constantly remained above the trust target of 4.2%,

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
270 12 Acute Hospital Liaison Service (B845)	10%	9%
270 12 C R H T Team - North (B436)	11%	5%
270 12 C R H T Team - South (B435)	7%	6%
270 12 Crisis Helpline (B737)	1%	1%
270 12 Rapid Resolution Medical (B340)	0%	0%
270 12 Section 136 Suite (C694)	16%	7%
270 12 The Warren (B861)	1%	4%
Core service total	8%	6%
Trust Total	6%	5%

Medical staff

Staff told us that there was adequate medical cover day and night. This ensured that a doctor could attend quickly in an emergency.

Between 1 February 2017 and 31 January 2018, bank staff to cover sickness, absence or vacancy for medical locums filled two shifts.

In the same period, agency staff covered zero shifts. No shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
UCAT	1560	2	0	0
Core service total	1560	2	0	0
Trust Total	26472	173	3508	0

Mandatory training

The compliance for mandatory and statutory training courses at 31 January 2018 was 49%. Of the training courses listed 16 failed to achieve the trust target and of those, 13 failed to score above 75%.

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	This core service	Trust target %	Trust wide mandatory/ statutory training total %
Raising concerns and whistleblowing	150%	90%	24%
Infection Prevention (Level 1)	100%	90%	37%

Training course	This core service	Trust target %	Trust wide mandatory/ statutory training total %
Safeguarding Adults Level 1	100%	90%	43%
Safeguarding Children (Level 1	100%	90%	43%
Falls Prevention Training - Level 2	100%	90%	93%
Resuscitation Level 3 - Immediate Life Support	100%	90%	62%
Fire Safety	89%	90%	72%
Infection Prevention (Level 2)	79%	90%	74%
Information Governance	76%	90%	67%
Safeguarding Adults (Level 2)	61%	90%	41%
Safeguarding Children (Level 2)	56%	90%	32%
Falls Prevention Training - Level 1	52%	90%	81%
Resuscitation Level 2 - Adult & Paediatric	48%	90%	62%
Duty of Candour	44%	90%	54%
Health, Safety and Welfare	41%	90%	19%
Safeguarding Prevent Health WRAP	34%	90%	32%
Resuscitation Level 1	29%	90%	16%
Learning Disability Awareness	26%	90%	31%
Conflict Resolution	25%	90%	39%
Equality and Diversity	25%	90%	23%
Mental Capacity Act DoLS	24%	90%	43%
Moving and Handling	20%	90%	29%
Core Service Total %	49%		47%

The trust provided refreshed training data at the time of inspection due to changes in the trusts recording of mandatory training. Overall core service compliance to mandatory training between October 2017 and May 2018 was at 86%. This was below the trusts target of 90%. During the same period there were two elements of mandatory training that fell below 75%; resuscitation level 2 at 67% and freedom to speak up at 71%.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed comprehensive risk assessments for patients and updated these regularly. We reviewed 31 care records and found that staff completed a risk assessment of every patient at the point of referral as part of the initial assessment. Staff updated the risk assessment as and when required. Staff used the trust risk assessment tool to assess and review risk.

Risk assessments were comprehensive and included risk to self, risk to others, risk to children physical risk, risk of neglect and risk history. A crisis plan was developed in conjunction with the patient where required.

Management of patient risk

Staff identified and recorded risks following incidents on the individual patient risk assessment form within the electronic system.

Staff increased the observations of patients when required to support patients in reducing the risk they posed where required.

We observed staff at the crisis and telephone support service dealing with risks from those who accessed the telephone support line by appropriately signposting, offering advice and referring onto other services were required.

Managers ensured that staff followed policies and procedures for the use of observation. Staff kept up to date records of the observations that were undertaken on the wards.

There had been no use of restrictive interventions across the core service in the last 12 months.

The trust was smoke free and had policies and procedures in place to support patient with this. Patients in the health based places of safety could access electronic cigarettes and patients at the crisis house could smoke in the community.

Informal patients at crisis house could leave at will; patients we spoke with confirmed this.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority have their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made 12 safeguarding referrals between 1 January 2017 and 31 December 2017, of which 12 concerned adults and zero children.

Referrals		
Adults	Children	Total referrals
12	0	12

Staff we spoke with on inspection showed detailed knowledge of safeguarding and described how they identified and made a safeguarding referral. Managers ensured posters identifying the safeguarding team and contact information were visible within the ward. Managers and staff reported a good relationship with the local authority.

Northamptonshire Healthcare NHS Foundation Trust has submitted details of zero serious case reviews commenced or published in the last 12 months (1 February 2017 to 31 January 2018) that relate to this core service.

Staff access to essential information

The trust used an electronic patient record system that all staff could access. All information needed to deliver patient care was available. When patients transferred from acute services staff relayed on paper records.

Medicines management

Medicines were stored securely in accordance with the provider policy. There was no dedicated clinic room across the core service. At acute mental health liaison services medication was

dispensed via Accident & Emergency. At the health based places of safety medication was dispensed from the adjacent wards. At the crisis house, patients bought in and stored their own medication in the bedroom safe; staff prompted and supported patients to take the required medication. The crisis and home resolution service shared the clinic room with other services.

Staff at the crisis and home resolution service in Kettering did not maintain accurate records of all medication. We reviewed 20 prescription charts and found that staff were not routinely recording on the prescription chart when they had given patient medication upon discharge.

Staff reviewed the effects of medication on patients' physical health regularly and in line with National Institute for Health and Care Excellence (NICE) guidance. This included electrocardiograms and blood results, which doctors reviewed.

All patients were spoke with told us that staff regularly explained their medication and side effects and impact on any physical health issues.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 January 2017 and 31 December 2017 there were four STEIS incidents reported by this core service. Of the total number of incidents reported, all incidents were under the category of apparent/actual/suspected self-inflicted harm. There was one incident that resulted in an unexpected death.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.

	Number of incidents reported			
Type of incident reported on STEIS	UCAT	Acute Hospital Liaison Service	The Warren	Total
Apparent/actual/suspected self-inflicted harm	2	1	1	4
Total	2	1	1	4

Reporting incidents and learning from when things go wrong

Staff described the electronic system to report incidents and their role in the reporting process. All staff, including bank had access to an online electronic system to report and record incidents.

Managers described the trust system from reporting the incident through to dissemination of incidents back to the service.

Managers discussed incidents with staff and learning points were discussed in team meetings, staff supervision and via emails, staff we spoke with were able to provide examples of service

improvement. At the crisis resolution and home treatment services we saw evidence of discussing incidents and lessons learnt at the weekly team meeting.

Managers held debrief meetings with staff and patients after incidents. Staff told us that they received support following incidents.

Staff across the service attended regular supervision, training and reflective practice sessions (STAR).

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no 'prevention of future death' reports sent to Northamptonshire Healthcare NHS Foundation Trust.

Is the service effective?

Assessment of needs and planning of care

Staff completed assessments for patients on referral and/or admission. We looked at 31 care plans. Generally care plans were up to date, personalised, holistic, recovery orientated and included physical health checks. Care plans at the crisis resolution and home treatment team in Kettering were generic and not person centred; there was little evidence of patient involvement.

