Care Quality Commission

Northamptonshire Healthcare NHS Foundation Trust

Evidence appendix

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Date of inspection visit:

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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 25 locations registered with the CQC (on 1 August 2019).

Registered location	Code	Local authority
St Mary's Hospital	RP1A1	Northamptonshire
Manfield Campus	RP1A2	Northamptonshire
The Squirrels	RP1D7	Northamptonshire
Corby Community Hospital	RP1E1	Northamptonshire
Isebrook Health Campus	RP1F2	Northamptonshire
St James Community Health Clinic	RP1G9	Northamptonshire
Danetre Hospital	RP1J6	Northamptonshire
John Greenwood Shipman Centre	RP1JG	Northamptonshire
Her Majesty's Prison (HMP) Onley	RP1M9	Northamptonshire
Battle House	RP1N5	Northamptonshire
Willowbrook Health Centre	RP1P1	Northamptonshire

Registered location	Code	Local authority
Willow Close	RP1Q9	Northamptonshire
Berrywood Hospital	RP1V4	Northamptonshire
The Sett	RP1V6	Northamptonshire
Trust Headquarters	RP1X1	Northamptonshire
Isebrook Health Campus	RP1X3	Northamptonshire
HMP Rye Hill	RP1X4	Northamptonshire
HMP Bedford	RP1X5	Bedfordshire
Kent Close	RP1X7	Northamptonshire
HMP Swinfen Hall	RP1X9	Staffordshire
HMP Stocken	RP1Y1	Rutland
Her Majesty's Prison Whitemoor	RP1Y4	Cambridgeshire
HMP Littlehey	RP1Y5	Cambridgeshire
Rainsbrook Secure Training Centre	RP1Y6	Northamptonshire
Danetre Hospital	RP1Y8	Northamptonshire

The trust had 349 inpatient beds across 26 wards, 20 of which were children’s mental health beds. The trust also had 84 acute outpatient clinics, 60 community mental health clinics 60 community physical health clinics per week and 31 dedicated EOLC inpatient beds.

Total number of inpatient beds	349
Total number of inpatient wards	26
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 acute outpatient clinics per week	84
Total number of community mental health clinics per week	60
Total number of community physical health clinics per week	60
Total number of dedicated EOLC inpatient beds	31

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is this organisation well-led?

Leadership

The executive board consisted of a range of people from a variety of clinical professions and business backgrounds, appropriate to their roles in the trust. The board had representation from minority groups and groups with protected characteristics. The executive board had no black and

minority ethnic (BME) members and three women. The non-executive board had one BME member and five women.

It was clear that those appointed to all positions of senior leadership had the appropriate skills, knowledge and experience to perform their roles. Directors and deputy directors were in place for all services for adults and children across mental health and community health services. Executive directors and non-executive directors had clinical services aligned to their roles, which they regularly visited, completed board walks and supported teams within those services. We reviewed five personnel files of director posts and found fit and proper person checks were robust and well organised and reviewed regularly.

The board had a strong focus on leadership development through the 'Leadership Matters Programme'. This programme of training and development for leaders across the trust, placed an emphasis on inclusivity, collaboration, working across boundaries, relationship building and collective leadership. We heard how all staff were empowered to take responsibility for nurturing cultures of high-quality compassionate care. The trust embedded their PRIDE and leadership values within this programme and considered them integral to all interventions (taking responsibility, embracing change, being authentic and working together). Over 1500 staff attended the programme between 01 April 2018 and 30 June 2019.

The trust delivered a range of additional Leadership Matters events between April 2018 to June 2019, where 981 staff attended festivals, conferences, and workshops. These events included topics such as health and well-being, the trust strategy, 'Keeping everyone safe week' and career development sessions.

The trust had demonstrable succession planning at board level. In April 2019, the board delivered a talent workshop at senior executive board where agreement for next steps in succession planning were made. We saw evidence of the talent management programme in place and a recent update provided to the executive board in August 2019. It included a plan for the forthcoming five months. This consisted of a redesign of talent paperwork, a data capture process to realise the scope of staff ready to progress; plans to identify a senior talent pool and a plan to pilot a talent programme concluding in December 2019 with the aim of a full roll out to the trust in 2020. Executive directors had completed talent conversations with their team members and in total, 39 staff were ready for promotion into executive roles, now or with development (42% of senior leaders).

The trust was recognised nationally for an extensive array of local and national awards between 2018 and 2019. These awards acknowledged a variety of innovations and quality care, but also recognised outstanding leadership. In November 2018, the trust won the Health Service Journal (HSJ) Trust of the year 2018 award. The chief executive was ranked by the HSJ in the top 30 of chief executives nationally in 2019, and the director of human resources (HR) and organisational development was shortlisted for HR director of the year in 2019.

The leadership team had a comprehensive knowledge of current priorities and challenges across all sectors of the county healthcare system and took action to address them. The trust had a significant leadership role in the county through the Northamptonshire Health and Care Partnership (NHCP) Board. The CEO was chair and executive sponsor. Other directors and senior leaders had a strong place in the wider system where they influenced, led or were involved in a specific role with the NHCP. This meant the trust had a strong position to drive important areas of healthcare delivery for the county; in particular, finance, workforce, communications, and sponsored workstreams in community, social care and mental health. The board were well sited

on challenges within the wider health system, nationally and locally and we saw evidence of the issues facing the trust (local government finances, safeguarding, social care constraints) had been discussed and monitored at board, and the potential impact for the trust. Such leadership in the wider system led collaborative work with the commissioning groups to form a Mental Health Transformation board. This group, led by the CEO steered care pathways, and sought to develop a new longer-term outcome based approach to mental healthcare for users and carers.

The trust had ensured sustained involvement in leadership networks, clinical networks and partnership working. For example, we saw how seven managers had active roles in leading projects and service innovation in areas such as older adult mental health, reducing restrictive practice; psychosis national and regional forums; special interest groups, crisis custody and perinatal service workstreams, and secure environment forums. This demonstrated how managers shared their knowledge and expertise in their fields, with a drive to improve their own services as leaders.

Since our last inspection, the trust had fulfilled many requests from other NHS organisations to share their journey from good to outstanding. Board members shared their experience, the trust strategy and other corporate strategies. In the summer of 2019, at the request of NHS Improvement / England, the trust set up a formal buddy arrangement with a neighbouring NHS trust. Subsequently, based on the high performance of NHFT and their track record for outstanding culture and leadership, the chief executive became the joint CEO for both trusts. The succession planning in place, confidence and strength of those on the board, allowed the CEO to take up the joint role. We saw evidence of robust discussion in the lead up to the decision, internally and with external stakeholders. We heard how roles of the executive team had been extended within the wider system, to cover that of the CEO. A deputy chief executive role was appointed to at NHFT, and succession planning in place served to create additional development opportunities for others.

Non-executive directors and governors had opportunity to challenge and question the idea of the joint role, and not until all parties agreed and supported of the idea, did the arrangement go ahead. During the initial three to four months of the arrangement, the board continued to explore the support systems in place for all board members, the CEO, and had oversight of the process. We were struck by the level of care the board and governors had for the well-being of the CEO.

The role was mutually beneficial for quality improvement and was supported by NHS Improvement and the Care Quality Commission. Since the role started, there had been significant positives and learning for both organisations.

We would encourage the board to continue with this approach and ensure robust oversight of the arrangement continued, opportunity at board to challenge and review the CEO's joint role and ensure that NHFT do not lose their focus on their own priorities.

Vision and strategy

The trusts' mission, vision and values were soundly embedded and continued to resonate with all staff we spoke with in the trust. They culminated in a trust road map, which was a thread of all communications across the trust. The trust mission of 'Making a difference for you, with you' continued to be the foundation pillar of the organisation. Staff across the trust were clear on the trusts' direction and clearly and eloquently described what it meant to them personally. All material produced by the trust clearly communicated its' vision. The trust vision 'To be a leading provider of outstanding, compassion care' was a visible and palpable goal for everyone we spoke

with. From ward to board, staff knew how their day to day work contributed to both the mission and vision. This message had weaved deeper into the make-up of the organisation since our last inspection.

The trusts' co-produced strategy (5:4:3:2:1) was clear, robust and understandable to all. We were assured the strategy was well scrutinised, had oversight and was realistic. It was presented in five simple pages with symbols, pictures and words. The board were sited on the progress of the strategy, and minutes of board meetings demonstrated discussions which reviewed the progress against the strategic plan. We saw how the board had approved five strategic priorities for 2019 to 2020 which worked towards the overall strategic objectives. Each priority had sub projects to deliver, with 71 in total. We saw that 70% had been completed, 28% were on track for completion and 1% was off track.

The trust was fully aware of the issues to challenge the success of the strategy. These challenges were directly linked to the wider health system and the social care economy. The executive and non-executive directors were well sighted on these challenges and knew the wider system well due to their involvement in the HCP, and wider national networks. The challenges were a growing and ageing population, changing expectations, funding challenges, less opportunity to embrace innovation and less opportunity to work in partnership.

The five themes of the strategy remained consistent since our last inspection. The acronym DIGBQ continued to describe what the trust needed to accomplish in order to achieve their vision.

- Develop in partnership
- Innovation
- Grow our staff capability
- Build a sustainable organisation
- Quality and safety at the foundation of all we do

The trust leadership behaviours were well communicated and embedded across the trust. The leadership matters programme and events rolled out to almost 2,500 senior staff ensured they knew how to contribute through their behaviour to the trust strategy and mission (taking responsibility, embracing change, being authentic and working together).

PRIDE values remained consistent and were soundly embedded in the working lives of staff. It was evident during our inspection; these values drove the day to day behaviours of staff.

Culture

The organisational wide positive and caring culture had continued to grow from strength to strength since our last inspection. Kind and caring attitudes were seen throughout the trust in interactions between staff, patients, families, and with each other. From ward to board we saw mutual respect, compassion and a drive to deliver high quality, person-centered care. The trust used hashtags to identify themselves in communications across the trust and externally: #weareNHFT and #teamNHFT.

There was a culture of appreciation and recognition in the trust. The trusts' intranet page (the staff room) had a section called the 'thank you initiative'. Whilst we saw this at our last inspection, this work had continued. Staff publicly thanked their colleagues for a gesture, a kind word or something which had impacted another. Senior leaders sent personal postcards and pin badges to staff to thank them for their contributions.

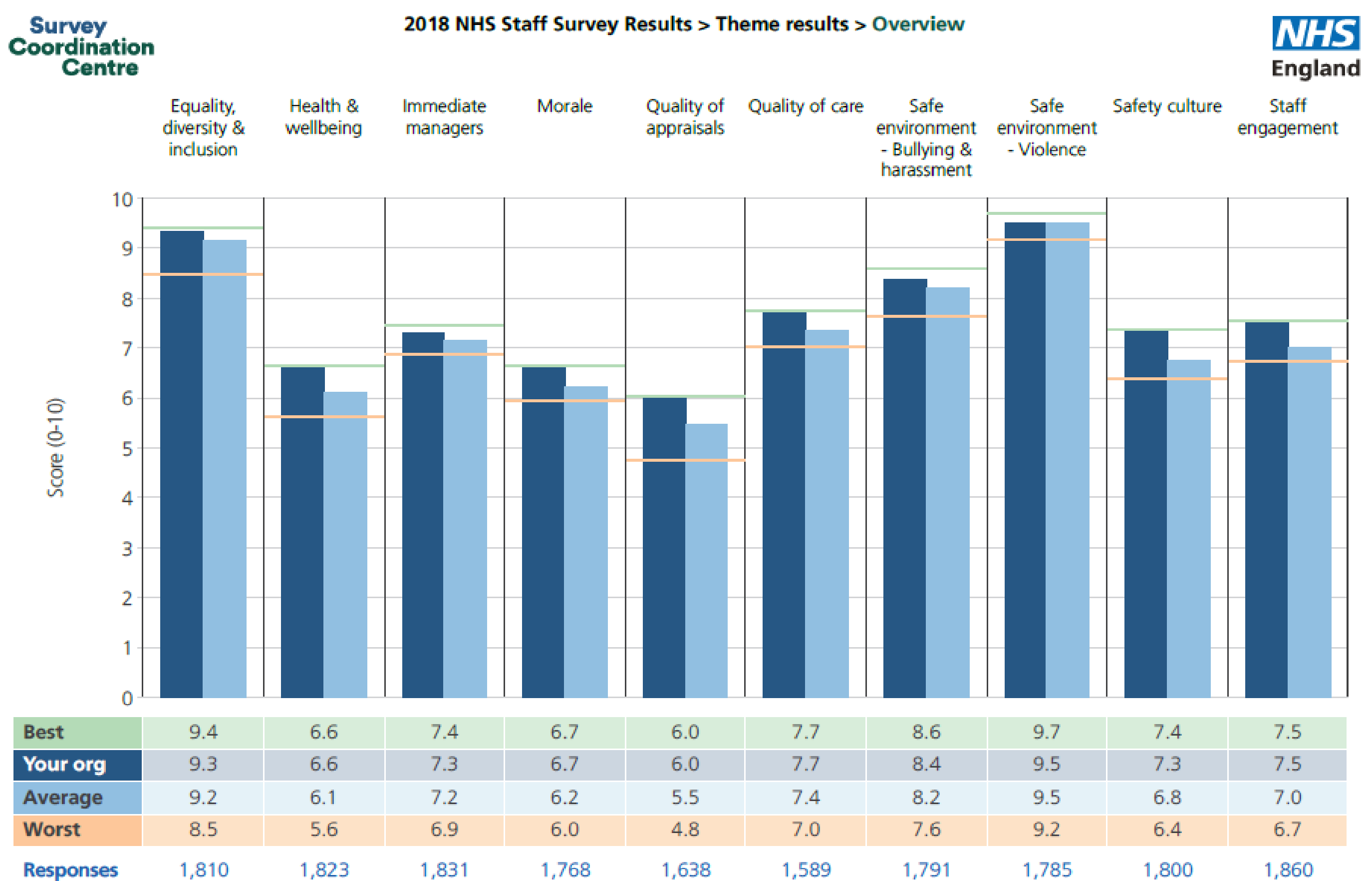
As a result, in May 2019, the trust was shortlisted for the HSJ Patient Safety award in the Changing Culture category. Criteria for the award considered that cultural change was 'an institutional endeavour' and included everyone form board to frontline staff. Evidence considered for the award was how the trust implemented a supportive culture where errors can be voiced, and staff felt free to speak up and raise concerns without fear. This category recognised the trust where cultural change had driven clear acceptance and belief that patient safety was the responsibility of all staff. The award required evidence to show that all staff were involved in cultural change across the organisation.

The trust had sustained accreditations in place for health and well-being, which included the 'Workplace well-being charter', endorsed nationally by Public Health England, a living wage

employer, a disability confident employer, (a government scheme which works with employers to remove barriers and increase understanding to ensure disabled people have opportunity to fulfil their potential); Armed Forces Covenant employer – silver recognition (a scheme to be supportive of those who served in the armed forces) and 2019 Stonewall Diversity Champions (inclusive employers for LBGTQ+ employees).

The trust continued to celebrate staff success with their NHFT Quality Awards within nine award categories, two of which are open to patients, carers and families to vote for staff. Three award categories were presented at an annual awards event. We heard from staff how these awards contributed to the feeling of pride to work for the trust and recognised high quality standards of care.

The following illustration shows how this provider compares with other similar providers on ten key themes from the 2018 NHS Staff Survey. Possible scores range from zero to ten – a higher score indicates a better result.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.4	6.6	7.4	6.7	6.0	7.7	8.6	9.7	7.4	7.5
Your org	9.3	6.6	7.3	6.7	6.0	7.7	8.4	9.5	7.3	7.5
Average	9.2	6.1	7.2	6.2	5.5	7.4	8.2	9.5	6.8	7.0
Worst	8.5	5.6	6.9	6.0	4.8	7.0	7.6	9.2	6.4	6.7
Responses	1,810	1,823	1,831	1,768	1,638	1,589	1,791	1,785	1,800	1,860

In addition to the strategic objectives, the board agreed additional focus in four key programmes: digital transformation, primary care networks and PLACE, mental health and the ‘Keep everyone safe’ project. They served as a way for the trust to continue to develop, innovate, grow and build on the trust culture, and deliver on their mission of ‘Making a difference for you, with you’. The board delivered these key programmes via three leadership matters events since our last inspection.

The trust’s 2018 scores for the following themes were significantly better when compared to the 2017 NHS Staff Survey:

- Health & wellbeing
- Immediate managers
- Safety culture
- Staff engagement

Year on year improvements in five questions of the staff survey, showed the trust treated staff fairly if involved in a near miss or incident; staff had an appraisal in the last 12 months; staff were satisfied with the value the organisation places on their work; staff were satisfied with levels of pay and staff were satisfied with the level of recognition received for the work they did.

The trust was above the national average in five further areas; staff regularly received updates of patient experience feedback; the trust took positive action on health and well-being (second nationally); recommended the trust as a place to receive care; would recommend as a place to work; and a safe culture (fourth nationally). The trust was the highest scoring trust on the theme of morale.