Care plans at the crisis house captured the patients' views, short term goals and future plans. Patients' views and wishes were noted across all treatment records. We found that daily entries in patients' notes were personalised and captured the patients' day in a meaningful manner.

Due to the nature of the core service, care plans were brief but relevant and focused on short term goals and crisis management. Staff reviewed and updated care plans regularly across the service.

Best practice in treatment and care

Treatment interventions were suitable to the patient group and the nature of the service. Crisis resolution and home treatment offered a range of psychological interventions in line with the National Institute for Health and Care Excellence guidance.

Staff supported patient to have access to the GP for physical healthcare issues and follow up appointments. Physical healthcare screening took place across the service. The crisis resolution and home treatment held weekly physical health clinics to support patients in managing their physical health issues.

This core service participated in one clinical audit as part of their clinical audit programme 2017-2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Quarterly Record Keeping Audit	All clinical services both community and inpatient participate in the audit	Clinical	Not provided (carried out quarterly)	All areas have specific designed questions for their areas.	Quarterly Record Keeping Audit

Skilled staff to deliver care

There was a full range of professionals across the service to support care and treatment. The crisis resolution and home treatment teams had social workers, doctors, nurses, psychologists and support workers in post. They were recruiting for occupational therapy staff. Some services had student nurses and social workers on placement. The crisis house had volunteers and ex-service users in post that complimented the support workers.

Staff we spoke with were experienced and knowledgeable and had the essential skills to meet the needs of the patients group.

New staff attended induction and mandatory training and there was a period of shadowing from more experienced staff whilst they settled in to their roles. Support workers were encouraged to complete the care certificate.

Staff we spoke with told us that they felt supported in their role and could access appropriate training to assist them with their specific roles. Specialist training was available for those that needed enhanced training to deliver psychological therapies.

Appraisals for permanent non-medical staff

The trust's target rate for appraisal compliance is 90%. As at 31 January 2018 the overall appraisal rates for non-medical staff within this core service was 93%.

The one team failing to achieve the trust's appraisal target was C R H T Team - South with an appraisal rate of 88%

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
270 12 Crisis Helpline (B737)	4	4	100%
270 12 Section 136 Suite (C694)	4	4	100%
270 12 The Warren (B861)	11	11	100%
270 12 Acute Hospital Liaison Service (B845)	25	24	96%
270 12 C R H T Team - North (B436)	29	26	90%
270 12 C R H T Team - South (B435)	25	22	88%
Core service total	98	91	93%
Trust wide	3236	2934	91%

The trust did not supply any information regarding appraisals of medical staff for this core service

The trust's measure of clinical supervision data is sessions delivered

Between 1 January 2017 and 31 December 2017, the average rate across all 10 teams in this core service was 186% of the trust's target. Three of the four teams were below 100%, with the lowest compliance being reported at The Warren, with 25%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
270 12 Acute Hospital Liaison Service (B845)	82	79	96%
270 12 C R H T Team - North (B436)	132	355	269%
270 12 Crisis Helpline (B737)	16	6	38%
270 12 The Warren (B861)	8	2	25%
Core service total	238	442	186%
Trust Total	7604	9378	123%

Multidisciplinary and interagency team work

Regular team meetings were taking place across most of the services. Staff that worked within multi-disciplinary teams spoke positively about working with their colleagues and valued their contributions.

All locations had regular and effective handovers meetings where all patients were discussed. We saw evidence of good working relationships with external professionals and other organisations including GPs, local authority social services, housing, benefits and local support groups.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

As of 31 May 2018, 98% of the workforce in this core service had received training in the Mental Health Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

Staff we spoke with demonstrated a sound understanding of the Mental Health Act and the relevance to their patient group and their specific role. Staff at the health based places of safety were aware of recent changes in legalisation and explained to patients their rights.

Staff knew how to contact the approved mental health professional (AMHP) service. Acute mental health liaison teams discussed Mental Health Act assessments during handover.

We saw posters in various locations with details of an independent mental health advocacy service, which people using the service could contact for advice.

Good practice in applying the Mental Capacity Act

As of 31 January 2018, 24% of the workforce in this core service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

Staff we spoke with demonstrated a good understanding of the Mental Capacity Act and its five statutory principles. Staff knew how to access this knowledge and expertise within their team and within the trust and gave us examples to support this.

Across the service staff discussed and recorded capacity during the assessment and routinely thereafter. All patients at the crisis house had capacity to consent to an informal admission and management of their medication; which was documented in their care records.

There were no Deprivation of Liberty Safeguards applications made in the last six months across the service.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We observed staff to be caring, warm, empathic and respectful towards patients. Staff attitudes and behaviours when interacting with patients were responsive and provided appropriate emotional and practical support.

Staff supported patients to understand their treatment needs and consistently explained medication, side effective and treatment options.

Staff appropriately signposted patients to other services for additional support and treatment.

We observed a home assessment where we saw a good relationship between staff and the patient, including joint working and collaborative discussions at the crisis resolution and home treatment teams. We observed caring and compassionate interactions between staff and patients in the health based places of safety and at the crisis house.

All patients told us that they felt positive about the care they received from staff. Patients told us that staff were willing to help and treated them with consideration and dignity.

Involvement in care

Involvement of patients
At the crisis house and health based places of safety staff orientated patients to the environment upon admission. We saw that staff supported newly admitted patients and provided reassurance and support.

We reviewed 31 care and treatment records and saw evidence in care records of patient involvement in care plans across most locations.

Staff communicated with patients openly and honestly. Staff involved patients in discussion and decision around treatment.

Staff provided all patients the opportunity to give feedback on the service that they received.

An advocacy service was available. We saw posters and leaflets across locations for patient information. Patients were aware of this service.

Involvement of families and carers
Patients we spoke with told us that their carers were appropriately involved in their care planning. Carers confirmed that they were kept up to date and offered support. Carers were able to contact staff directly if they had had concerns regarding their relative.

Staff supported carers to give feedback on the service and there was an active carer's support group in place at crisis house.

Carers were provided with information on how to access a carer's assessment where appropriate.

Is the service responsive?

Access and waiting times

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'assessment to treatment'.

The core service met the referral to assessment target in the only target listed of the targets listed, which was for the Crisis Resolution Home Treatment Team

Name of hospital site or location	Name of team	Days from referral to initial assessment		Days from assessment to treatment		Comments, clarification
		Target	Actual (mean)	Target	Actual (mean)	
Trust headquarters	Crisis Resolution / Home Treatment	4 hours	0	4 hours	0	Treatment begins at the first face to face contact (where advice and support is given to the service user directly), so there is no difference between the two measures.

The crisis resolution and home treatment teams took a proactive approach to engaging with patients who found it difficult or were reluctant to engage with mental health services. This included re-engaging with patients who did not attend their appointments. A protocol was in place which included cold calling, contacting other professionals known to the patient and requesting a police welfare check.

Staff at the crisis resolution and home treatment teams started discharge planning with patients during their first appointment and at each contact thereafter.

Staff carrying out home visits in crisis resolution and home treatment teams offered morning, afternoon or evening appointments and gave patients three-hour timeslots.

The crisis house had no waiting list. Staff admitted patients without delay if there was a bed available. Patients could stay at crisis house for up to 7 days however extended admissions were provided when required.

The health based places of safety met there 24-hour targets and patients were always discharged or moved to a suitable placement within this timeframe.

The facilities promote comfort, dignity and privacy

The crisis resolution and home treatment teams saw most people within their homes; teams also had adequate rooms in their premises to see patients.

At the crisis house patients had their own bedrooms with a sink and storage. There were separate male and female toilets and bathrooms. Staff catered for patients' individual food preferences. Patients had access to a large garden area with outdoor seating and could access the garden at any time. There was open access to the kitchen where patients were encouraged to make their own drinks and meals.

On occasion the crisis house permitted patients to stay at their service that had not been formally admitted. This was due to a lack of appropriate bed space elsewhere in the trust. These patients did not have access to a bed but were offered the recliner chair in the lounges. The service only allowed one reclining chair to be used at any one time and ensured the privacy and dignity of the

patient was protected. Patient groups had been involved in the service design for the crisis house and had full involvement in how the service was operated. Between January 2018 and June 2018 four patients were admitted to these chairs, on three of these occasions there was no bed available for patients to sleep in overnight. Evidence showed one patient had avoided an impatient admission as a result of this intervention. Staff supported patients on a one to one basis when the reclining chairs were used.

Patients at the crisis house could personalise their bedrooms with items from home should they wish to. Due to the short admission period most chose not to.

Patients had access to their personal mobile phones at the crisis house and the Health-Based Place of Safety. Ward phones were available upon request.

The health based places of safety in Northampton and Kettering offered patients access to fresh air within a safe setting. Patients were able to enter the adjoining acute admission ward to use the garden area under staff supervision.

All patients we spoke with were positive about the meal choices available. Patients at the crisis house had access to the kitchen 24 hours a day; staff encouraged them to make their own drinks and meals. Patients described the service as a home from home.

Patients' engagement with the wider community

Most patients that accessed this service lived in the community. Admissions to wards were for the shortest period of time. Admission to the crisis house was voluntary and patients could leave at their own will.

Staff across the core service encouraged and supported patient to access community services. Staff supported patients to maintain contact with their family and carers. The crisis house had flexible visiting hours and staff encouraged patients to spend time at home and in the community.

Meeting the needs of all people who use the service

All locations we visited were accessible for people with mobility difficulties.

Information available was written in English. Staff said they could request literature in different languages if there was a need to do so. Staff were able to access hearing loops and sign language interpreters if required.

Staff ensured that patients were aware of their rights and provided them with written information. Staff provided information on local services and how to make a complaint.

Patients at the crisis house were able to choose their meals and were encouraged to shop and cook for themselves. Special dietary requirements, allergies and client preferences were catered for.

Listening to and learning from concerns and complaints

At the time of inspection, there were posters and leaflets in communal areas advising how to make a complaint. Staff knew how to deal with complaints and described how they advised patients to make a complaint. All patients we spoke with new how to make a complaint.

This core service received eight complaints between 1 January 2017 and 31 December 2017. One of these was upheld, two were partially upheld and three were not upheld. One complaint is ongoing and one was withdrawn.

Team name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Withdrawn	Ongoing
Acute Hospital Liaison Service	6	1	1	2	1	1
Acute Liaison Service and Liaison Psychiatry	1			1		
Urgent Care Assessment Team	1		1			
Total	8	1	2	3	1	1

This core service received 11 compliments during the last 12 months from 1 January 2017 to 31 December 2017 which accounted for 1% of all compliments received by the trust as a whole. We saw numerous compliments displayed in the staff office at crisis house thanking staff for the support and assistance provided to them.

Is the service well-led?

Leadership

Managers had a good understanding of their service and had the knowledge and experience to perform their role.

Staff we spoke with said that the managers and senior managers were visible and approachable and always available to them. Staff felt supported in their roles.

Managers told us that they had development opportunities and that they felt valued in their roles.

Vision and strategy

Staff we spoke with were aware of the organisation's values. All staff were passionate, caring and focused of patient recovery. During the inspection we observed staff displaying the values in their interactions with colleagues and patients.

Staff felt involved in service development and changes within their teams, they were aware of recruitment and future plans for the service. Staff at the crisis house were excited about the possibility of similar services opening in the future.

Staff we spoke with knew who the most senior managers in the organisation were.

Culture

Staff felt respected and valued in their roles. Staff felt positive about their roles and supported locally by their manager, staff were proud to work in the service.

Staff we spoke with said they knew how to raise concerns and knew that the trust had a whistle blowing policy which they could use if they needed to. Staff reported that they would do this without fear of retribution. All staff told us that their managers were approachable.

Morale at all teams was high, staff we spoke with told us there was a good level of team working and staff were happy to help each other out. Staff said they enjoyed coming in to work.

There were ongoing no bullying or harassment cases at the time of the inspection.

The trust had systems for monitoring compliance with annual appraisal of staff. Data provided showed 93% of staff had received an annual appraisal over the past 12 months. Most staff told us they received regular supervision and felt supported in the role.

The staff sickness rate for this core service was 6% between February 2017 and January 2018 which is above the trusts average of 4%.

Staff could access services and support for their own physical and emotional wellbeing.

During the reporting period there were zero cases where staff have been either suspended, placed under supervision or were moved to a different team. Zero staff have been suspended, zero were placed under supervision and zero were moved team.

Caveat: Investigations into suspensions may be ongoing, or staff may be suspended, these should be noted.

Governance

Most teams were having regular team meetings. These meetings had a clear agenda and ensured that essential information was shared including lessons learnt. In addition, there was regular supervision, training and reflective practice days. At the crisis house formal team meetings were not taking place however the manager ensured staff received essential information via handovers and supervision.

Staff were aware of lessons learnt and changes in practice across the trust. Staff told us they would get updates via team meetings and the trust intranet.

Staff across the core service worked together to ensure that the needs of the patients were met. Staff from the acute wards supported the health based places of safety on a rota bases to ensure that it was always appropriately staffed. Due to the nature of the service staff maintained in contact with each other and external services to ensure the needs of the patients were met.

The trust have provided their board assurance framework, which details any risk scoring 27 or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. The four strategic ambitions outlined by the trust relating to this core service are as follows:

1 – Develop in partnership

2 - Innovate

3 – Build a sustainable organisation

4 - Quality

5 – Grow our staff capability

The trust has provided a document detailing their nine highest profile risks. Each of these has a current risk score of 15 or higher. None relate to this core service.

Management of risk, issues and performance

Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required. Ward staff were able to submit items to the risk register. Staff ad a commitment to managing risk in a positive way.

The services had contingency plans in place for emergencies, for example, adverse weather conditions or a flu outbreak.

Information management

All teams visited used effective and robust systems to collect data from wards and directorates.

Staff had access to the equipment and information technology needed to carry out their roles. The information technology infrastructure was sufficient for staff to do their jobs.

Staff were aware of the need for patient confidentiality. Patient records could only be accessed with staff identity and a password.

Team managers had access to information to support them within their role. This included information on the performance of the service, staffing and patient care.