The areas for improvement within the staff survey included reducing bullying and harassment between colleagues, better involvement from managers when making decisions which affect staff, address longer working hours which may impact on health and well-being and incidents that could have hurt patients. The trust focused on a theme of a ‘Let’s talk’ engagement plan to address these issues.

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

The percentages of White and BME staff in each of the Agenda for Change (AfC) pay bands 1 to 9, and at Very Senior Manager (VSM) level (including executive board members), compared with the percentage of staff in the overall workforce: From 2018 to 2019, overall BME representation in the workforce increased from 10.13% to 11.76%. Representation increased in three out of six bands at 8a and above.

In 2019, white candidates were 1.39 times more likely than BME candidates to get jobs for which they had been shortlisted. The trust performance against this measure has improved from 1.72 times more likely in 2018.

BME staff were 1.96 more likely to be disciplined when compared with white staff. This had decreased from 2.31 times more likely in 2018.

In 2019, white staff were 1.00 times more likely to take part in voluntary training than BME staff.

The percentage of BME staff on the board was 14% compared with 11.76% BME staff in the overall workforce. The percentage difference between the board voting membership and overall workforce was -6.0%.

At our last inspection, we acknowledged positive work the trust had done to improve equality and diversity across the trust. An enthusiastic appetite remained which embraced the needs of a diverse workforce and we heard plans of how the trust wanted to action this. Executive directors and senior leaders fully supported the equality and inclusion agenda. We heard about internal initiatives and strong links with community groups to support the agenda.

At this inspection, we saw that the trusts' staff networks (with executive director leads) were more established and had increased in their memberships. The trust had seen improvements in six out of nine workforce race equality standards (WRES). Links with national and local equality networks had continued. We heard of the trusts' three-year journey that had promoted courageous conversations, encouraged career progression and barriers to opportunity for minority groups. However, challenges remained for this agenda. Whilst there had been an improvement in membership of networks, in particular the BME network, not all middle managers were supportive of staff attending or understanding the needs of this minority group. Some BME staff told us they were not aware of the opportunities available for career progression and felt that managers attitudes towards them was derogatory, less favourable than their white colleagues and prejudice remained in some areas of the trust. Other BME staff spoke positively about improvements they had seen and stated they felt positive to speak up, executive directors had embraced BME issues, and "working here was like another world".

Executive directors and senior leaders acknowledged there was work still to be done in forging ahead with the equality and inclusion agenda. This included how the trust encouraged BME staff to speak up with confidence, and afforded opportunity to BME members for career progression. The staff survey and the results of the latest WRES data demonstrated an increase in BME staff who reported feeling harassed or bullied. Executive directors told us this was unacceptable and needed to change. In response to the challenges, the trust delivered career development workshops, reverse mentoring, equality and inclusion awareness training, listening groups and roles for cultural ambassadors. An additional question had been added to the staff survey about cultural and spiritual needs to ensure data capture was more accurate.

The trust delivered three 'Unlocking potential' (career development workshops) for BME staff to attend to raise awareness of career progression. We heard examples where a Band 5 nurse succeeded into a team leader role as a result of attending the workshop; three BME staff had been successful to secure nurse prescriber roles. A BME executive committee was planned for band 7 staff to support BME staff to apply for higher grade positions in the trust.

Reverse mentoring had been embraced by eight executive directors since the summer of 2018. This opportunity saw BME staff mentor executive directors and the chance for them to share experiences, challenge thinking and support each other. Both BME mentors and executive directors relayed stories of how powerful and life changing the experience had been. BME staff told us the executive directors' enthusiasm for the scheme was refreshing. They told us that trust, respect and support amongst staff had improved in the last year. The approach was moving to a second cohort at deputy director level within the organisation in October 2019 with volunteers to act as mentors identified.

The trust had six cultural ambassadors to act as role models, representatives and a critical friend for staff of BME backgrounds in grievances, complaints and disciplinaries. In 2018 to 2019 the number of disciplinaries for BME staff had decreased from 10 in the previous year to six.

The trust had many other equality, diversity and inclusion initiatives underway to further develop their already strong position. The BME network had supported a project to deliver a 'Culture Web' to measure the trusts' culture for equality, diversity and inclusion to support the action plans for

this agenda. The trust was proactive in promoting access to mental healthcare for minority groups in the wider community. It delivered a project called ‘Moving Ahead’ which delivered public engagement events with the two main local acute trusts, libraries, commissioners, and local community minority groups to raise awareness of access to mental healthcare. As part of the project, the trust delivered a conference in February 2019 for stakeholders in Northamptonshire to address the challenges and approaches to minority groups accessing mental healthcare.

A workforce disability equality standard (WDES) was in progress to address the needs of staff with disabilities. We heard about an inclusion passport to be developed for staff with protected characteristics which would highlight their needs wherever they worked within the trust. Ideas to develop a cultural toolkit, a transgender policy and inclusion ambassadors strengthened the action plan for the future.

The Patient Friends and Family Test asked patients whether they would recommend the services they have used based on their experiences of care and treatment. The trust scored between 87% and 82% between June 2017 to May 2019. The data shows a shift from September 2018 to March 2019.

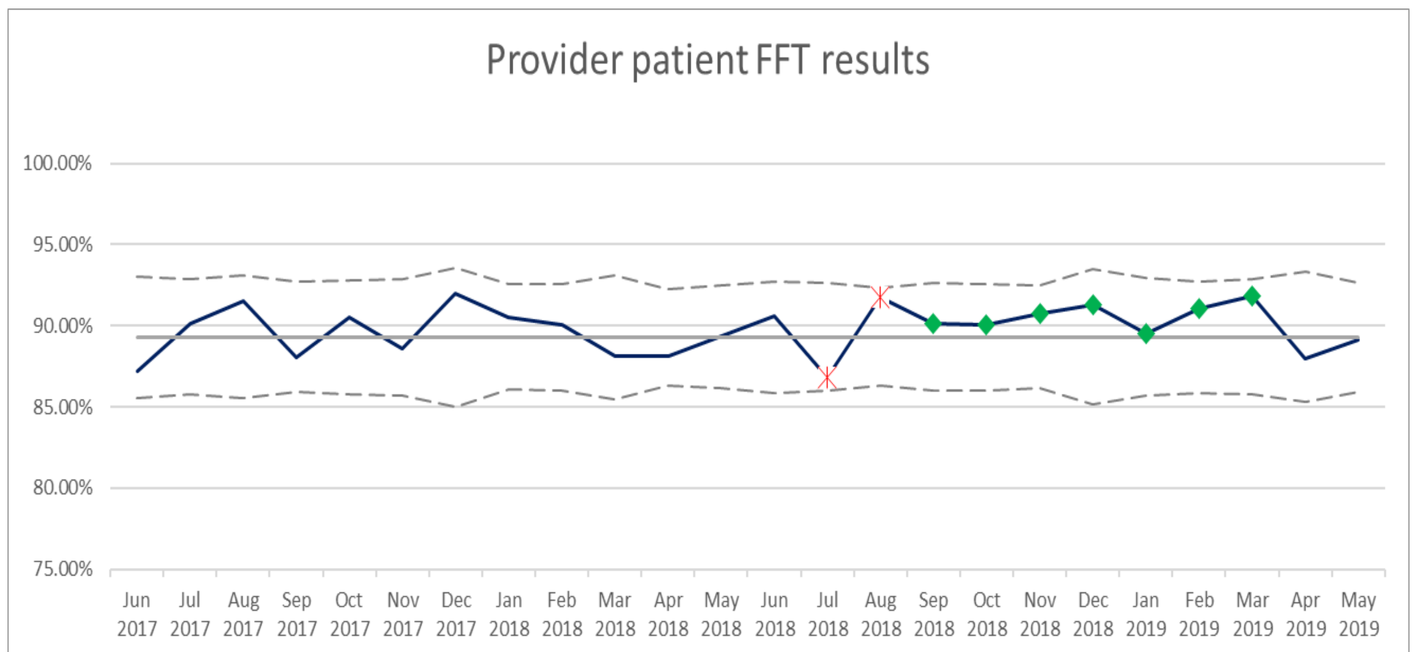
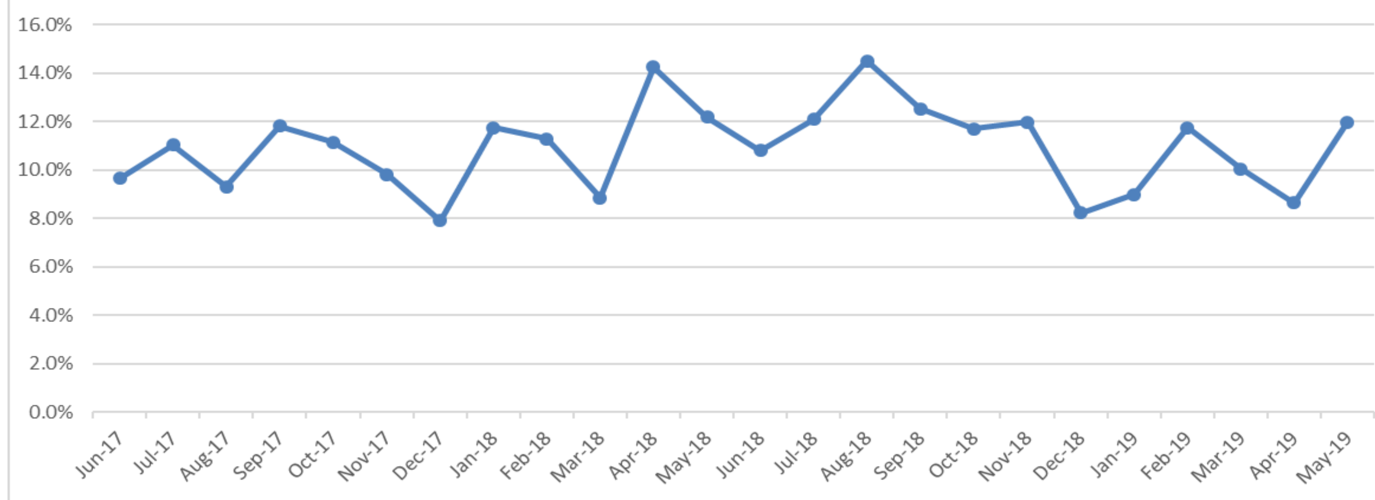


Figure 1



The Staff Friends and Family Test asked staff members whether they would recommend the trust as a place to receive care and also as a place to work. The percentage of staff that would recommend this trust as a place to work in quarter 2, 2018 to 2019, increased when compared to the same time last year. The percentage of staff that would recommend this trust as a place to receive care in quarter 2, 2018 to 2019, stayed the same when compared to the same time last year. There was no reliable data to enable comparison with other individual trusts or all trusts in England.

Staff felt valued by their peers and their managers. Staff verbalised an overwhelming sense of pride to work for the trust and we heard many examples that described a culture of positivity and desire to deliver great care. Updated data from the trust at the time of inspection showed that 81% of staff in the staff friends and family test (quarter 1 2019 to 2020), recommended NHFT as a place to work (an increase of 8%). In addition, the staff friends and family test showed the trust as a place to receive care was 88%, a rise of 3%, supported by the feedback responses received from 'I want great care' showed a 4.81 out of 5-star rating in quarter 1 2019 to 2020 for receiving care at NHFT.

However, two teams during our core service inspection told us that morale had been affected by organisational change. In long stay rehabilitation wards, the lack of staff in key posts (such as occupational therapy) had impacted on the team ability to deliver rehabilitation programmes. In community mental health services for people with learning disability or autism, staff told us that organisational changes, and staff changes had impacted on morale.

Staffing

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

The board had agreed assurance from the quality and governance committee and Safe Care Leads about staffing levels, and risks associated with staffing. These two sub committees provided regular updates to board to provide assurance that the trust met the NHSi 'developing workforce safeguards' recommendations. New or changed risks to staffing included acute wards for adults of working age, forensic inpatient wards and long stay / rehabilitation wards where unplanned

absences increased filled rates; Cynthia Spencer Hospice had increased staff sickness (both long term and short term) and vacancies had been added to the risk register; community nursing had further staffing challenges for district nursing vacancies and sickness added to the risk register. Mitigations were in place around the identified risks. Children's and young people ADHD team and PCART North team had resolved their staffing risks. Safe Care Leads reported into Quality and Governance committee and reported staffing issues had not impacted on patient safety. Although four short staffing incidents had been recorded in the trust in July 2019 (one in mental health and LD services, three in Children's services).

The below chart showed the breakdown of staff in post WTE from 1 April 2018 to 31 March 2019.

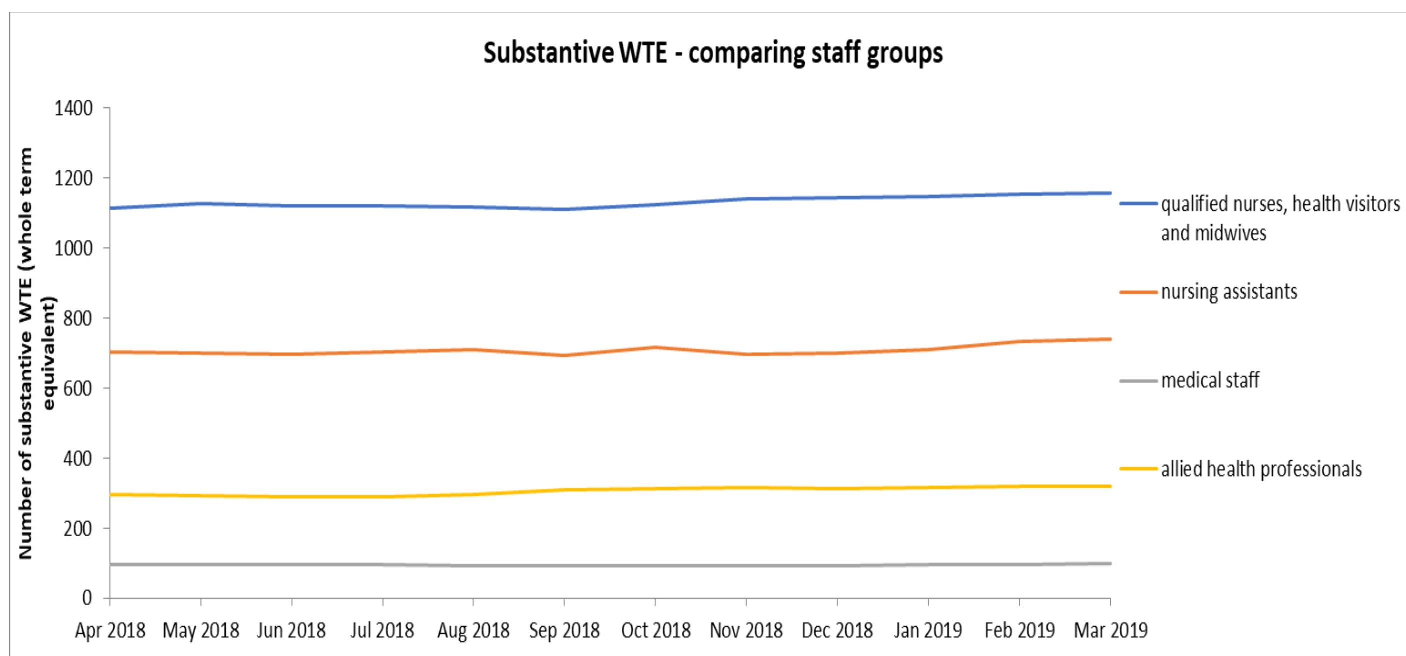


Figure 2

Annual staffing metrics

	Core service annual staffing metrics (1 April 2018 – 31 March 2019)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual "unfilled" hours (% of available hours)**
All staff	3853.2	11%	11%	4.8%			
Qualified nurses	1431.8	12%	9%	5.2%	197573 (11%)	95693 (5%)	7259 (<1%)
Nursing assistants	853.2	11%	10%	6.6%	238860 (24%)	3391 (<1%)	11033 (1%)
Medical staff	133.4	15%	29%	1.0%	4147 (2%)	16077(2%	13832 (6%)
Allied Health Professionals	311.9	0%	8%	2.1%			

Vacancies

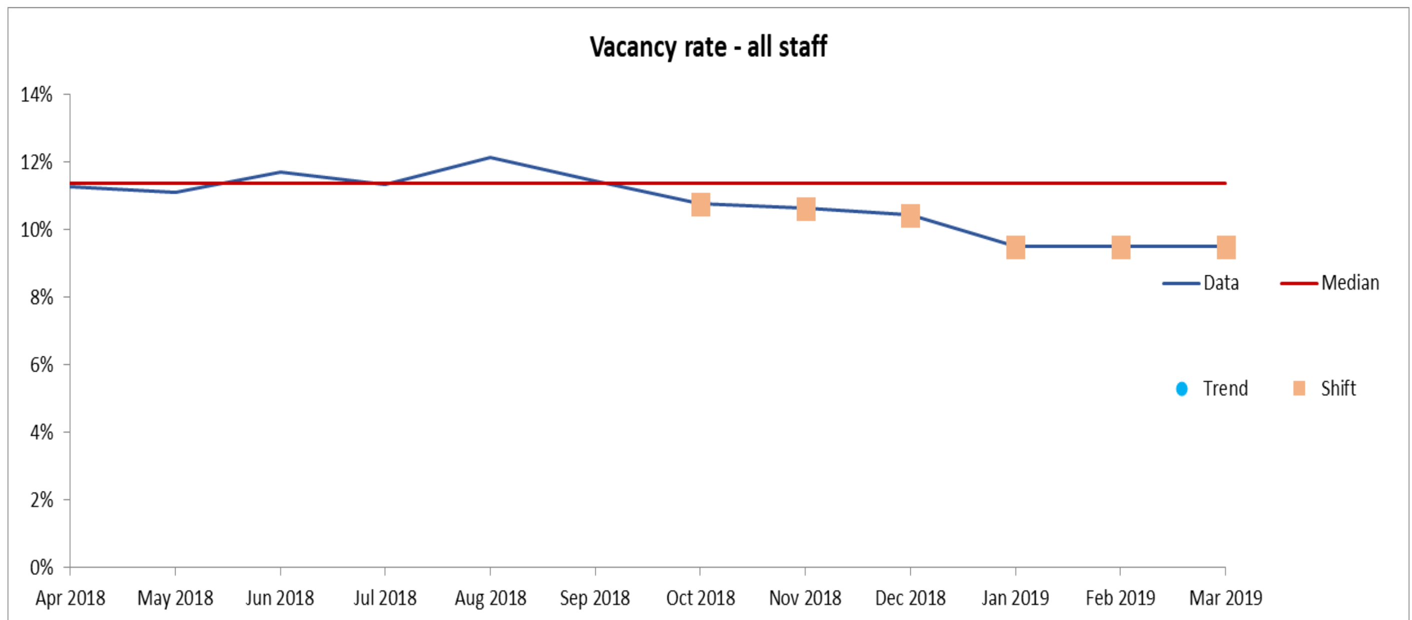


Figure 3

Monthly vacancy rates for all staff across the 12 months showed a downward shift from October 2018 to March 2019 (see figure 3).

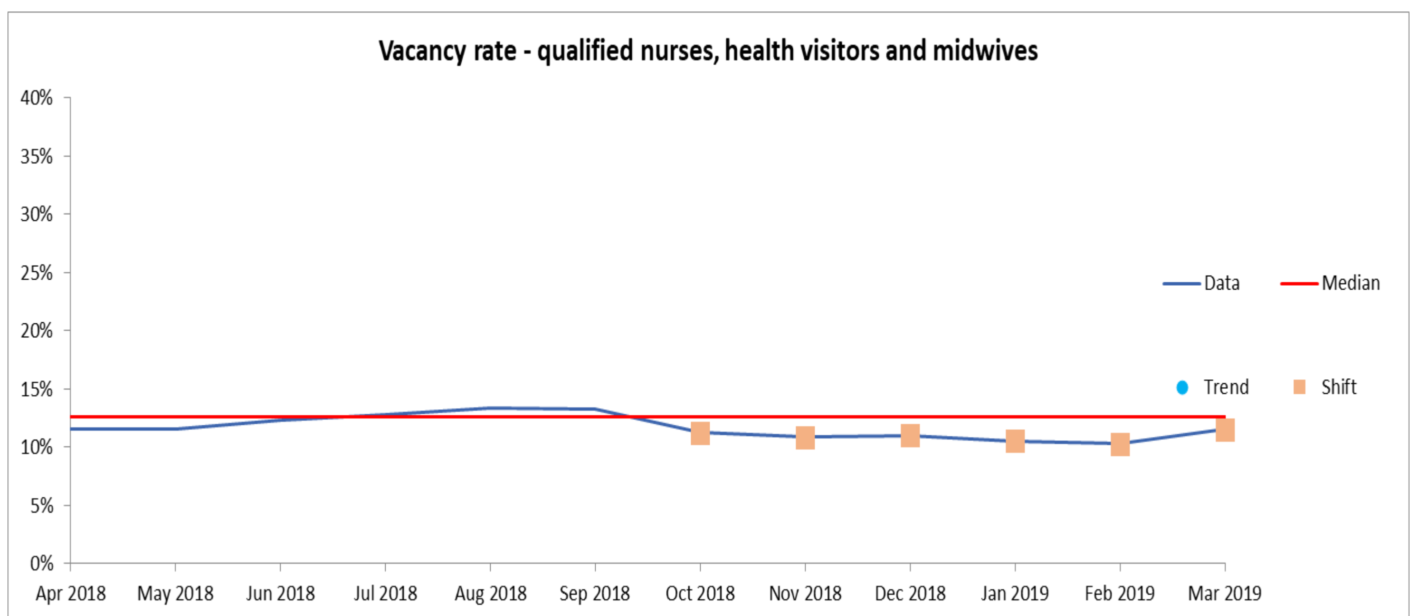


Figure 4

Qualified nurses, health visitors and midwives vacancy rates across the 12 months showed a shift from October 2018 to March 2019 (see figure 4).

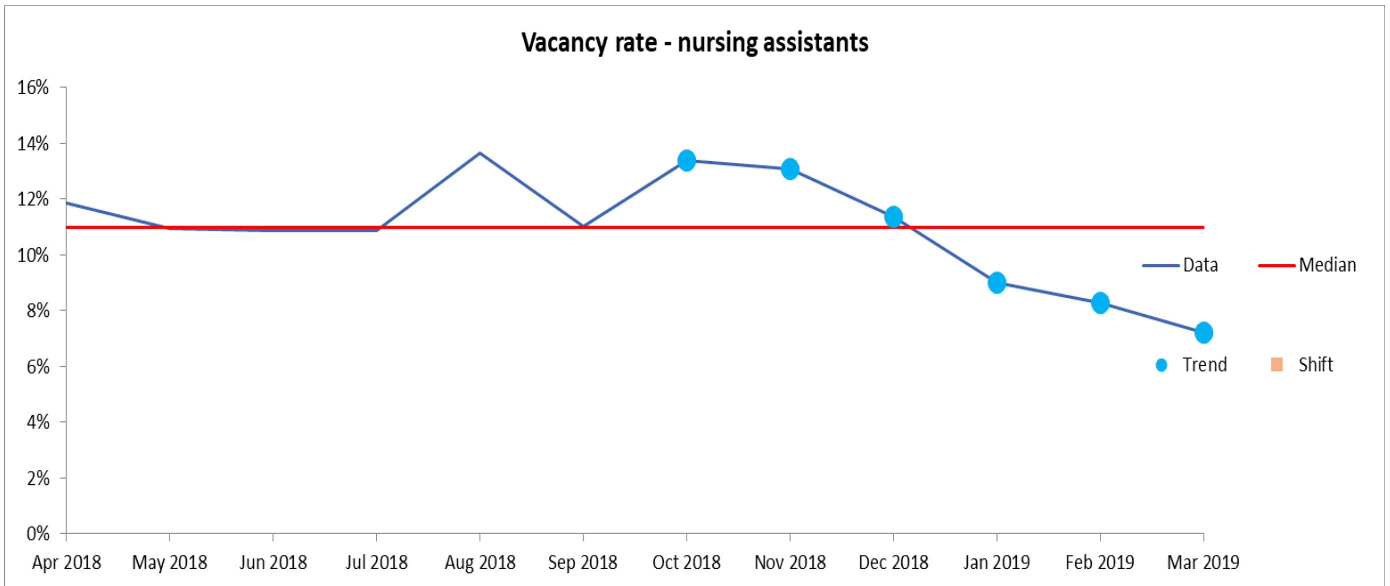


Figure 5

Nursing assistant vacancy rates across the 12 months showed a downward trend from October 2018 to March 2019 (see figure 5).

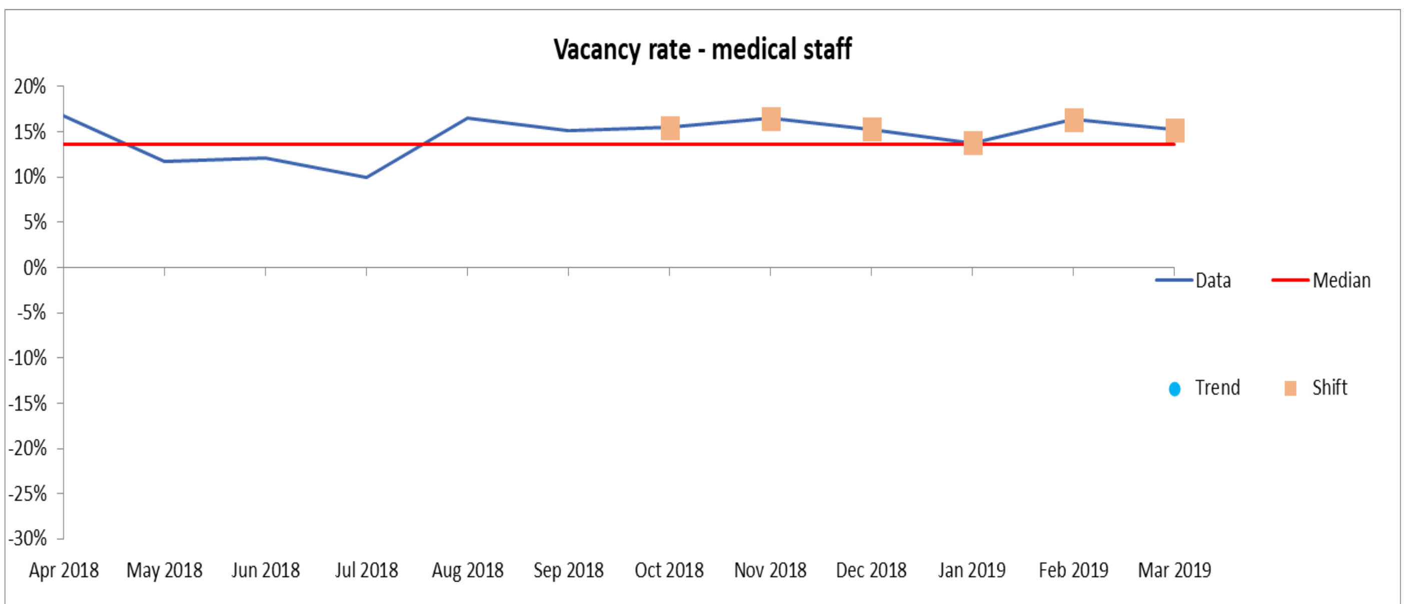


Figure 6

Monthly vacancy rates for medical staff showed a shift from October 2018 to March 2019 (see figure 6).

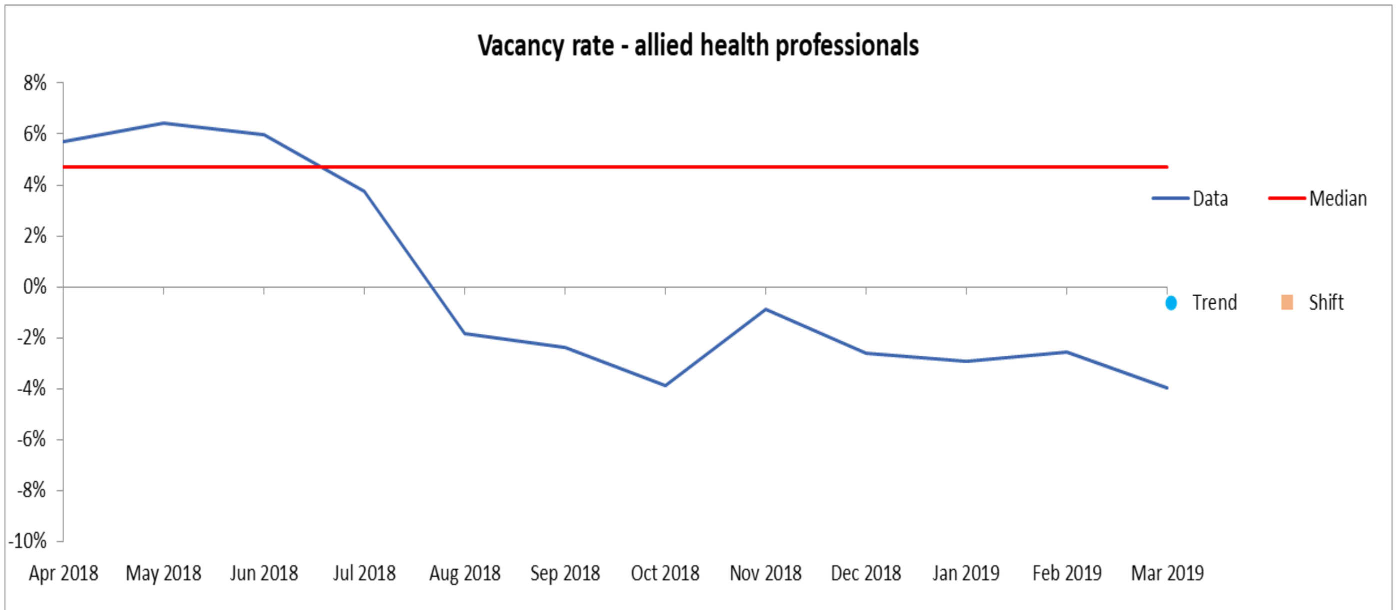


Figure 7

Allied health professional vacancy rates over the last 12 months were not stable and maybe subject to ongoing change (see figure 7). However, the average vacancy rate for allied health professionals was in the lowest 25% when compared to other similar trusts nationally.

Turnover

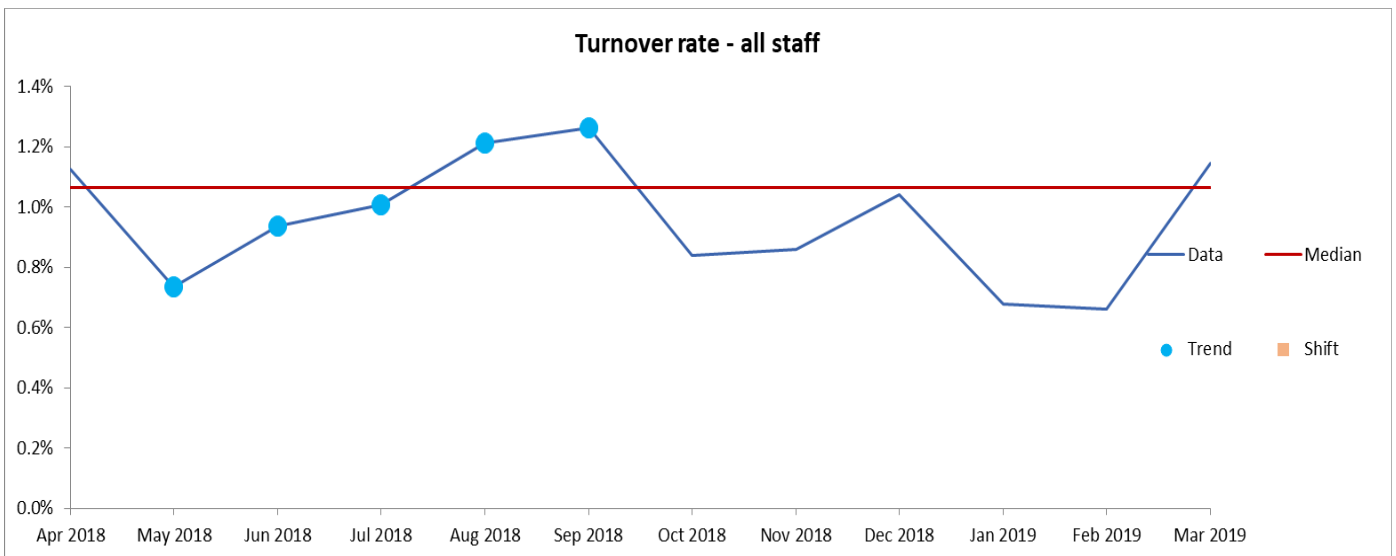


Figure 8

Turnover rates over the last 12 months for all staff showed an upward trend from May to September 2018 (see figure 8).

Turnover for medical staff appeared stable across the 12 months, however the annual turnover rate for medical and dental staff was in the highest 25% when compared to other similar trusts nationally.