Staff made notifications to external bodies as needed.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used – for example, through the intranet, bulletins, and newsletters.

Regular updates were provided to ward staff.

Patients and carers had many opportunities to give feedback on the service they received in a manner that reflected their individual needs. Staff encouraged all patients to give immediate feedback about their experience of the service.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements**.** There are surveys, carers meeting and “Have you say” sessions. We saw “you said, we did” feedback displayed at some locations.

Patients and carers were regularly involved in decision-making about changes to the service**.** Collaboration between staff, carers and patients was clear and service development involved the participation of patients. For example, the crisis house was co-produced with patients and carers involvement in service development.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. Staff had opportunities to participate in research.

The service aimed to support individuals in the community to avoid admission to a hospital setting. Crisis house was a supportive, caring and alternative environment to hospital and reduced the number of admissions to wards.

Staff used quality improvement methods and knew how to apply them. Managers had access to staffing budgets.

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

There were no services within this core service have been awarded an accreditation in the period 1 January 2017 to 31 December 2017.

Community-based mental health services for older people

Facts and data about this service

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Danetre Hospital, London Road, Daventry, Northants, NN11 4DY	Older Adults CMHT Long Term Team	Not provided	Mixed
Watermill Resource Centre, Berrywood Hospital, Berrywood Drive, Upton, Northampton, NN5 6UD	Older Adults CMHT Long Term Team	Not provided	Mixed
Stuart Road Clinic, Corby, NN17 1RJ	Older Adults CMHT Long Term Team	Not provided	Mixed
The Rushden Centre, Newton Road, Rushden, Northants, NN10 0PT	Older Adults CMHT Long Term Team	Not provided	Mixed
Trust headquarters	Early Onset Dementia	Not provided	Mixed

Is the service safe?

Safe and clean environment

Staff completed regular risk assessments of the care environment. Some of the locations were used as a base only for staff. Locations attended by patients had ligature audits in place, or managers had a full awareness of the risks in the environment and added them to the risk register for the service. Risk was mitigated by staff escorting patients in all patient areas.

Interview rooms were fitted with alarms at some of the locations. Staff used rooms with alarms if needed where patient risk deemed it necessary.

There was a lone working protocol in place and staff used this effectively to manage risk. A duty system was in place which ensured someone was always responsible for checking staff whereabouts and safety at the end of each day. All locations used boards to show the whereabouts and appointments of staff and we heard examples of when managers contacted staff in emergencies or at the end of the day to ensure their safety. This was an improvement since the last inspection.

The service did not use clinic rooms as staff were not administering medication for any of the patients.

All areas were visibly clean, had good furnishings and were well maintained. Cleaning records were up to date and demonstrated that all locations were cleaned daily.

Staff adhered to infection control principles. We saw hand wash signs and hand wash throughout all locations.

Staff maintained equipment well and kept it clean. Clean stickers were visible and in date.

Safe staffing

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	31 January 2018	66.6	N/A
Total number of substantive staff leavers	1 February – 31 January 2018	7.2	N/A
Average WTE* leavers over 12 months (%)	1 February 2017 – 31 January 2018	11%	8-12%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	31 January 2018	7.1	N/A
Total vacancies overall (%)	31 January 2018	9%	10%
Total permanent staff sickness overall (%)	Most recent month (31 January 2018)	6%	4.2%
	1 February 2017 – 31 January 2018	6%	4.2%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	31 January 2018	30.6	N/A
Establishment levels nursing assistants (WTE*)	31 January 2018	25.4	N/A
Number of vacancies, qualified nurses (WTE*)	31 January 2018	-0.1	N/A
Number of vacancies nursing assistants (WTE*)	31 January 2018	2.6	N/A
Qualified nurse vacancy rate	31 January 2018	-0.3%	10%
Nursing assistant vacancy rate	31 January 2018	10%	10%
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 February 2017 to 31 January 2018	14	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 February 2017 to 31 January 2018	0	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 February 2017 to 31 January 2018	4	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 February 2017 to 31 January 2018	Data not provided	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 February 2017 to 31 January 2018	Data not provided	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 February 2017 to 31 January 2018	Data not provided	N/A

*Whole-time Equivalent

This core service reported an overall vacancy rate of -0.3% for registered nurses on 31 January 2018.

This core service reported an overall vacancy rate of 10% for registered nursing assistants on 31 January 2018.

This core service has reported a vacancy rate for all staff of 9% as of 31 January 2018.

	Registered nurses			Health care assistants			Overall staff figures		
Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
270 12 CPN Elderly Daventry (B409)	0.0	3.7	0%	1.1	2.3	48%	1.0	6.7	15%
270 12 Kettering/Corby OPCMHT (B417)	0.0	4.0	0%	0.0	3.0	0%	-0.5	7.5	-7%
270 12 Memory Assessment Service North (B415)	0.0	3.0	0%	1.1	1.8	61%	1.6	6.3	26%
270 12 Memory Assessment Service South (Daventry & S.Northants) (B414)	0.0	2.7	0%	1.0	3.7	27%	1.0	9.2	11%
270 12 Memory Assessment Service South (Northampton) (B408)	0.0	3.0	0%	0.0	2.5	0%	0.0	7.2	0%
270 12 Memory Assessment Service Well/Rushden (B852)	0.0	2.8	0%	-0.5	1.5	-33%	-1	5.8	-17%
270 12 Rushden/Wellingborough OPCMHT (B416)	0	4.5	0%	-0.3	4.7	-6%	0.2	9.7	2%
270 12 Watermill Resource Centre (B418)	-0.11	4.89	-2%	0.2	3.4	5%	0.08	8.31	1%
270 12 Young Persons Dementia Services (B447)	0	2	0%	0.003	2.5	0%	0.003	5.27	0%
Medical elderly South	-	-	-	-	-	-	4.8	9.8	49%
Core service total	-0.1	30.6	-0.3%	2.6	25.4	10%	7.1	75.7	9%
Trust total	141.2	1260.38	11%	123.7	990.5	12%	279	2560.1	11%

NB: All figures displayed are whole-time equivalents

Between 1 February 2017 and 31 January 2018, bank staff filled 14 of shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered zero shifts for qualified nurses and four shifts were unable to be filled by either bank or agency staff.

Team	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Early Onset Dementia	0	0	0
Older Adults CMHT Long Term Team	14	0	4
Core service total	14	0	4
Trust Total	14171	10118	1440

The trust did not supply any bank and agency data for this core service for nursing assistants.

This core service had 7.2 (11%) staff leavers between 1 February 2017 and 31 January 2018.

Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
270 12 CPN Elderly Daventry (B409)	5.7	0	0%
270 12 Kettering/Corby OPCMHT (B417)	8	2	24%
270 12 Medical Elderly South (B360)	4	1	24%
270 12 Memory Assessment Service North (B415)	4.7	0.8	14%
270 12 Memory Assessment Service South (Daventry & S.Northants) (B414)	8.2	1	12%
270 12 Memory Assessment Service South (Northampton) (B408)	7.2	1	13%
270 12 Memory Assessment Service Well/Rushden (B852)	6.8	0	0%
270 12 Rushden/Wellingborough OPCMHT (B416)	8.5	1.4	21%
270 12 Watermill Resource Centre (B418)	8.2	0	0%
270 12 Young Persons Dementia Services (B447)	5.3	0	0%
Core service total	66.6	7.2	11%
Trust Total	3011.4	288.2	9%

The sickness rate for this core service was 6% between 1 February 2017 and 31 January 2018. The most recent month's data (January 2018) showed a sickness rate of 6%.