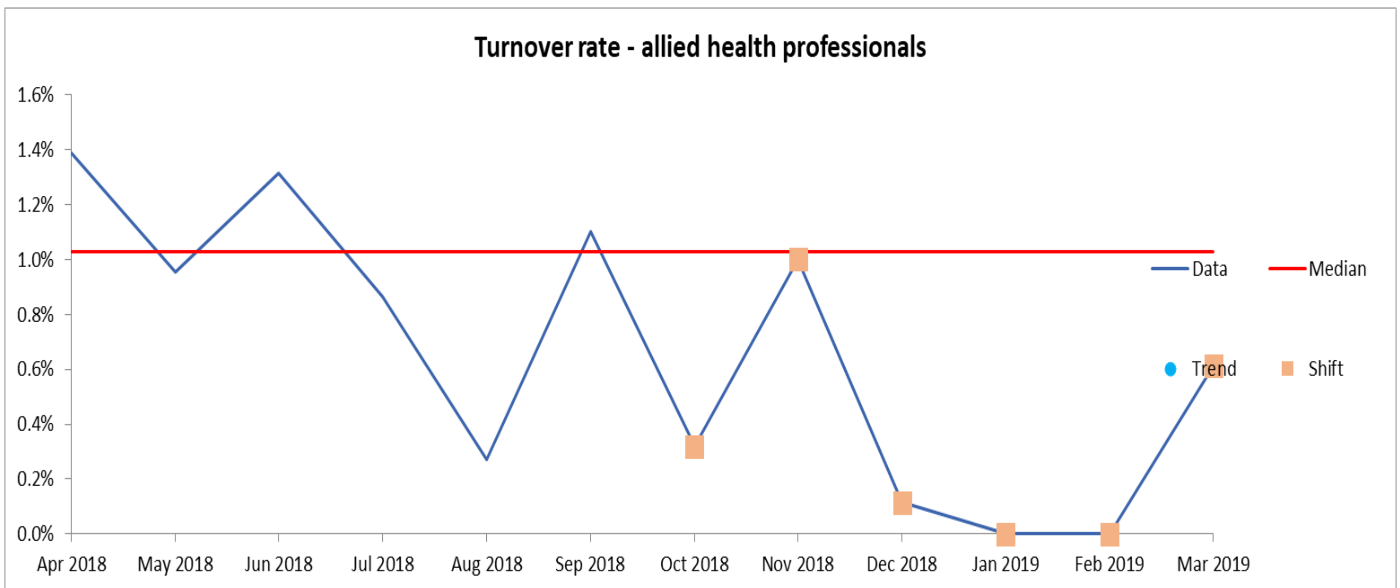


Figure 9

Turnover rates for allied health professionals over the last 12 months showed a shift from October 2018 to March 2019 (see figure 9). However, when comparing allied health professional to similar trusts nationally, they were in the lowest 25%.

Sickness

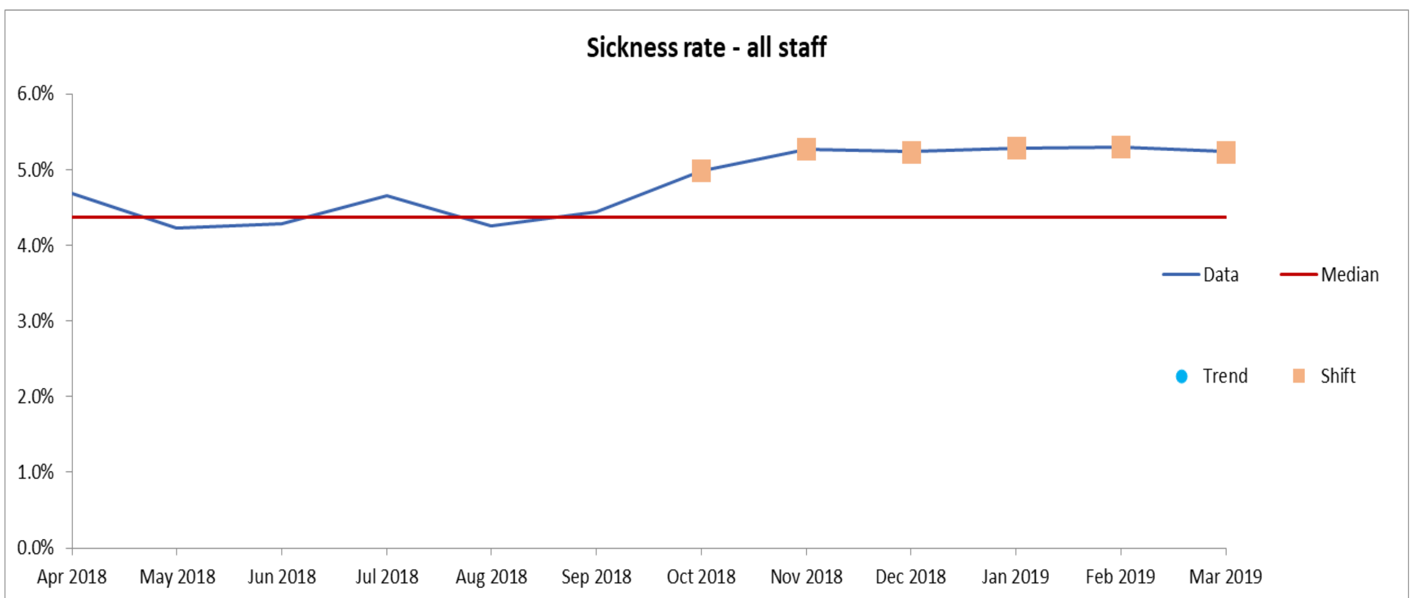


Figure 10

Monthly sickness rates for all staff over the last 12 months showed a shift upwards from October 2018 to March 2019 (see figure 10).

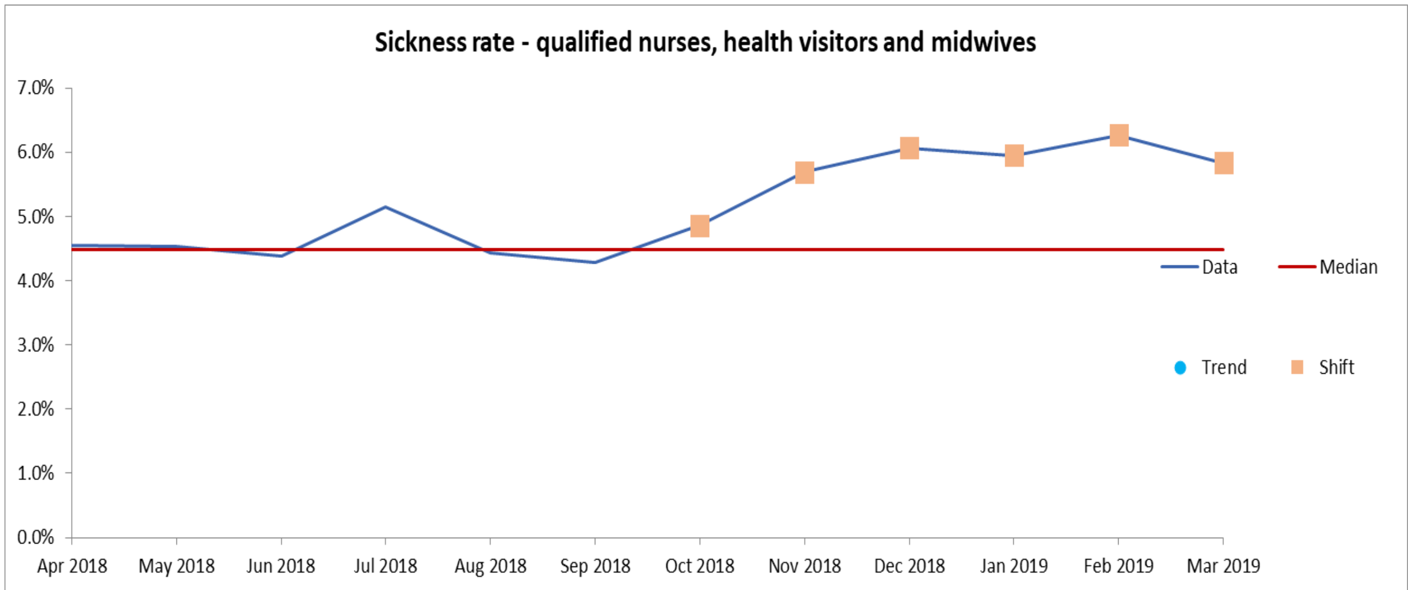


Figure 11

Sickness rates for qualified nurses, health visitors and midwives over the last 12 months showed a shift upwards from October 2018 to March 2019 (see figure 11).

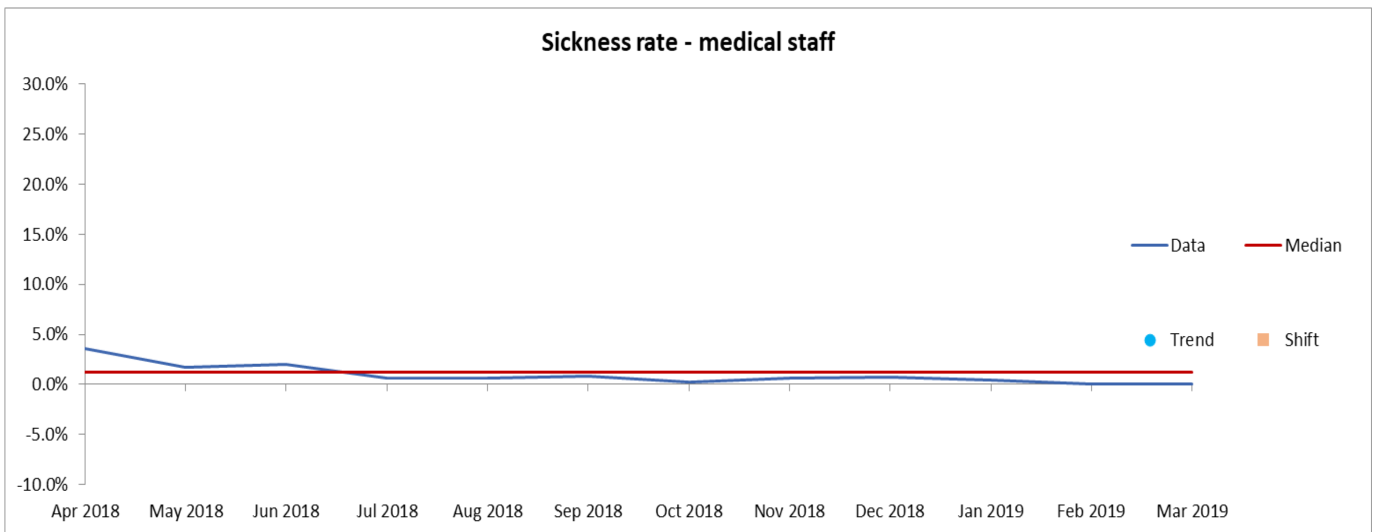


Figure 12

Sickness rates for medical staff over the last 12 months were not stable and may be subject to ongoing change (see figure 12). However, when compared to other similar core services nationally, they are in the lowest 25%.

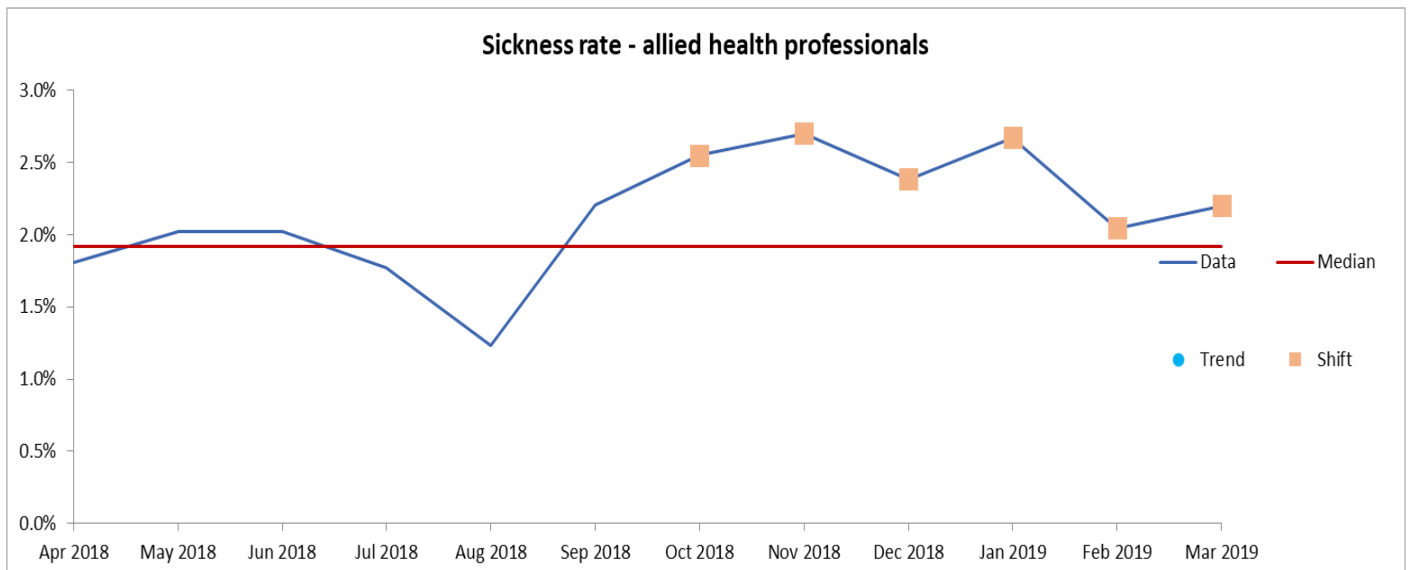


Figure 13

Monthly sickness rates for allied health professionals across the 12 months showed a shift from October 2018 to March 2019 (see figure 13). However, when compared to other similar core services nationally, they are in the lowest 25%.

The trust had put in place initiatives to improve sickness rates across the trust. The trust focused on and promoted well-being strongly amongst the staff group. The sickness and absence policy was revised to incorporate well-being, flexible working, and work life balance conversations. Staff told us the revised policy was better and encouraged staff to think about returning to work after sickness more proactively. A well-being wheel had been incorporated into one to one discussion between staff in supervision sessions.

The board were regular sited on all staffing data. Regular updates were provided to board by the Performance committee and dashboard and statistical process charts gave greater detail of the trusts' staffing picture in all services.

This was accompanied by recruitment and retention updates to board. Initiatives for recruitment and retention had continued. Links with universities, apprenticeships and nurse development roles continued.

Bank usage

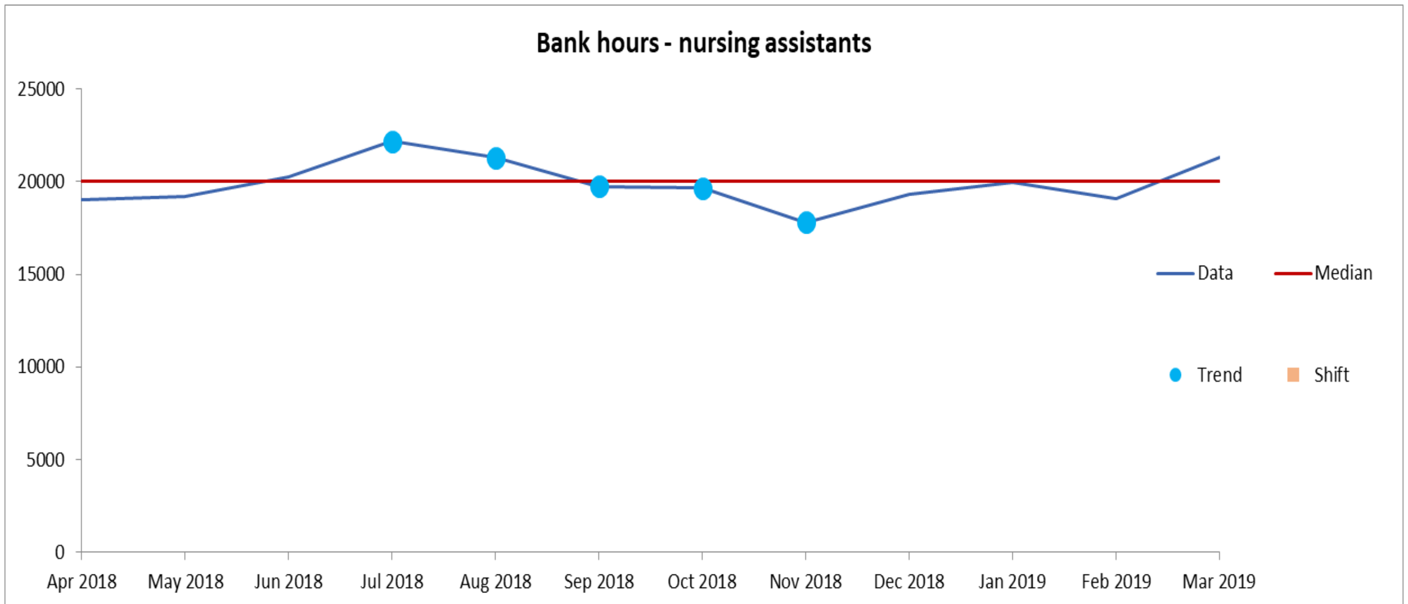


Figure 14

Monthly bank hours for nursing assistants showed a downward trend from July 2018 to November 2018 (see figure 14).

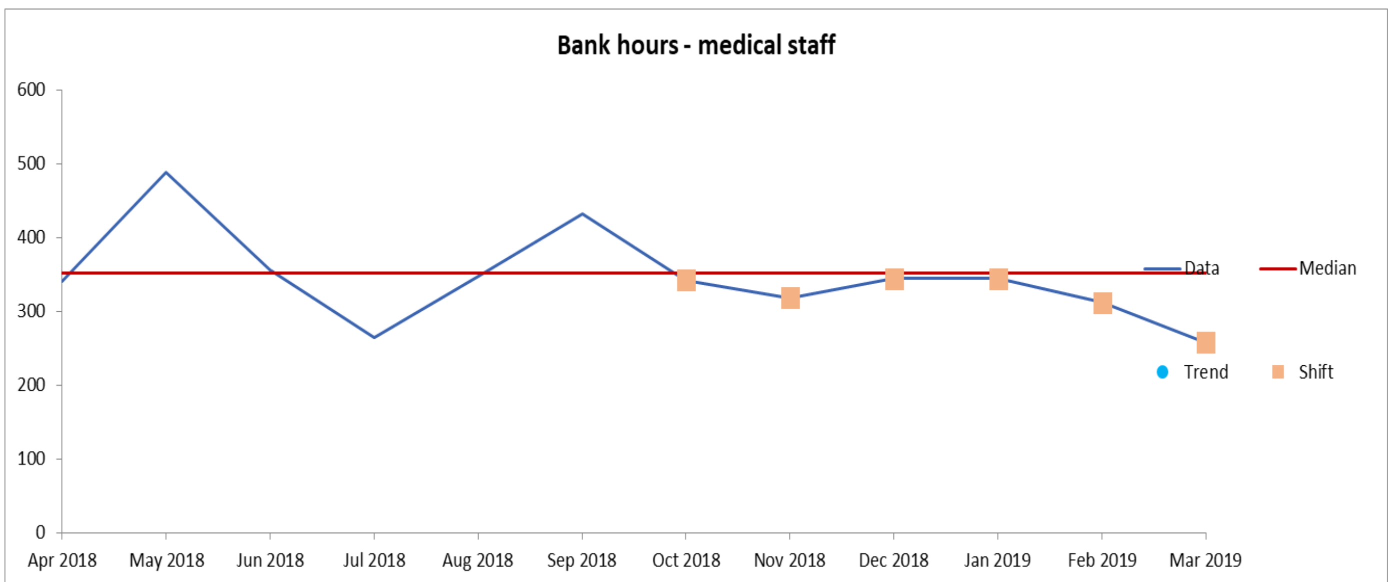


Figure 15

Monthly bank hours over the last 12 months for medical staff showed a shift from October 2018 to March 2019 (see figure 15).

Agency usage

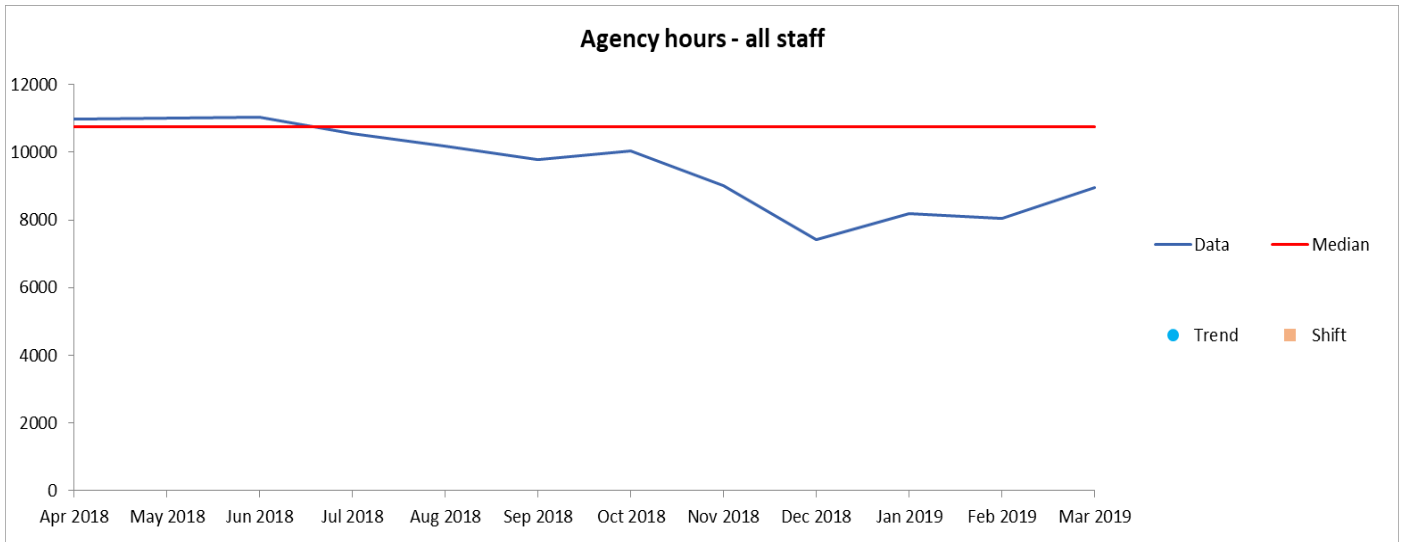


Figure 16

Monthly agency hours over the last 12 months for all staff were not stable and may be subject to ongoing change (see figure 16).

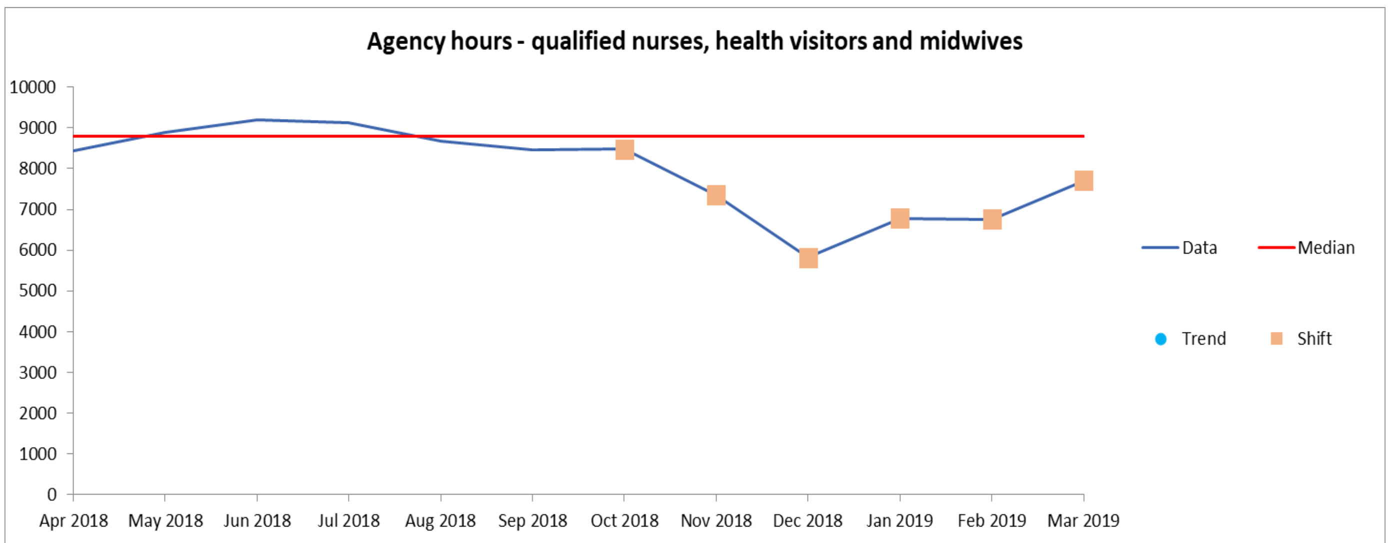


Figure 17

Monthly agency hours over the last 12 months for qualified nurses, health visitors and midwives showed a shift from October 2018 to March 2019 (see figure 17).

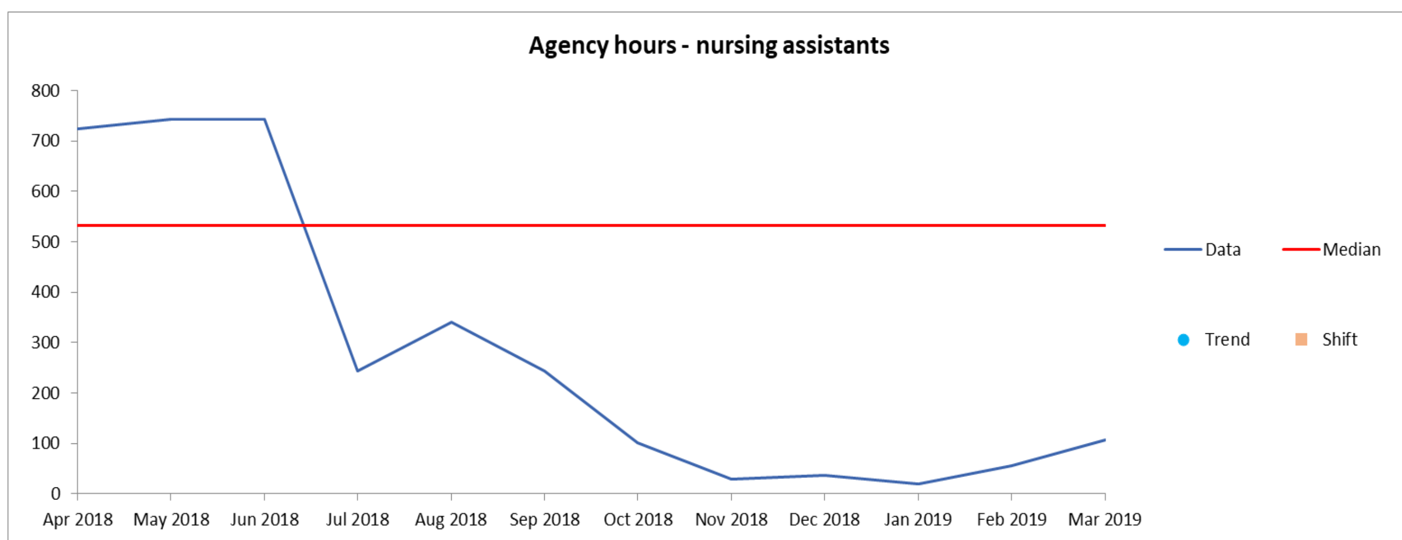


Figure 18

Monthly agency hours over the last 12 months for nursing assistants were not stable and may be subject to ongoing change (see figure 18).

The board had clear oversight of agency spend and we saw evidence of assurance to board through regular agency control meetings with executive directors. The Workforce Control group monitored agency usage monthly. The NHS Improvement Agency Spend Control Target for 2019/20 was £8,960,000. The trust had set itself a lower control target of £7,400,000 for 2019/20. During August 2019 (month 5) the trust spent £391,000 on agency staff; this was against a maximum target spend of £616,000. This represented a reduced spend of £225,000 against the months control target. During August 2019 (month 4) the trust spent £92,000 on locum medics; this was against a maximum target spend of £142,000. This represent a reduced spend of £50,000 against the months control target. Year to date (months 1 – 5), the trust spent £2.112 million on agency staff, this was against a maximum target spend of £3.078 million. This represented a reduced spend of £966,000 against the year to date control target.

The trust set a target of 90% for completion of mandatory and statutory training. The compliance for mandatory and statutory training courses at 31 March 2019 was 90%. Of the training courses listed seven failed to achieve the trust target and of those, none failed to score below 75%.

Training was reported on a month by month basis.

The training compliance reported for this provider during this inspection not comparable to the last inspection.

At the time of our inspection we saw updated compliance figures for training. Since January 2019, month on month compliance was above 91% and ranged between 91% and 93%.

The trust did not submit figures of compliance rates for training in prevention and management of violence and aggression for any core service.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✗	Higher ↑	No change →	Lower ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Resuscitation Level 4 - 4 Years	1	1	100%	✓
Resuscitation - Level 1 - No Specified Renewal	730	699	96%	✓
Safeguarding Adults - Level 2 - 3 Years	3021	2887	96%	✓
Safeguarding Children (Version 2) - Level 2 - 3 Years	2328	2221	95%	✓
Safeguarding Children (Version 2) - Level 1 - 3 Years	710	673	95%	✓
Safeguarding Adults - Level 1 - 3 Years	711	673	95%	✓
Resuscitation - Level 2 - Adult Basic Life Support - No Specified Renewal	730	690	95%	✓
Resuscitation - Level 2 - Paediatric Basic Life Support - No Specified Renewal	730	690	95%	✓
Information Governance and Data Security - 1 Year	3725	3490	94%	✗
Health, Safety and Welfare - 3 Years	3725	3489	94%	✓
Moving and Handling - Level 2 - 2 Years	78	73	94%	✓
Moving and Handling - Level 1 - 3 Years	3725	3482	93%	✓
Infection Prevention and Control - Level 1 - 3 Years	929	861	93%	✓
Safeguarding Children (Version 2) - Level 3 - 3 Years	694	637	92%	✓
Fire Safety - 1 Year	3725	3414	92%	✓
Resuscitation - Level 1 - 1 Year	2993	2708	90%	✓
Infection Prevention and Control - Level 2 - 1 Year	2757	2476	90%	✗
Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year	2624	2352	90%	✗
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year	2624	2352	90%	✗
Infection Prevention and Control - Dental - 5 Years	38	34	89%	✗
Moving and Handling - Level 2 - 1 Year	1364	1191	87%	✗
Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year	365	292	80%	✗
Total	**38327**	**35385**	**90%**	

Supervision and appraisal systems continued to be embedded. Supervision and appraisal meetings discussed topics which promoted a positive work culture. They included, career progression, training and development, safety and well-being. The trust had rolled out a well-being wheel which leaders used in supervision and appraisal to discuss work-life balance of their staff.

The trust’s target rate for appraisal compliance was 90%. At the end of last year (1 April 2018 to 31 March 2019), the overall appraisal rate for non-medical staff was 92%. This year so far, the overall appraisal rate was 92% (as at 24 May 2019). Eighteen of the 21 teams (86%) achieved the trust’s appraisal target. The services with the lowest compliance were ‘wards for people with learning disabilities or autism’ with 80%, ‘community based mental health services for older people’ with 86% and ‘provider wide’ with 89%.

The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 91% reported at the last inspection.

At the time of inspection, we saw updated data which demonstrated ongoing compliance with the trust appraisal target of 90%. From March 2019 to August 2019 the compliance rate was consistently above 90% ranging from 90% to 92%.

Core Service	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 24 May 2019)	% appraisals (previous year 1 April 2018 - 31 March 2019)
MH - Long stay/rehabilitation mental health wards for working age adults	18	18	100%	100%
MH - Secure wards/Forensic inpatient	28	28	100%	93%
MH - Wards for older people with mental health problems	93	92	99%	96%
MH - Child and adolescent mental health wards	66	64	97%	93%
CHS - Community Dental	31	30	97%	100%
Other - PMS service	153	146	95%	92%
CHS - Sexual Health	46	43	93%	90%
CHS - End of Life Care	135	126	93%	94%
MH - Acute wards for adults of working age and psychiatric intensive care units	237	221	93%	92%
CHS - Children, Young People and Families	503	468	93%	93%
MH - Other Specialist Services	161	149	93%	92%
Other	118	109	92%	96%
CHS - Community Inpatients	212	195	92%	96%
MH - Community mental health services for people with a learning disability or autism	111	102	92%	89%
MH - Mental health crisis services and health-based places of safety	57	52	91%	88%
MH - Community-based mental health services for adults of working age	146	133	91%	90%
MH - Specialist community mental health services for children and young people	115	104	90%	98%
CHS - Adults Community	765	691	90%	91%
Provider wide	626	559	89%	89%
MH - Community-based mental health services for older people	78	67	86%	82%

Core Service	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 24 May 2019)	% appraisals (previous year 1 April 2018 - 31 March 2019)
MH - Wards for people with learning disabilities or autism	20	16	80%	95%
Total	**3719**	**3413**	**92%**	**92%**

At the end of last year (1 April 2018 to 31 March 2019), the overall appraisal rate for medical staff was 80%. This year so far, the overall appraisal rate was 87% (as at 24 May 2019). Eleven of the 18 teams (61%) achieved the trust's appraisal target. The services with the lowest compliance were 'secure wards/forensic inpatient' with 0%, 'provider wide' with 0%, community based mental health services for people with a learning disability or autism with 50%, CHS – community dental with 58%, mental health crisis services and health-based places of safety with 75%, CHS-Community inpatients with 83% and 'CHS-Children, young people and families with 88%.

The rate of appraisal compliance for medical staff reported during this inspection was lower than the 84% reported at the last inspection.