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
270 12 CPN Elderly Daventry (B409)	17%	9%

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
270 12 Kettering/Corby OPCMHT (B417)	3%	4%
270 12 Memory Assessment Service North (B415)	0%	12%
270 12 Memory Assessment Service South (Daventry & S.Northants) (B414)	1%	2%
270 12 Memory Assessment Service South (Northampton) (B408)	5%	3%
270 12 Memory Assessment Service Well/Rushden (B852)	5%	10%
270 12 Rushden/Wellingborough OPCMHT (B416)	8%	3%
270 12 Watermill Resource Centre (B418)	11%	11%
270 12 Young Persons Dementia Services (B447)	0%	3%
Core service total	6%	6%
Trust Total	6%	5%

Medical staff

Between 1 February 2017 and 31 January 2018, 573 shifts were filled by agency staff to cover sickness, absence or vacancy for medical locums. Of these, 399 were at consultant grade and 174 were at middle grade.

In the same time period, bank staff covered zero shifts and zero shifts were left unfilled.

The trust was unable to break this information down to team level for this core service

Ward/Team	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Core service total	0	573	0
Trust Total	173	3508	0

Managers met monthly with their human resources business partner. Safe staffing levels were determined by calculating the number and grade of the multidisciplinary team required.

The number, profession and grade of staff in post matched the trust's staffing plan.

Managers assessed the size of the caseloads of individual staff regularly and helped staff manage the size of their caseloads. This was done routinely at during staff supervision. Caseloads at the Younger Persons Dementia service were approximately 40 per staff member.

The whole service used a duty worker system. This was a rota system that identified a staff member each day to respond to queries from patients and carers, arrange urgent appointments and cover the workload for staff who may be absent. This ensured patient safety within the service.

All community locations had rapid access to a psychiatrist if this was required and urgent appointments were arranged on the same day. However, there was limited access to a psychiatrist in the Young Persons Dementia service as this was a nurse-led service. A psychiatrist who worked within the inpatient older people's wards, was available to offer advice, see patients where necessary but was not assigned to the service.

Mandatory training

The compliance for mandatory and statutory training courses submitted by the trust at 31 January 2018 was 63%. Of the training courses listed all other than Safeguarding Children (Level 3), Falls Prevention Training - Level 1 and level 2 and, Resuscitation Level 1 failed to achieve the trust target and of those, 16 failed to score above 75%.

During the inspection we accessed updated data on mandatory training compliance. As of May 2018, mandatory training was at 91% for this core service. One training course, moving and handing level 2 failed to reach the trust target of 75% and was at 67%. All other mandatory training courses were well above the trust target.

Key:

Below CQC 75%	Between 75% & trust target	Trust target and above

Training course	This core service %	Trust target %	Trust wide mandatory/ statutory training total %
Resuscitation Level 1	120%	90	16%
Falls Prevention Training - Level 2	109%	90	93%
Falls Prevention Training - Level 1	102%	90	81%
Safeguarding Children (Level 3)	100%	90	40%
Infection Prevention (Level 2)	78%	90	74%
Resuscitation Level 2 - Adult & Paediatric	78%	90	62%
Safeguarding Adults Level 1	75%	90	43%
Safeguarding Children (Level 1	75%	90	43%
Duty of Candour	74%	90	54%
Information Governance	69%	90	67%
Fire Safety	67%	90	72%
Learning Disability Awareness	63%	90	31%
Infection Prevention (Level 1)	60%	90	37%
Safeguarding Prevent Health WRAP	55%	90	32%
Safeguarding Adults (Level 2)	52%	90	41%
Moving and Handling	50%	90	29%
Conflict Resolution	48%	90	39%
Dementia Awareness (inc Privacy and Dignity Standards)	48%	90	28%
Safeguarding Children (Level 2)	48%	90	32%
Mental Capacity Act DoLS	45%	90	43%
Resuscitation Level 3 - Immediate Life Support	40%	90	62%
Equality and Diversity	38%	90	23%
Health, Safety and Welfare	30%	90	19%
Raising concerns and whistleblowing	20%	90	24%
Total	63%	90	47%

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed 32 patient care records. Staff completed an initial risk assessment which they updated annually and routinely after any incidents. Of the risk assessments reviewed we found that 30 out of 32 contained robust and up to date information.

Staff used the trust risk assessment tool and the Health of the Nation Outcome scale (HoNOS) as part of their assessments.

We saw crisis plans and advance decisions in the patient care records.

Management of patient risk

Staff responded promptly to a sudden deterioration in a patient's health. There was a duty system in place at each location and staff escalated concerns and requested urgent contact with the psychiatrist if required.

Staff monitored patients on waiting lists at the weekly allocations meeting to identify and respond to increases in the level of risk. This happened at each location.

There was a lone working policy in place. Staff adhered to the lone working processes and managers and staff escalated any concerns effectively to ensure that safety was maintained.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made seven safeguarding referrals between 1 January 2017 and 31 December 2017, of which seven concerned adults and zero children.

Referrals		
Adults	Children	Total referrals
7	0	7

This trust has submitted details of no external case reviews commenced or published in the last 12 months that relate to this core service.

Staff access to essential information

All patient records were securely stored on an electronic recording system.

Staff had access to all the information needed to deliver patient care when they needed it. However, some staff were unsure of where and how to locate documents on the electronic recording system. The system allowed access to patient information via different routes, which meant where staff stored or entered information was in different places across the locations. Managers had identified this training need and had requesting further training on behalf of their staff teams.

Staff recorded assessments on a paper document and then scanned this onto the electronic patient record system. Other documents such as GP medical reviews and best interest assessments were scanned and stored in the patients' record.

Medicines management

There was no medication stored or dispensed to patients from the locations for community mental health services for older people. All locations used FP10 prescriptions. The use of prescription pads was routinely audited and doctors used lockable cabinets to store the prescription pads. Medication was also prescribed by the general practitioner (GP) and intra muscular medication was held by pharmacy. All relevant staff had sharps boxes for the disposal of needles.

There was a shared protocol between the service and the GP practices. Staff regularly reviewed the effects of medication on patients' physical health. Patients who were prescribed anti-psychotic medication had their physical health reviewed at six weekly, 12 weekly and annual intervals. The reviews were in line with guidance from the National Institute for Health and Care Excellence. Some GPs had access to electronic health records and in those cases physical healthcare was thoroughly documented. Staff ensured that where GPs who did not have access to the electronic record, they received regular updates from the GP about the physical health condition and medication reviews of their patients.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 January 2017 and 31 December 2017 there were two STEIS incidents reported by this core service. Both incidents were of the category Apparent / actual / suspected self-inflicted harm meeting SI criteria.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.