Core Service	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals (as at 24 May 2019)	% appraisals (previous year 1 April 2018-31 March 2019)
Other - PMS service	1	1	100%	100%
CHS - End of Life Care	7	7	100%	100%
MH - Child and adolescent mental health wards	3	3	100%	100%
MH - Acute wards for adults of working age and psychiatric intensive care units	6	6	100%	100%
CHS - Sexual Health	6	6	100%	100%
MH - Community-based mental health services for older people	8	8	100%	100%
MH - Specialist community mental health services for children and young people	8	8	100%	83%
MH - Long stay/rehabilitation mental health wards for working age adults	1	1	100%	100%
CHS - Adults Community	1	1	100%	100%
MH - Other Specialist Services	5	5	100%	100%
MH - Community-based mental health services for adults of working age	10	9	90%	100%
CHS - Children, Young People and Families	8	7	88%	83%
CHS - Community Inpatients	6	5	83%	83%

MH - Mental health crisis services and health-based places of safety	4	3	75%	100%
CHS - Community Dental	12	7	58%	69%
MH - Community mental health services for people with a learning disability or autism	2	1	50%	100%
Provider wide	1	0	0%	0%
MH - Secure wards/Forensic inpatient	1	0	0%	0%
Total	**90**	**78**	**87%**	**80%**

Between 1 April 2018 and 31 March 2019, the average rate across all 13 core services was 207%. The rate of clinical supervision reported during this inspection was higher than the 123% reported at the last inspection.

The trust had a variety of ways in which to record supervision. The trust submitted data which showed compliance rates of over 100% in some teams. The trust captured various forms of meetings which they classed as supervision, including clinical, managerial, group supervision, reflective practice and safeguarding supervision. All staff recorded meetings for supervision within their own electronic staff record (ESR). This accounted for the high percentage of compliance with supervision. However, team leaders in core services reported they were assured that all staff received clinical supervision in line with trust policy.

At the time of inspection, we saw data which confirmed compliance with supervision met the trust target of 90%. Quarter four showed compliance across the trust was 94%, and quarter one compliance for 2019 was 95%.

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

Core service	**Clinical supervision sessions required**	**Clinical supervision delivered**	**Clinical supervision rate (%)**
CHS - Adults Community	74	141	191%
CHS - Children, Young People and Families	134	137	102%
MH - Acute wards for adults of working age and psychiatric intensive care units	1458	2459	169%
MH - Child and adolescent mental health wards	360	619	172%
MH - Community mental health services for people with a learning disability or autism	492	641	130%
MH - Community-based mental health services for adults of working age	650	2604	401%
MH - Community-based mental health services for older people	434	1209	279%
MH - Long stay/rehabilitation mental health wards for working age adults	118	224	190%
MH - Mental health crisis services and health-based places of safety	408	1016	249%

Core service	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
MH - Other Specialist Services	596	998	167%
MH - Secure wards/Forensic inpatient	192	485	253%
MH - Specialist community mental health services for children and young people	668	1146	172%
MH - Wards for older people with mental health problems	544	994	183%
Trust Total	**6128**	**12673**	**207%**

Between 1 April 2018 and 31 March 2019, the average rate across all eight core services for medical staff was 158%. The rate of clinical supervision reported during this inspection was not comparable to the last inspection.

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

Core service	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
MH - Acute wards for adults of working age and psychiatric intensive care units	24	26	108%
MH - Child and adolescent mental health wards	20	29	145%
MH - Community-based mental health services for adults of working age	64	119	186%
MH - Long stay/rehabilitation mental health wards for working age adults	8	18	225%
MH - Mental health crisis services and health-based places of safety	24	31	129%
MH - Other Specialist Services	16	19	119%
MH - Secure wards/Forensic inpatient	0	0	0%
MH - Specialist community mental health services for children and young people	46	77	167%
Trust Total	**202**	**319**	**158%**

Governance

The trust had reviewed and refreshed its governance structures, systems and processes since our last inspection. Governance arrangements were clear, structured and well aligned to allow the trust to perform highly effectively. Sub committees, divisional committees and team meetings had direct accountability to and from each other.

The governance structural chart was simple, easy to understand and showed clear lines of accountability. Staff in the trust knew who executive directors and non-executive directors were and how to contact them and raise issues. Operational staff and leaders knew which meetings,

and committees they could raise issues to, report progress and escalate risk where needed in their own core services and beyond. We heard staff felt managers had autonomy to raise issues to the executive board if needed, were happy to do so, and leaders knew they would be respected for their view and would be listened to. We heard that at the highest level of the trust, executive directors were responsive and replied to queries promptly. We saw clear lines of accountability and both executive directors and non-executive directors held portfolios appropriate to their experience and expertise.

We saw minutes of meetings at all levels of the organisation. This included board meeting minutes, subcommittee minutes, stakeholder engagement meetings, divisional and core service meetings. The board took assurance from the sub committees with papers presented at regular intervals, and the board was asked to approve proposals and decisions. Decisions were made after robust scrutiny and after opportunity for challenge had been afforded. We observed a board meeting during our inspection. The trust had a balanced agenda between quality, finance, performance and strategy. Discussions were balanced, and opportunity to generate discussion, challenge and scrutiny was available. Papers presented were clear, non-executive directors shared views and gave appropriate challenge where needed. Behaviours of members during the meeting were kind, respectful and professional.

The board had delivered governance masterclass workshops for the senior leadership team to enhance learning and awareness of trust governance. In addition, governors received workshops on key issues to enhance understanding, such as finance and risk.

The trust continually measured itself against external standards and demonstrated the strong appetite for learning. It undertook a number of internal and external audits of its governance systems and processes. As part of the trust horizon scanning (a way to detect early signs of potential threat and opportunity) the strategic executive board considered the UK Code of Governance and the National NHS Providers Governance Survey, which sets out standards of good practice in governance. The trust was compliant with the standard and expectations.

The trust used the organisational risk register as its board assurance framework to support good governance. An audit of the trusts' framework of governance, risk management and control systems were completed and published in May 2019. It resulted in the identification of one high, 14 medium and ten low risk findings to improve operating effectiveness. The area of high risk was associated with admission avoidance and medium risks were associated to financial systems for procurement and cash offices. Areas of good practice identified included risk management, achievement of CQUINs and Freedom to Speak Up. The audit reported that 22 actions remained outstanding as of May 2019 with insufficient evidence to show they had been completed.

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

On 9 May 2019, the trust was categorised as having 'maximum autonomy' by the NHS Improvement Single Oversight Framework.

We heard about 'I want great care' at our last inspection. This was a system that collected feedback from patients, carers and relatives. The trust incorporated this feedback into the work it completed on complaints, and many other threads that underpinned its mission and strategy.

We saw robust processes in place to handle complaints. A key quality of the organisation was the willingness to listen, change and improve in response to complaints made. Staff across the trust knew how to raise complaints themselves, or to support others to do so. A team of staff had oversight of complaints and compliments and reported to the quality forum complaints review committee and trust board. Staff who investigated complaints had training to carry out the role. The trust had appointed complaints investigators specifically for the three care directorates. The complaints team recently responded to feedback from a carer about delays to investigations. As a result, the team reported to board the number of requests for extensions to investigations by investigators, to improve oversight.

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	**Current Performance**
What is your internal target for responding to* complaints?	3	100%
What is your target for completing a complaint?	25	100%
If you have a slightly longer target for complex complaints, please indicate what that is here	Not stated	Not stated

* 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

Data collected during inspection showed, in the last 12 months from 01 September 2018 to 11 September 2019, the trust received 240 complaints, 170 of which were closed. The number of complaints closed within the 25-day target were 103 with 25 complaints ongoing.

Data collected during inspection demonstrated that figures reported to the July 2019 board showed 67% (55) of complaints had been closed within the 25-day target. Eighteen required extensions to the investigation process. Reasons for extensions included annual leave (3); investigator unable to contact the complainant (2) and due to the complexity of the complaint (13) required more time.

We sampled complaints during our inspection and found the trust were robust in their investigations and met targets for responding to complaints in those we sampled. The complaints team held a comprehensive database in which all details of complaints were held. This gave robust oversight of how the trust handled complaints and reported accurate data to the board. We saw examples of apologies given where standards fell below that expected by the trust. Response letters to complaints were kind, compassionate and clear and apologies were sincere. The trust followed duty of candour principles where needed. Staff across the trust knew what duty of candour was, its principles and believed the trust were open and apologised when needed.

	Total	**Date range**
Number of complaints resolved without formal process*** in the last 12 months	582	1 April 2018 to 31 March 2019
Number of complaints referred to the ombudsmen (PHSO) in the last 12 months	3	April 2018 to 31 March 2019

**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

This trust received 1752 compliments during the last 12 months from 1 April 2018 to 31 March 2019. This was higher than/lower than/the same as /not comparable to the 1291 reported at the last inspection. 'CHS – End of life care' had the highest number of compliments with 24%, followed by 'acute wards for adults of working age and psychiatric intensive care units' with 16% and 'CHS-Community inpatients' with 14%.

The trust submitted details of eight external reviews commenced or published in the last 12 months (1 April 2018 to 31 March 2019).

Seven were conducted by the PHSO and in the final case the trust commissioned an external independent investigator to carry out an investigation into a re-opened complaint. Of the seven cases completed by the PHSO one was upheld, three were partially upheld and three were not.

Of the cases investigated and with upheld or partially upheld three related to adult mental health, learning disabilities and speciality services and the final case related to adult services.

Key outcomes were identified:

- The trust should ensure that informal patients who need to be secluded are given a Mental Health Assessment as soon as possible. This resulted in the trust updating their policy and a local scrutiny group monitor this practice monthly.
- The need to remove blanket rules within inpatient settings. The trust had already commenced work with Implementing Recovery through Organisational Change which has led to the creation of 2 patient groups, their first completed tasks was the removal of the blanket rules by providing a person-centred approach.
- A recommendation showed that staff treated as patients should have the option to choose where they are treated should they require an inpatient stay. The trust therefore ensures that staff are given this option.
- The outcome of a case showed that staff needed to be aware of the proper transfer of Care Programme Approach (CPA) cases along with care co-ordination when a patient moves between services. Staff were also to have a clearer understanding of the Care Co-Ordinators role. This was shared and discussed with the community mental health teams for Older Adults along with a presentation focussed on the CPA policy.
- Another outcome concluded this year showed the need for a responsive booking system to be in place for appointments to see a psychiatrist within the Planned Care and Recovery Team. The trust has now put in place bookable appointments for each day that are not pre-booked to ensure availability for patients in need.

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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 and DoLS related activity, a detailed report was discussed. Issues of concern were escalated to the quality and governance subcommittee of the trust board.

Management of risk, issues and performance

The organisational risk register (ORR) process was well embedded. The 2019 / 2020 version was informed by a refresh of the trust strategy. The strategic executive board considered and updated the full ORR. The quality and governance committee and the performance committee had delegated responsibility to update and gain assurance on risks. After assurance was gained, the ORR was updated, and a revised summary presented to board for director agreement. Risks, risk levels and risk owners were identified, and each risk had been aligned to an objective of the trust strategy. 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 corporate risk register was underpinned by those in directorates.

The ORR identified the following two risks as high (score above 20) at the September 2019 board:

- Financial performance does not meet plan due to internal and external risk
- Lack of expertise and good systems which inhibits success.

The board agreed a system where any risk above 20, any risk which increased in risk rating or a risk with a period of time with no improvement seen, would be subject to a deep dive by board committees.

Executive directors told us that added risks included workforce – the ability to recruit and retain staff, efficiency (financial) challenges around the wider local health system and changes to the wider healthcare system locally such as safeguarding and children's services.

The trust wide risk register held 55 risks, 17 rated high, 35 moderate and three low. CHS adults held the highest number of risks at 18, nine of which were high and acute wards for adults of working age held the second highest number of risks at 13, with nine rated high. CHS community inpatients held eight, CHS young people and families held seven.

Staff in services knew how to raise risks and teams felt able to escalate risks onto their own team risk register. Systems were in place for teams to escalate risks to their core service and directorate risk register.

The trust board and committees completed quality impact assessments on all cost improvement schemes, as well as equality impact assessments.

The trust participated in a number of internal and external audits of performance and governance systems, which included safety, finance and risk. In April 2019 the trusts' internal auditors reviewed the effectiveness of its risk management arrangements. A low risk classification provided the board with assurance of a sound risk culture and the executive and non-executive directors had a good understanding of the trusts risks and how they were managed. As a result, the strategic executive board agreed a risk management development plan to continue to monitor risks.

The trust had introduced statistical process charts (SPC) to monitor areas of performance and risk. These charts provided additional scrutiny of the trust performance dashboard and allowed a more details looked into service data from the overarching dashboard. Managers in core services told us they were able to drill down into dashboard data to look at specific information. For example, safeguarding, incidents, restraints, sickness.

We had concerns about the high levels of restraints and seclusion in the trust. The total number of restraints was 6% higher in 2018 than the previous year (545 total). Seclusion had increased by 14.5% (241 total). However prone restraint had decreased by 13% since our last inspection, although 46% of all restraints were prone, a decrease from 56% at our last inspection. We saw the trust had a proactive approach to reducing restrictive practices with a specific group targeted to address such issues. We saw the trust board agreed a proposal to reduce restraint and the restrictive practice group had presented a paper for approval. This paper challenged guidance on restraint, but was cogent, reasoned and research based. In a board paper in March 2019, the trust set a target to reduce restraints to 319, but a later paper had removed any target. We were satisfied the trust were taking a reasoned response to reduce restraint levels but expected to see a faster reduction in figures. The Restraint Reduction Strategy developed in 2016, adopted in 2017 and co-produced with patients remained in place.

The trust ran a number of risk summits around specific issues, for example safeguarding and ICT caseloads. Local authority safeguarding processes had changed and the threshold for reporting had increased. The trust saw this as a risk to the trust but one that was difficult to influence. We were assured that the trusts' own systems and processes for raising, reporting and review of safeguarding were robust. The trust remained concerned that local authority thresholds impacted on cases which previously would have been investigated.

The trust reported a decrease in out of area placements at this inspection. This was a significant improvement since our last inspection. Compared to data from 2018 to 2019, figures for April 2019 had reduced by 234 from 317 to 83, for May 2019 by 487 from 556 to 69 and for June 2019 by 247 from 408 to 161.

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.

	Historical data		Projections	
Financial Metrics	Previous financial year (2 years ago) (1 April 2016 to 31 March 2017)	Last financial year (1 April 2017 to 31 March 2018)	This financial year (1 April 2018 to 31 March 2019)	Next financial year (1 April 2019 to 31 March 2020)
Actual income	£199,009,000	£199,109,000	£216,656,000	£216,927,000.00
Actual surplus (deficit)	£3,315,000	£7,745,000	£4,124,000	£1,816,000.00
Actual costs/expenditure - full	£195,694,000	£191,364,000	£212,532,000	£215,111,000.00
Planned budget or (deficit)	£195,694,000	£191,364,000	£212,532,000	£215,111,000.00

The trust was clear on their cost improvement programme (CIP) targets and the trust board were updated regularly on progress of financial issues. The total CIP for 2019/20 was £3.28 million. The total value of CIP realised at the end of June 2019 was 58%. We saw several reports presented to board which clearly outlined month on month expenditure and risks associated with potential for not meeting targets. Agency spend was closely monitored and the trust knew and understood their control targets, and additional stretch targets to achieve. A reduction in trusts' agency spend each quarter helped to generate the overall cost improvement target.

We had concerns about pharmacy oversight across the trust. We identified a number of issues with safe management of medicines during our inspection of core services. This included storage of controlled drugs, disposal of out of date medication, dispensing out of hours for outpatients, and planning medication at discharge.

At the time of our inspection, a clinical pharmacy service was provided to all inpatient sites except for the respite learning disability unit at 1 Willow Close, although oversight of medicines policies and procedures was provided. During our inspection of Willow Close, we found an incorrectly stored controlled drug; the chief pharmacist assured us that this site would now be included within the audit programme for controlled drugs.

Outpatient dispensing was outsourced to an external pharmacy group until March 2020. The subsequent provision of this service was out to tender and included the potential of the provision of a 24 hour on-call service for medicines supplies. At the time of our inspection, there was no provision for the supply of medicines outside of the operating hours the external provider. This had previously been highlighted as a risk within the trust.

The process in place for supplying discharge medicines and checking discharge letters against the provision of medicines information, did not involve the trust pharmacy team. Patients did not get a copy of their discharge letter with a current list of medicines. Current staffing did not allow NHFT pharmacy staff to be actively involved in discharge planning and to ensure that discharge documentation met the Royal Pharmaceutical Society (RPS) core content of records for medicines when patients transfer care providers (RPS Keeping patients safe when they transfer between care providers – getting the medicines right June 2012).

Pharmacy staffing was the biggest risk to delivering the medicines optimisation agenda. Retention of staff was difficult, and we heard recruitment to key posts was difficult. The medicine safety officer (MSO) post was vacant although arrangements were in place to cover in the interim. Pharmacy staff found it difficult to attend core service MDT meetings.

The trust had a Guardian of Safer Working Hours in post. The guardian reported at regular intervals to trust board via the quality and governance sub-committee. The board were assured that doctors in training were safely rostered and were working hours that were safe and in compliance with terms and conditions of service. The guardians' role was well respected and given appropriate voice to raise concerns and seek to resolve them where necessary. The junior doctor's forum was well engaged within the trust and was able to resolve issues around rotas in a collaborative and proactive way through consultation.