Type of incident reported on STEIS	PCART	CMHTOP Northampton	Total
Apparent / actual / suspected self-inflicted harm meeting SI criteria	1	1	2
Total			

Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no 'prevention of future death' reports sent to this trust.

Incidents were reported on an electronic recording system. All staff knew what incidents to report and how to report them. Staff reported all incidents that should be reported.

Staff understood the duty of candour and could explain what this meant. Managers encouraged staff to be open and transparent. Staff explained to patients and carers when something went wrong.

Staff received feedback from the investigation of incidents. Lessons learnt was a standing agenda item and was discussed during team meetings. The trust intranet had a page called 'staff room' where lessons learned are shared.

The service had made improvements in safety by reviewing their falls risk assessment as it was focussed on inpatients rather than patients based in the community.

Staff were debriefed and received support after a serious incident. If additional support was required staff could access counselling support from the psychology service.

Is the service effective?

Assessment of needs and planning of care

We reviewed 32 patient care records. Staff completed a comprehensive mental health assessment on each patient.

Staff ensured that any necessary assessment of the patients' physical health had been undertaken using a protocol shared with GP practices. Staff were aware of and recorded any physical health problems.

We saw that care plans were not completed under the care plans section of the recording system in 80% of the records reviewed, although there was evidence of plans of care in other areas of the patient records. However, staff ensured plans for care were documented in other areas of the patient record and staff shared these with patients, carers and GPs. This was often in the form of a letter.

Staff developed care plans for patients under the care programme approach that met the needs identified during the assessment. Of the 32 care plans reviewed during the inspection, 26 were personalised, holistic and recovery oriented.

Staff updated care plans when necessary and wrote regular summary letters to GPs about the care they provided.

Best practice in treatment and care

This core service participated in two clinical audits as part of their clinical audit programme 2017-18

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
Quarterly Record Keeping Audit	All clinical services both community and inpatient participate in the audit	Clinical	Not provided (carried out quarterly)	All areas have specific designed questions for their areas.
Dementia and Driving	Older Adults CMHT	Clinical	1 November 2017	adequate documentation, education to patients on driving.

Skilled staff to deliver care

The trust's target rate for appraisal compliance is 90%. As at 31 January 2018 the overall appraisal rates for non-medical staff within this core service was 94%.

The teams failing to achieve the trust's appraisal target were Kettering/Corby OPCMHT with 89%, Memory Assessment Service South with 88% and Young Persons' dementia service with 83%.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
270 12 CPN Elderly Daventry (B409)	7	7	100%
270 12 Kettering/Corby OPCMHT (B417)	9	8	89%
270 12 Memory Assessment Service North (B415)	6	6	100%
270 12 Memory Assessment Service South (Daventry & S.Northants) (B414)	8	8	100%
270 12 Memory Assessment Service South (Northampton) (B408)	8	7	88%
270 12 Memory Assessment Service Well/Rushden (B852)	6	6	100%
270 12 Rushden/Wellingborough OPCMHT (B416)	10	9	90%
270 12 Watermill Resource Centre (B418)	10	10	100%
270 12 Young Persons Dementia Services (B447)	6	5	83%
Core service total	70	66	94%
Trust wide	3236	2934	91%

As at 31 January 2018, the overall appraisal rates for medical staff within this core service was 100%.

The trust was unable to split the medical appraisal data by team/ward.

During the inspection we reviewed the most recent data available which indicated that in May 2018, the appraisal rate of compliance was at 100% for this core service.

Team name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals
All mental health inpatient and community services for older people	2	2	100%
Trust wide	38	32	84%

The trust's measure of clinical supervision data is sessions delivered.

Between 1 January 2017 and 31 December 2017, the average rate across all 10 teams in this core service was 138% of the trust's target.

Supervision compliance figures were high, as the teams counted staff meetings and STAR days as supervision. At the Young People's Dementia service, a psychologist assisted with provision of supervision to staff to assist the manager. The community mental health team in Daventry, used a rating system in supervision to review caseloads. Ratings ranges from red to high, amber as a concern and green for manageable caseloads.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
270 12 CPN Elderly Daventry (B409)	24	35	146%
270 12 Kettering/Corby OPCMHT (B417)	28	38	136%
270 12 Memory Assessment Service North (B415)	26	42	162%
270 12 Memory Assessment Service South (Daventry & S.Northants) (B414)	24	38	158%
270 12 Memory Assessment Service South (Northampton) (B408)	24	22	92%
270 12 Memory Assessment Service Well/Rushden (B852)	8	12	150%
270 12 Rushden/Wellingborough OPCMHT (B416)	40	54	135%
270 12 Watermill Resource Centre (B418)	40	51	128%
270 12 Young Persons Dementia Services (B447)	16	26	163%
Core service total	230	318	138%
Trust Total	7604	9378	123%

Multidisciplinary and interagency team work

Staff held weekly multidisciplinary team (MDT) meetings. We attended two MDT meetings, and saw that there was a detailed discussion on patients accessing treatment and a review of patients on the waiting list.

Staff shared information about patients at team meetings, supervision and at the multidisciplinary team meetings.

The service had effective working relationships with other teams within the organisation including the crisis team and older adults' inpatient services.

There were effective and strong working links, including effective handovers with primary care, social services and other teams external to the organisation. Staff effectively and frequently signposted patients to other agencies.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

The trust did not supply any data relating to Mental Health Act training for this core service

We obtained up to date information during the inspection of this service. The compliance rate for Mental Health Act training was at 88% for this core service.

Staff had a basic understanding of community treatment orders. There were very few patients who were on community treatment orders or any other section of the Mental Health Act.

Staff sought support on the Mental Health Act and the Code of Practice from the Mental Health Act office. Staff knew who the Mental Health Act administrators were.

The trust had an up to date Mental Health Act policy which reflected the most recent guidance.

Staff had easy access to the Mental Health Act Act policies and procedures and to the code of practice.

Staff were unable to give examples of any occasions in which they had worked with a patient detained under the Mental Health Act.

Good practice in applying the Mental Capacity Act

As of 31 January 2018, the trust submitted data to show 45% of the workforce in this core service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

At the time of inspection, we reviewed up to date data, and saw Mental Capacity Act training was above the trust target of 90%.

Staff that we spoke with had a good understanding of the Mental Capacity Act and the five statutory principles. The trust had a policy on the Mental Capacity Act and staff knew where this as and could access it easily.

Staff sought advice from the Mental Health Act office regarding the Mental Capacity Act.

Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the capacity to make it.

Staff assessed and recorded capacity to consent appropriately for patients who may have had impaired capacity. This was done on a decision specific basis with regard to significant decisions.

Staff held best interest meetings and made decisions in patients' best interests where they lacked capacity. Staff recognised the importance of the persons wishes, feelings, culture and history. We saw examples of best interest assessments, and decisions stored in the patients' records.

The service carried out regular audits of the Mental Capacity Act.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We were impressed by staff who were discreet, highly respectful and incredibly responsive in their interactions with patients. Patients told us that staff were always kind compassionate and very supportive. Of the 18 carers that we spoke with, without exception, all told us that staff were extremely dedicated, compassionate and supportive to both patients and families.