The trust has submitted details of eight serious case reviews commenced or published in the last 12 months.

Reference Number	Team/Ward/Unit	Recommendations	Actions Taken	Outstanding Actions
DHR: Ref006	PCART North	Patient not open to NHFT Services	None for NHFT	Not applicable
DHR: Ref007	Sandpiper, St Marys Hospital	3 recommendations: review of risk assessments, contemporaneous record keeping and professional curiosity being part of everyday practice	Working on actions and sharing with operational teams	On-going work to evidence and audit due Dec 2019
DHR Cambridge	PCART North	3 recommendations: Handovers, transfer of care out of county and assurance re working with risk policy	Actions complete	Audit due August 2019 to ensure changes in place as result of actions
SAR: Ref008	DN Kettering	None identified for NHFT	None identified from NHFT IMR	None for NHFT
SAR: 010	Summers Unit	3 actions from NHFT IMR re access to health records, MCA training compliance and promote use of self-neglect toolkit	Working on actions and sharing with operational teams	On-going work to evidence and updates due to NSAB Sep 2019
SCR: Ref053	0-19 Northampton 1, FNP	Review of DNA policy and understanding neglect	Policy under review, NHFT working with partners around neglect agenda	Policy revised and due to be submitted for sign off June 2019
SCR: Ref064	0-19 Northampton 1, FNP	Multi agency recommendations around information sharing	Awaiting final report however reviewed NHFT escalation process	Awaiting publication of overview report and will work on actions once published as whole health economy
SCR: Ref070	0-19 Kettering	4 recommendations around Safeguarding supervision, professional curiosity and information sharing between services	Currently being shared with services	On-going work to evidence updates to NSCB end May evidencing work is being undertaken with teams at this time

We analysed data about safety incidents from three sources: incidents reported by the trust to the National Reporting and Learning System (NRLS) and to the Strategic Executive Information System (STEIS) and serious incidents reported by staff to the trust's own incident reporting system. These three sources are not directly comparable because they use different definitions of severity and type and not all incidents are reported to all sources. For example, the NRLS does not collect information about staff incidents, health and safety incidents or security incidents.

Between 1 April 2018 and 31 March 2019, the trust reported 44 serious incidents. The most common type of incident was 'pending review (a category must be selected before closing)' with 11. These were incidents where the trust had not yet assigned a category. Ten of these incidents occurred in Other – PMS service.
We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was not comparable with STEIS with 42 reported. The reason

for the difference of two was due to the trust downgrading two of the incidents and removing from STEIS.

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. The trust reported no never events during this reporting period.

The number of serious incidents reported during this inspection was higher than the 36 reported at the last inspection.

Type of incident reported (SIRI)	**CHS - Adults Community**	**CHS - Children, Young People and Families**	**CHS - Community Inpatients**	**CHS - End of life care**	**MH - Child and adolescent mental health wards**	**MH - Community mental health services for people with a learning disability or autism**	**MH - Community-based mental health services for adults of working age**	**MH - Forensic inpatient/secure wards**	**MH - Mental health crisis services and health-based places of safety**	**MH - Other Specialist Services**	**MH - Specialist community mental health services for children and young people**	**Other**	**Other - PMS service**	**Total**
Pending review (a category must be selected before closing								1					10	11
Medication incident meeting SI criteria	1		1	1									3	6
Apparent/actual/suspected self-inflicted harm meeting SI criteria							1		1			1	3	6
Unauthorised absence meeting SI criteria					3			1						4
Apparent / actual / suspected self-inflicted harm meeting SI criteria					3									3
Treatment delay meeting SI criteria	1	1									1			3
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)			1			1								2
disruptive / aggressive / violent behaviour meeting SI criteria					1			1						2
Pressure ulcer meeting SI criteria	1													1
Abuse / alleged abuse of adult by third party								1						1

Slips/trips/falls meeting SI criteria			1											1
Other	1													1
confidential information leak / Information governance breach meeting SI criteria								1						1
Confidential information leak/information governance breach meeting SI criteria										1				1
Environmental incident meeting SI criteria			1											1
Total	**4**	**1**	**4**	**1**	**7**	**1**	**1**	**5**	**1**	**1**	**1**	**1**	**16**	**44**

Providers are encouraged to report patient safety incidents to the National Reporting and Learning System (NRLS) at least once a month. The average time taken for the trust to report incidents to NRLS was 16 days which means that it is considered to be a consistent reporter.

The highest reporting categories of incidents reported to the NRLS for this trust for the period 1 April 2018 to 31 March 2019 were self-harming behaviour, implementation of care and ongoing monitoring/review and patient accident. These three categories accounted for 4083 of the 6361 incidents reported. Self-harming behaviour and treatment, procedure accounted for two of the deaths reported.

Ninety-seven of the total incidents reported were classed as no harm (68%) or low harm (32%).

Incident type	**No harm**	**Low harm**	**Moderate**	**Severe**	**Death**	**Total**
Self-harming behaviour	1066	542	71	3	1	1683
Implementation of care and ongoing monitoring / review	280	1021	32	1		1334
Patient accident	657	338	64	7		1066
Medication	599	12				611
Access, admission, transfer, discharge (including missing patient)	414	7	6			427
Infrastructure (including staffing, facilities, environment)	300	2				302
Disruptive, aggressive behaviour (includes patient-to-patient)	193	34	2	1		230
Documentation (including electronic & paper records, identification and drug charts)	211	1				212
Treatment, procedure	165	9	3		1	178
Consent, communication, confidentiality	157	1				158
Other	67	6	1	4		78
Medical device / equipment	42	2				44

Incident type	No harm	Low harm	Moderate	Severe	Death	Total
Clinical assessment (including diagnosis, scans, tests, assessments)	16					16
Infection Control Incident	8	3	1			12
Patient abuse (by staff / third party)	7	1	2			10
Total	**4182**	**1979**	**182**	**16**	**2**	**6361**

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 1 April 2018 to 31 March 2019 compared with the previous 12 months. Moderate incidents have fallen when compared to the previous year (24%) and the number of deaths has also fallen from 20 to two this current year. However, the number of reported severe incidents has increased by seven when compared to 2017/2018.

At the time of inspection, we had received notification from the trust of four further deaths three of which were apparent suicides. One on Cove ward, one on Marina ward, both of which were suicides. A patient's death occurred within the UCAT team, whilst the patient waited admission to the Warren and a further death was reported within one of the trust's prison services. Investigation into all four deaths was ongoing.

Level of harm	1 April 2017 to 31 March 2018	1 April 2018 to 31 March 2019 (most recent)	Difference (+/-)
No harm	3887	4182	295 (7.6%) ↑
Low	2051	1979	72 (-3.5%) ↓
Moderate	240	182	58 (24.1%) ↓
Severe	9	16	7 (77.7%) ↑
Death	20	2	-20 (90%) ↓
Total incidents	6207	6361	154 (2.5%) ↑

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.

We reviewed four 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.

Improvements had been made by the trust since our last inspection, in learning from serious incidents and deaths. The trust had introduced a mortality lead role, which sat within the patient safety team. It was the same staff member who had oversight for serious incident investigation. The patient safety team received all electronic incident reports, raised by clinical teams. A new stage of the process had been introduced called the Internal Assurance Meeting (IAM). Any incident could be re-designated or regraded as an incident requiring or not requiring an investigation. We heard that a very small number of deaths had been recategorised as requiring an investigation following the IAM meeting. A new IT system was in use called SMART which allowed a variety of search parameters to be inputted following incidents or deaths to gain insight into themes and trends. We heard that this was in early stages since June 2019 and more was to be done to maximise the potential of the system.

We heard how the trust had created a family liaison worker role. This post was created following feedback from families who had experienced the death of a loved one whilst receiving care from the trust. The family liaison worker was appointed to investigations from the outset and contacted families immediately. They remained in constant contact with the family during the investigation until its end and signposted them to external services for additional support. We heard that a family group was now in place which involved three family members who reviewed themes from investigations and developed learning from incidents to be shared across the trust.

We heard how learning lessons from deaths had become a focus for the trust in the last 12 months. The electronic incident system had a facility which identified actions from learning and could be updated as they were completed. A dashboard showed actions not completed or open which could be followed up by the safety team. Service delivery issues were categorised, and themes reported. The trust told us the new approach had given more transparency and openness when things went wrong. They told us that families who had been involved in developing lessons learnt and with the family liaison worker had reported a positive experience.

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. The trust completed 52 audits, both local and national in the last year. Examples included: audits of falls, national audit of intermediate care, clinical audit of psychosis, sexual health audits, pathway audits, fluoride provision in special care dentistry, fatigue management, NEWS (national early warning scores).

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

We were assured that the board operated with the required information needed to ensure safety and analysis and agreement of risk and performance. The board received a wide range of

information for scrutiny, review and approval. The process for review was observed during our inspection and we saw opportunity afforded for challenge, discussion and approval. Trust wide dashboards were in operation and included metrics such as workforce, recruitment, training, supervision, out of area placements, caseloads vacancy rates and serious incidents.

Team managers in core service had access to information needed to ensure oversight of their services. If managers had difficulty accessing this, they knew where to seek help to do so. Local dashboards were effective, and managers told us they had the right level of access to ensure oversight.

The trust had introduced statistical process charts (SPC) to monitor areas of performance and risk. These charts provided additional scrutiny of the trust performance dashboard and allowed a more detailed look into service data from the overarching dashboard. Managers in core services told us they were able to drill down into dashboard data to look at specific information. For example, safeguarding, incidents, restraints, sickness. Senior leaders told us these had been an improvement and positive step to deeper dives into data for their services. As part of the trusts' board development programme, workshops were planned on the use of SPC led by NHS improvement.

Community teams had improved IT access and connectivity to be able to carry out their roles. The trust had worked with staff to test which technology was most suitable for their roles. In total, 86 participants trialled a variety of devices. We heard examples where flexible working from satellite sites and from home was possible with a virtual VPN called PULSE. A new stage login for staff working from home was quicker and easier. Laptops and iPads for community teams allowed easier access to clinical records and for prescribing. We also heard an example where the technology had allowed staff to make onward referrals to other teams more quickly.

The patient safety team uploaded action plans from serious incidents onto the incident reporting system. This improved the monitoring and reporting of actions from investigations into the governance assurance process of the trust.

The trust continued its journey to electronic systems for staff information. The electronic staff record (ESR) was able to upload and hold additional information since our last inspection. More elements of staff information had been included, such as sickness and training.

The trust implemented an accelerated roll out of an electronic rostering system in line with Carter recommendations. Staff told us it had been helpful when planning staffing and checking staff leave allocations.

The roll out of an electronic prescribing system had been delayed but a system had been procured and there was a dedicated pharmacist and technician to support delivery. The roll out was estimated for the mental health wards for summer 2020.

Staff told us that training for any new IT system introduced by the trust had been easy to access. An E-Systems super user group had been established with 122 users trust wide. This group were trained in a variety of E-Systems (payroll, leave, training, supervision, rostering) and over the course of three network events, the super users were in a place to educate and share knowledge across the trust.

Information governance (IG) systems in place were effective and accountability sat with the audit committee (a subcommittee of the board). The trust improved its compliance with the NHS Digital Information Governance Toolkit, scoring 96.6%, an improvement since our last inspection which

scored 90%. The trust had formed a data governance group within the wider healthcare system which included commissioning groups and the two local general hospitals and the leads for information governance from each organisation. Information governance breaches had been reported as required, with no serious incidents reported. Minor incidents included lost notebooks, which required further education for staff.

The trust assured itself around cyber security and had undertaken 'game of threats' facilitated by an external provider.

The trust submitted notifications to external bodies as required.

The annual Community Mental Health Survey is the only national survey in the UK focusing on people's experience of using these services that enables direct comparison between providers. However, there were major errors in the trust's sampling or submission to the 2016 Community Mental Health Survey that put the usability or quality of the data at risk, which unless rectified could mean the trust's data could not be used.

When a patient is detained under the Mental Health Act (MHA) in hospital, the provider is required to submit a record to the Mental Health Services Data Set each month until the detention ends. Between December 2017 and November 2018, the trust only provided end dates for 52.5 % of Mental Health Act episodes for detentions, which had ended. This gives an incomplete picture about the provider's use of the MHA and indicated there may be problems with recording or sharing data externally.

Engagement

We continued to be impressed with the high and extensive levels of engagement within the trust and with stakeholders and external agencies.

The trust had a staff engagement plan called 'Let's talk' launched in 2018 linked to the trusts' mission. This was a visual, colourful two-page document with the trust values deliberately shown across the top of each page. It captured how staff could be involved in engagement, raised awareness of use of the trust intranet page 'the staff room', encourage staff to make nominations of colleagues for the quality awards, and to thank a colleague and comment on trust activities. It also highlighted the 'Let's talk plan' which showed two-year goals to achieve and areas which will make a difference for staff and improve care delivered. It also identified areas of strength and improvement from the 2018 staff survey and included locality objectives for each of the three trust directorates. Results from the 2018 staff survey showed the 'Let's Talk' plan achieved significant positive outcomes for staff engagement. The engagement score rose to 7.5 (7th nationally of all trusts as a place to work, and an increase year on year, the highest score for trusts nationally). The trust also achieved significant improvements in health and well-being (second nationally), and in safety culture (fourth nationally). The 'Let's talk' initiative was a key part to the trust being awarded, in September 2019, a Chartered Institute for Personnel and Development (CIPD) awards in the Best Employee Experience category.

We heard about a recent project called 'Civility saves lives' which started in August 2019. This had two executive directors as leads. It was established because of the staff survey which showed above average results of bullying and harassment or abuse from other colleagues (17%). The project had an outline, rationale and evidence for its existence, objectives scope and exclusions, a timeline and milestones to deliver objectives, key risks, benefits and how it was communicated and delivered to staff. It aimed to deliver workshops to staff with HR, and staff side; a project group and terms of reference to deliver objectives with an aim to redesign a 'resolution

policy’ to replace the grievance and bullying policy; it set out to design ‘working together conversations’ for staff and a plan to host engagement events with staff to co-produce working together frameworks across the trust.

We were impressed with the further work the trust had achieved with Freedom to Speak Up (FTSU) since our last inspection. The trust fostered a positive culture of speaking up and ensured that issues raised were seen as opportunity to learn and make improvement. There were 135 whistleblowing concerns between 01 April 2018 and 31 March 2019 with the highest concerns being raised in relation to patient safety and bullying and harassment. The number of concerns were below the national average. The number of anonymous concerns raised was 7% less (9 total), in comparison to a year ago. 84% of concerns raised were assessed as low or moderate risk and four as significant risk.

The trust viewed fewer concerns raised anonymously was positive and felt that staff were more able to give their details when raising a concern, as the trust encouraged openness and honesty. Staff told us they felt able to raise concerns and that senior leadership took action. The trust delivered listening events for staff to attend to raise issues and conducted some case reviews of particular concerns to identify learning. The trust implemented a ‘Respect and compassion’ charter for all staff to sign within their teams to address issues around bullying and harassment.

The trust had a substantive Freedom to Speak Up Guardian (FTSUG), who was very active in their role, visible to staff and approachable. Events were publicised well and attended by staff. Drop in sessions took place in communal areas of the organisation to promote the role of FTSU. The trust had robust oversight of concerns raised and scrutiny of issues took place in the quality and governance forum and at board. The FTSUG also presented to the strategic executive board quarterly to allow scrutiny of individual cases and analysis of themes and trends.

The trust had 26 FTSU champions and a FTSU champions forum was in place. This commenced in January 2019 and ran quarterly. Forums provided an opportunity for champions from across the trust to come together and discuss how FTSU worked. Champions included members from each minority group in the trust. In addition, monthly meetings took place between the forum and executive leads.

The FTSUG completed a review in September 2018, of the trust approach to speaking up and used the NHSi self-review tool. This reviewed actions in place to develop FTSU. The FTSUG completed a second review in July 2019, and the board confirmed their assurance that processes in place met the needs of speaking up and the trust was compliant in all areas of the review. This review contributed to the trusts ‘Let’s talk’ engagement programme. The board reviewed the FTSU strategy and progress to date had been agreed with all four areas rated as completed. The trust was shortlisted as a finalist for the Freedom to Speak Up organisation of the year award. Results will be announced in November 2019.

In 2018 we heard about the feedback survey run by the trust called ‘I want great care’. The trust continued to participate in this initiative. This service allowed patients and carers to comment on the care they had received. The trust reported an additional 30,979 pieces of feedback since our last inspection. The initiative remained embedded into governance, quality and strategy processes. Examples of how feedback led to improvements in services included the introduction of Saturday health visiting clinics; improvements to diabetes courses; new appointment systems in CAMHs services, SPOA and district nursing service; personality disorder training for carers; raising awareness of transgender issues in sexual health services; service development of a

second crisis house and improvements to the complaints handling process to further involve carers.