Staff always supported patients to understand and manage their care, treatment or condition. Staff provided patients and carers with information about their condition and treatment and followed up with further explanations on request. We saw several examples of this in appointments we were part of, and staff handed leaflets to patients and carers and gave every opportunity for them to ask questions.

Staff across all teams had excellent links with other services in the community to enhance the care of their patients. Staff frequently signposted patients to an extensive range of other services such as third sector organisations, carers groups, Alzheimer's society, Age Concern, Mind and the

citizens advice bureau. When patients and carers needed support to access other services, staff would make the referral for them. We heard frequent examples of staff escorting patients to appointments with other services.

Without exception, patients told us that staff treated them well and behaved appropriately towards them. We saw this when we observed eleven episodes of care during the inspection. Staff interaction with patients and carers was warm and heartfelt, understanding and sensitive, yet realistic and truthful, given the difficult circumstances of a patient's diagnosis.

Staff totally understood all the individual needs of their patients, including their personal, cultural, social and religious needs. The impact of the diagnosis on family and carers played a large part of the caseload held by staff, and staff held as much importance around the wellbeing of them as patients themselves.

Staff that we spoke with said that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.

Staff maintained the confidentiality of information about patients. Patient care records were stored securely and staff sought signed consent to share information.

Involvement in care

Involvement of patients

Staff always provided patients with a welcome pack when they accessed the service to inform them of the different services and support available. This included service leaflets, external leaflets, pathway information, medication information, and details on how to contact the service and out of hours support.

Staff involved patients, families and carers in their care planning and risk assessment through participation in care programme approach meetings and during appointments and home visits.

Staff communicated clearly with patients in a way that they understood their care and treatment. They used a range of methods of communication including using signers, easy read leaflets and by seeking support from carers and families where appropriate. Staff style of communication was soft, caring and meaningful and we saw this in all 11 episode of care we were part of during the inspection.

Staff involved patients in decisions about the service where ever they could. Some patients were working with the involvement team at the trust. The aim of this was to support co production in older adult services and included the recruitment and interviewing of new staff. Patients were also invited to participate in the service user reference group. We saw an example where a patients' family member delivered sporting activities to the local community. They made a suggestion to staff to use this opportunity to start a group with patients from the service. Staff embraced the idea and offered the family member further opportunity with their manager to discuss ideas.

A feedback survey was given to each patient at the end of each appointment. This allowed patients to routinely provide feedback on the service. The survey results were displayed at each location and updated monthly and the results were consistently high. In January 2018, the average score for all survey questions at the Danetre Hospital, Daventry was five out of five, with 100% of patients likely to recommend the service. In March 2018, the average score for all survey questions at the Rushden centre was five out of five, with 100% of patients likely to recommend the service.

Staff supported patients to make advance decisions. This was done gradually and sensitively, to allow patients to participate in the process at their own pace.

There were advocacy leaflets and posters on display in the reception areas of each location. Staff explained the advocacy service to patients and carers and made referrals as required

Involvement of families and carers

Staff informed and involved families and carers consistently and appropriately in the care of patients and provided them with support when needed. Staff offered access to carers groups in the local community because of the way they had forged strong links with such services. Staff embraced family members and carers as part of patient care. The wellbeing of family and carers was seen as highly important by staff working in this area.

Staff enabled families and carers to give feedback on the service they received via surveys which could be completed after each contact with staff. At Danetre Hospital, Daventry the survey score for staff was 100%, with patients rating dignity and respect towards them at 100%.

Staff provided carers with information about how to access a carers assessment. There were posters displayed on the walls on carers assessments and information was provided in the welcome pack when patients accessed the service.

Is the service responsive?

Access and waiting times

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'assessment to treatment'.

The core service met the referral to assessment target in one of the targets listed.

The core service met the assessment to treatment target in one of the targets listed.

Name of hospital site or location	Name of team	Service Type	Days from referral to initial assessment		Days from assessment to treatment		Comments, clarification
			Target	Actual (mean)	Target	Actual (mean)	
Trust headquarters	Older Peoples Community Mental Health Team (CMHT OA)	CMHT OA	126	55	126	55	Treatment begins at the first face to face contact (where advice and support is given to the service user directly), so there is no difference between the two measures.

The service had a clear criterion for which patients would be offered a service. This did not exclude patients who needed treatment and would benefit from it.

There were target times from referral to assessment and from assessment to treatment. The services provided were all within agreed targets.

The team could see urgent referrals quickly as the duty worker followed these up daily. Non-urgent referrals were seen within an acceptable time. At night and during the weekend patients were directed to contact the Crisis and Telephone Support Service (CATSS) which was open 24 hours per day, seven days per week.

The team responded promptly and adequately when patients telephoned the service. For urgent telephone calls the staff provided an appointment the same day.

Staff engaged with people who found it difficult or were reluctant to engage with mental health services. They did this by being flexible with appointment times, visiting the patient at home, considering the availability of carers or by contacting other services engaged with the patient to discuss joint visiting.

Staff attempted to make follow up contact with people who did not attend appointments by offering further appointments at flexible times, telephoning the patient, visiting the patient at home or seeking guidance from other services involved with the patient to try to promote engagement.

Staff were flexible in the appointment times offered to patients and considered the availability of carers where appropriate.

Staff rarely cancelled appointments. When appointments were cancelled, staff telephoned the patient to explain why and an alternative appointment time was provided.

Appointments usually ran on time and staff informed patients in person or by telephone call when they were running late.

Waiting lists were monitored weekly and patients on the waiting list were provided with contact numbers for the service and the Crisis and Telephone Support Service. However, the Young People's Dementia service had a waiting list of 74 patients waiting for assessment since their initial referral in March 2018. The service was a county wide service and staff took referrals from any source, both within the trust and from outside the trust. Staff made initial telephone contact with patients on receipt of the referral, but did not have capacity to see all appropriate referrals in a timely way. The service had started a process to review caseloads and discharge those who no longer needed input. Staff told us where previously, they would keep patients on their cases for intermittent reviews and monitoring as a safety net, this was no longer possible due to the demand on their service. The caseload review looked to discharge more patients from their caseload who no longer needed infrequent reviews.

Staff supported patients during referrals and transfers to other services for example, if they needed treatment within inpatient services.

Facilities that promote comfort, dignity and privacy

There was a range of rooms and equipment to support treatment and care at all the locations where patients were seen. Waiting areas had adequate seating, access to cold water, fruit juice, tea and coffee and disabled toilets. There were clinic rooms with couches to examine patients at the locations which were attended by patients. There were interview rooms and group rooms which staff used to provide services to patients.

Interview rooms had adequate soundproofing to ensure patient confidentiality.

Patients' engagement with the wider community

There was a range of rooms and equipment to support treatment and care at all the locations where patients were seen. Waiting areas had adequate seating, access to cold water, fruit juice, tea and coffee and disabled toilets. There were clinic rooms with couches to examine patients at

the locations which were attended by patients. There were interview rooms and group rooms which staff used to provide services to patients.

Interview rooms had adequate soundproofing to ensure patient confidentiality.

Meeting the needs of all people who use the service

There was disabled access and disabled toilets at all the sites attended by patients. There was a loop system in place at the Rushden Centre.

Staff provided patients with a welcome pack containing information about what to expect for the service. This included information on the range of available treatments, patient information, access to records, care programme approach meetings and advance decisions. There was an extensive range of leaflets and information on treatments, local services, advocacy, carers groups and carers assessments on display at all the locations

There were easy read leaflets available on request. Leaflets in different languages were available on request.

Managers ensured that staff and patients had easy access to interpreters and signers.

Listening to and learning from concerns and complaints

This core service received six complaints between 1 January 2017 and 31 December 2017. none of these were upheld, one was partially upheld and two were not upheld. Two complaints are ongoing and one was withdrawn.

Team name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Ongoing	Withdrawn
CMHTOP	2				2	
CMHTOP Corby	2			2		
CMHTOP Kettering	1		1			
CMHTOP Northampton	1					1
Total	6		1	2	2	1

This core service received eight compliments during the last 12 months from 1 January 2017 to 321 December 2017 which accounted for 1% of all compliments received by the trust as a whole.

Patients knew how to complain or raise concerns.

When patients complained or raised concerns, they received feedback from managers.

Staff protected patients who raised concerns or complaints from discrimination or harassment.

Staff knew how to handle complaints appropriately and could explain how they would support patients and carers to take complaints forward.

Staff received feedback on the outcome of the investigation of complaints and acted on the findings. Lessons learned was a standing agenda item and was discussed during team meetings. The staff intranet had a page called ‘staff room’ where lessons learnt were shared.

Is the service well-led?

Leadership

Leaders had the specialist clinical and managerial skills, knowledge and experience to perform their roles.

Senior managers had a good understanding of the services that they managed. They could explain clearly how the teams were working to provide high quality care.

Staff told us that senior managers were visible and approachable within the services.

Leadership development opportunities were available across the staff roles. Examples included clinical administrators within the service being given more complex duties to develop their skills, whilst being supported to study a level four diploma in Business and Professional studies. The service also employed staff on an apprentice scheme, which enabled them to gain work experience whilst being supported to gain relevant qualifications such as a national vocational qualification in business. Health care assistants were supported to study for nurse training and there was flexibility in the shift pattern to accommodate this.

Vision and strategy

Staff knew and understood the trusts vision and values and used them in their everyday work.

There were posters of the vision and values throughout all the locations within this core service.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing.

Staff could explain how they were working to deliver high quality care within the budgets available. Managers met with their HR Business partner monthly to discuss budgets and plans for service delivery.

Culture

During the reporting period there were zero cases where staff have been either suspended, placed under supervision or were moved to a different team. Zero staff have been suspended, zero were placed under supervision and zero were moved team.

We spoke with 30 staff during the inspection. All said that they felt respected, supported and valued by their immediate managers and by the trust as a whole.

Staff felt positive and proud about working for the trust and their team.

Staff felt able to raise concerns without fear of retribution. There was an open culture within the service and managers were described as approachable and transparent by staff.

The trust had a whistle blowing policy and staff knew where to access this and how to use it. Staff had been given a presentation by the Freedom to Speak Up Guardian and were familiar with this role.

Managers dealt with poor performance when needed. Senior managers and the human resources team provided support and guidance to managers.

Teams worked well together and where there were difficulties, managers dealt with them appropriately.

Staff appraisals included conversations about career development and how it could be supported. Staff told us that they had support from managers who would vary role responsibilities, working hours and offer support and guidance in career development.

Staff reported that the trust promoted equality and diversity in its day to day work and in providing opportunities for career progression. Staff with disabilities told us that managers provided reasonable adjustments, and staff with children with disabilities told us that managers were flexible and supportive in recognising responsibilities as carers.

Staff sickness and absence rates at this core service were low at 6%.

Staff had access to support for their own physical and emotional health needs through an occupational health service.

The trust and managers recognised staff success within the service and certificates of recognition and trophies were on display in staff offices.

Governance

The trust has provided their board assurance framework, which details any risk scoring 27 or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. The four strategic ambitions outlined by the trust relating to this core service are as follows:

1 – Develop in partnership

2 - Innovate

3 – Build a sustainable organisation

4 - Quality

5 – Grow our staff capability

The trust provided a document detailing their nine highest profile risks. Each of these has a current risk score of 15 or higher. None relate to this core service.

There were systems and procedures in place to ensure that all locations were safe, clean and secure. Staffing numbers were adequate with effective systems in place to maintain good patient care if there were unexpected staff absences.

All staff were trained, supervised and had annual appraisals at which value led objectives and goals were set for the coming year. Referral and waiting times were well managed, although there was a waiting list at the Young People's Dementia service. Patients were treated extremely well and given significant support to access this service and external services if required. The needs of carers were always considered and feedback, co-production and carers groups were fully embedded into the service.

There was a clear framework of what must be discussed within teams or taken higher to directorate level to ensure that essential information, such as learning from incidents and complaints was shared and discussed.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service and trust level.

Staff participated in clinical audits. The audits provided sufficient assurance and staff acted on the results when needed.

Staff understood arrangements for working with other teams both within the service and external to meet the needs of the patients. Staff liaised with the CATSS team daily to follow up on any out of hours referrals received the night before or during the weekend.

Management of risk, issues and performance

Managers maintained and had access to the risk register at team and directorate level and could escalate concerns when required.

Staff concerns matched those on the risk register.

The service had policies and contingency plans for emergencies such as adverse weather or a flu outbreak.

There were no cost improvements taking place which compromised patient care.

Information management

The service used systems to collect data that were not over burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructures, including the telephone system worked well and helped to improve the quality of care. However not all staff were clear on how to use the patient information system and struggled to locate documents quickly.

Information governance systems included confidentiality of patient records and confidentiality agreements were routinely signed by patients and stored appropriately.

Team managers had access to information to support them with their management role. This service had implemented an electronic dashboard system which provided a robust process for information gathering that managers used with ease and efficiency.

Information was in an accessible format and was timely, accurate and identified areas for improvement. The dashboard highlighted when action needed to be taken, for example to ensure that training or supervision remained within compliance targets.

Staff made notifications to external bodies as needed.

Engagement

Staff, patients and carers had access to up to date information about the work of the trust and the services they used. This was available through posters, leaflets and ‘you said we did’ boards which were displayed in reception areas.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Staff encouraged patients to complete the “I want great care” feedback leaflet after each appointment.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

Patients and carers were involved in decision making about changes to the service

Patients and staff could meet with members of the trusts’ senior leadership team and governors to give feedback.

Directorate leaders engaged with external stakeholders such as commissioners and HealthWatch.

Learning, continuous improvement and innovation

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

There were no services within this core service have been awarded an accreditation in the period 1 January 2017 to 31 December 2017

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. All staff attended STAR days, held every six weeks. STAR days also provided a forum for staff training and to discuss future plans for the core service and the trust as a whole.

Staff had opportunities to participate in research. Teams had participated in two national research projects. Managers were working with National Health Service Executive on developing services for younger people with dementia across counties. Staff at the Young People's Dementia service were experts in their field and had links with national networks and leading clinicians in this area. At least three of the five locations met with a regional group who led on innovations in the field of dementia.

Staff used quality improvement methods and knew how to apply them.