In the 2018 Community Mental Health Survey, the trust scored 6.8 out of 10 for patients having been given enough time to discuss their needs and treatment, which was worse than the average range of 5.3 to 6.7 out of 10. In the 2018 Community Mental Health Survey, the trust scored 2.8 out of 10 for patients having been given information about getting support from people with experience of the same mental health needs, which was worse than the average range of 2.8 to 4.1out of 10.

The trust had a deeply embedded approach to co-production. At our last inspection we heard many examples of quality improvement initiatives and projects which had been co-produced. We saw the trust continued this approach and it was accepted as part of the trust culture, and everyday business as usual. Staff had a truly patient-centred ethos and where any opportunity arose, staff, patients' families and carers were involved in decisions about care, service redesign, policy changes and the launch of new projects and events. Each directorate had a co-production group who reviewed the feedback from IWGC and complaints. Feedback from IWGC was reviewed monthly at the patient experience group, the Quality Forum and operational management teams.

The trust gave us further examples of co-produced work. The Crisis Care Concordat was now chaired by carers; the Short Breaks services held joint meetings with parents and commissioners; a 'Moving Ahead' project (improving access to mental health services and improving patient experience for the BME community) took place; governors had contributed to the Public and Patient involvement strategy; the board consistently heard patient and staff stories at board meetings; a delayed transfers of care charter designed with patients.

The trust board approved and launched a Patient and Public Involvement strategy (2019 to 2022) in March 2019. This brought together work on involvement, engagement and volunteering in the trust. It outlined the trust plans to develop engagement. They included partnership working, training and support, projects for engagement, promotion and leadership of the strategy.

The trust had encouraged and developed volunteer roles since our last inspection. There were 16 paid 'involvees' from a group of approximately 80 volunteers who worked across the trust. Roles included group work, interviews, medicines management group attendance, attendance at conferences and roles in the Recovery College. The trust planned to review the hourly rate paid to involvees. The trust told us that patient involvement in community health services was more challenged.

A proactive carers group continued which met on a bi-weekly basis. The trust acknowledged it needed more carers to join. A carers strategy developed for 2017/18 had not been updated but the trust had a very strong relationship with Northamptonshire Carers Association.

We heard how the engagement with governors of the trust had improved in the last 12 months. Both governors, executive directors and non-executive directors told us how engaged and involved in discussions and decisions about services had improved. Governors meetings took place regularly and the voice of governors was heard at board. Governors played an active role in holding non-executive directors to account. The board ran specific sessions for governors to raise awareness of issues or explain specific topics; for example, the finance and performance committee delivered a session on trust finances. Governors played active roles in promoting healthcare services in their constituencies and countywide and told us they felt listened to at board

level and their views and concerns were taken seriously. In January 2019, a joint training event delivered by NHS providers facilitated networking between trust governors and governors of a local acute general hospital. However, some governors reported not all their ideas were embraced, or listened to, but there were always opportunities to share ideas.

The trust collaborated with and engaged extensively with the wider system, stakeholders, local businesses and national groups and networks. For example, carers partnerships, development of joint ventures and partnership working with primary care and third sector (crisis cafes); housing links with Kettering Borough Council; work with the Police and Crime Commissioner to develop health interventions for both victims and offenders; a revised model of healthcare in police custody and work with prisons to develop prison healthcare. The trust worked with local commissioners from April 2019 to move mental health services to an outcome focused provider collaborative. The trust hoped to build on existing work to operate as a lead provider.

The trust was the lead provider for the NHS England provide collaborative for CAMHS (Tier 4) care. Ten organisations were part of the collaborative and it meant the trust would be responsible for Tier 4 services in the East Midlands. Also, the trust had developed plans to form an East Midlands Mental Health Alliance between NHS providers, and third sector providers to work together to improve outcomes and develop workforce and raise the profile of mental health nationally.

The patient experience group included members from Northamptonshire Healthwatch.

The trusts' intranet was interactive, vibrant and easy to use. Called 'The Staff Room', staff had access to all trust information, governance structures and policies. Lessons learnt were shared, important messages communicated and there was a place for staff to acknowledge and thank colleagues for their work. At the time of our inspection, the trust had recorded over 1,000 staff thank you's in the last year.

The trust had a dominant, active social media presence with daily messages posted which promoted services, offered advice, advertised vacant posts and celebrated success. In total the trust recorded 11,508 social media followers at the time of our inspection. The website received 105,000 monthly views.

Learning, continuous improvement and innovation

We heard many examples of quality improvement and innovation that had a wide-reaching impact for staff and patients. The organisational wide approach, culture and practice of co-production had continued to grow from strength to strength. The opportunities for staff, patients, carers and stakeholders to be part of service delivery and innovation was extensive.

The trust had made a commitment to 2019 to 2020 to 'develop the culture, capacity and capability to support innovation and research within the trust'. The trust submitted details of 19 quality improvement projects across various core services, that have been trialed, tested or produced formal research papers or presentations. For example:

The project 'Moving Ahead' with an executive sponsor pushed forward the trusts' agenda for equality, diversity and inclusion. It stimulated discussion with stakeholders and the minority groups with the county and focused on equity for patients from BME backgrounds to access mental healthcare. It had several workstreams which raised awareness to the public, through listening events and conferences. A special research and innovation group, part of the project,

used data to record and code ethnicity data for all trust patients. This provided a dataset baseline with which to demonstrate any impact of initiatives on patients. Also included in the project, was the trusts use of IWGC data which asked two additional questions on cultural and spiritual aspects of care. In October 2018, there was 15,056 responses to the cultural questions and 13,644 response to the spiritual questions. Both pieces of work were presented at the Royal College of Psychiatrists transcultural mental health conference in February 2019 and at an East Midlands Mental health clinical network Diversity in mental health conference in June 2019.

The trust continued to pioneer research into rTMS (transcranial magnetic stimulation therapy for treatment of depression). The work undertaken continued to be promoted and recognised nationally and various research papers had been accepted for publication or presentation at conferences.

At our last inspection we reported on the trust initiative around body worn cameras. This innovative project has gone from strength to strength, and the trust presented at the NHS England use of restrictive practices in NHS commissioned care settings. At this inspection, we heard of a second evaluation of the project had been undertaken to produce a further paper for publication.

Within some mental health services, a project was established to measure weight, sleep, activity heart rate and exercise using a ‘wearable technology’, a less invasive way to monitor health vitals. The information can be viewed via a dashboard of information when downloaded and used to inform clinical decision making. The pilot project planned to use 30 patients and alongside a local university and NHSE, the feasibility project will be developed further.

Community nursing teams demonstrated results of a pilot which used a product to heal leg wounds. Results were presented to the commissioning group and support was given to continue the project.

The trust piloted the use of safety pods in seclusion rooms to reduce prone restraint. The pilot started in March 2019, and the trust expected to see a reduction of prone restraint by 20%.

Other innovation projects have included virtual reality relaxation; a treatment resistant depression pathway; ‘Be on the Team’ – an evaluation of immunization with group B meningococcal vaccines; late onset dementia genetic project; genetic research into childhood onset psychosis; a prevention pilot for indwelling urinary catheters; home heart failure monitoring;

Co-production of services played a large role in continuous improvement of pathways. The success of the crisis pathway which included crisis cafes was co-produced with patients following feedback on their experience. The Recovery College model continued to deliver person centered, goal-oriented education and recovery programme with patients’ ideas leading service design. The trust worked in partnership with local GP surgeries to design and deliver same day care pathways for children under six years, patients with musculoskeletal problems and frequent attenders with a mental health complaint.

We saw how the trust had made improvements to its learning culture following serious incidents and deaths. A culture of openness and honesty following incidents was in place.

Staff across services knew how to report incidents and were aware of the improvements the trust had made to its reporting systems to improve scrutiny and transparency of learning. We heard how the board were sighted on all incidents through sub committees and deep dives into incident data. The trust had created a family liaison worker role which had improved the connection between the trust and families who had been bereaved following an incident.

Staff development was integral to learning and continuous development of services. The trust Leadership Matters Programme, Quality Awards, Well-being events and innovation and creativity forums enabled staff to feel empowered to develop their skills and invest in the trust to improve services. Staff felt proud of their teams, felt included in decisions about services and felt their ideas were listened to. The trust facilitated external coaching for senior leaders across the Healthcare Partnership in the county. Senior leaders attended a leadership development programme facilitated by The Kings Fund. A number of nurses were awarded the 'Queen's Nurse Award' in recognition for their contribution to nursing in a community setting. The trust had a representative on the Florence Nightingale leadership programme delivered in the east midlands region. Reverse mentoring had a further cohort commencing in the autumn of 2019. The trust delivered a workshop called the 'Unconference'. The agenda was given over to participants to create the workshop conversation. We heard how this empowered distributed leadership and innovation of ideas amongst staff to improve services, led by staff in those services.

There was a strong appetite in the trust for learning and improvement in every opportunity. We heard from the trust board, that despite their successful inspection last year, the journey to achieve outstanding care was continuous.

Since the last inspection, and the rating achieved, the trust had engaged considerably with external organisations to share its journey and how it had achieved success. The premise of sharing their methodology was to enable other organisations to learn, the trust saw every situation and sharing of progress, as an opportunity to gain new learning for themselves.

The trust had entered into a buddy relationship with a neighbouring NHS trust in the summer of 2019, at the request of NHS improvement. Whilst the purpose of this arrangement was to support the neighbouring trust on a journey of improvement, this trust saw an opportunity to learn from them. Members of the senior leadership team at all levels, and staff from across the trust had met with their counterparts in the neighbouring organisation, spent time shadowing each other and understanding how each trust operated. Whilst the focus was on improvement of the other trust, this trust took every opportunity as potential for their own improvement.

The trust had established extensive networks with the wider healthcare system. The trust had numerous members of the board involved in stakeholder meetings, leading healthcare pathways and had a wide-reaching influence over healthcare in the county. This approach ensured the trust could spearhead ideas for joint working, commissioning and funding of care. The trust saw the future of healthcare in the county as challenging, but more of an opportunity to be the driver for outstanding care pathways for the population of Northamptonshire.

The trust had won a number of national awards in the last 12 months:

- CIPD – People management awards 2019 (September 2019) – winner of best employee experience awards for the trusts' 'Let's talk' plan, staff engagement strategy

- Nursing Times Workforce Summit awards 2019 (September 2019) – winner of best well-being and staff engagement initiative for the trust's NHFT: Your health, your well-being
- NHS Parliamentary awards: regional winner for Excellence in Mental Health award – for partnership working with MIND providing the Crisis Cafes (July 2019)
- HSJ Patient Safety Awards 2019 – Learning disability Initiative of the year for trusts' work on sexual offending of men with mild learning difficulties (July 2019)
- HSJ Patient Safety Awards 2019 – Mental Health Initiative of the year – for the trusts' crisis pathway and crisis cafes (July 2019)
- Healthcare People Management Association award for Effective Use of Diversity for the trusts' work on developing a diverse workforce, staff networks and reverse mentoring (June 2019)
- Healthcare People Management Association Highly recommended award for well-being
- HSJ Awards 2018 for Trust of the year (November 2018) recognised for offering excellent, patient centered care and shown to be innovative and forward thinking to meet the needs of the population.

The trust was also shortlisted for the following national awards:

- HSJ Patient safety award 2019 (to be announced November 2019)
- HSJ Freedom to speak up organisation of the year 2019 (to be announced November 2019)
- HSJ Staff engagement award 2019 (to be announced November 2019)
- National Older Peoples Mental Health and Dementia Awards 2019 for the Memory Assessment Service (June 2019)
- The Employee Well-being awards, Leadership and Culture Category – for the trust work which out well-being at eh heart of its culture (January 2019)
- Global Equality and Diversity Workplace Award – recognised the trusts' approach towards equality and diversity and use of research to make meaningful change (October 2018).

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) and the relevant dates.

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 has achieved GSF accreditation at Care Home Standard	Achieved September 2018, valid for three years
AIMS - WA (Working Age Units)	Acute mental health wards for adults of working age and psychiatric	Cove AIMS peer review took place on 25.8.2018 to 6.3.2021 Bay AIMS peer review took place on 6.3.2018 to 6.9.2019	Accreditation received February 2019

Accreditation scheme	Core service	Service accredited	Comments and Date of accreditation / review
	intensive care units	Harbour AIMS Peer review took place 29.05.2018 to 6.9.2020 Sandpiper - AIMS accreditation peer review took place 21.06.2018 Avocet - AIMS visit and review on the 27.06.2017 - further documentation submitted 30.01.19. Kingfisher - AIMS Accreditation Review visit – 20.06.2017	
AIMS - PICU (Psychiatric Intensive Care Units)	Acute wards for adults of working age and psychiatric intensive care units	Marina	accredited 5.9.2017
AIMS - OP (Wards for older people)	Wards for older people with mental health problems	Riverside Wards and Brookview - (Royal College of Psychiatrists -QNOAMHS Accreditation)	Accredited from 16th April 2019 – 15th April 2022
AIMS - Rehab (Rehabilitation wards)	Long stay/rehabilitation mental health wards for working age adults	Meadowbank	Accredited 23.05.2017 - 22.05.2020
Quality Network for Inpatient CAMHS (QNIC)	Child and adolescent mental health wards	The Sett - Accreditation obtained April 2019, valid for the next three years.	The Burrows had its first peer visit in January 2018, Accreditation planned for September 2019 (dates delayed due to QNIC peer's availability for the inspection).
ECT Accreditation Scheme (ECTAS)		Accreditation is scheduled for 20 Jun 2019.	
Psychiatric Liaison Accreditation Network (PLAN)		The ALMH team have been working to develop the service to meet the required standards for PLAN and as such are now in a position to develop an application for accreditation over the next two months. Service visit carried out late 2018	Accreditation received September 2019

Accreditation scheme	Core service	Service accredited	Comments and Date of accreditation / review
National Diabetic eye screening quality assurance service (SQAS)		Diabetic Eye Screening (EQA SQAS) - Last visit Oct 2015, next visit due June 2019 - 3 yearly timescale (accreditation maintained as all recommendations are signed off by the Programme management Board (May 2016)	
Quality Network for Forensic Mental Health Services (QNFMH)		'Wheatfield - Full inspection 20.02.2017 and minor inspection on 19.4.2018	Accredited February 2019
Living Wage Employer		NHFT is proud to have been accredited as a Living Wage employer since 2015	
Disability Confident Employer		The Trust is an accredited disability confident employer under the government scheme, which works with employers to remove barriers, increase understanding and ensure that disabled people have the opportunities to fulfil their potential and realise their aspirations.	
Investors in the Environment Green Award 2018		The national accreditation scheme looks at our environmental management plan to make sure we are reducing our core emissions, including gas, electricity and waste, by 2% per year. The Trust has done exceptionally well by managing to reduce carbon emissions by 24%.	
Eat out, eat well accreditation scheme: Gold - SMH, IBH, DAN, CSH Silver - BWH		The Trust's hospital cafes: • Berrywood Silver accreditation • Cynthia Spencer Gold accreditation • Danetre Gold accreditation • Isebrook Gold accreditation • St. Mary's Gold accreditation	
Armed Forces Covenant Employer Recognition Scheme - Silver		We are proud to be supportive of those who serve in the armed forces, including veterans, reservists, cadets and forces families	

Accreditation scheme	Core service	Service accredited	Comments and Date of accreditation / review
rTMS		Quayside: - Has received RCN accreditation for training events.	
Wellbeing charter		Accredited November 2017	

In addition to the above, the trust received accreditation for:

- Northamptonshire Carers Association, level 3 accreditation (Highest level of accreditation to encourage employers to provide better opportunities for carers.
- Stonewall Diversity Champions 2019
- Investing in Volunteers (UK quality standard for good practice in volunteer management. (August 2019)

We were impressed how the trust celebrated success, internally and externally, and saw how the conscious decision to do so, had a clear and positive impact on improving and sustaining staff morale.

MH – Mental health crisis services and health-based places of safety

Facts and data about this service

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Trust Headquarters	Triage Car	N/A	Mixed
Berrywood Hospital	136 Suite	N/A	Mixed
Kent Close	The Warren	N/A	Mixed
St Mary's Hospital	136 Suite	N/A	Mixed
Trust Headquarters	Urgent Care Assessment Team	N/A	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean environment

Staff completed and regularly updated thorough risk assessments, including ligature risk assessments. Staff removed or reduced any risks they identified.

The psychiatric liaison assessment rooms in both Northampton and Kettering general hospitals had been recently updated and reviewed against the Psychiatric Liaison Accreditation Network (PLAN) core standards. The standards describe what all liaison psychiatry teams are expected to achieve. The psychiatric liaison assessment rooms were found to be meeting the standards and the service received accreditation at the time of our inspection.

We assessed the physical environments of the Health-Based Places of Safety against the standards set out in: Standards on the use of S136 of the Mental Health Act 1983 (England and Wales), and The Royal College of Psychiatrists, July 2011.

The Health-Based Place of Safety at Berrywood Hospital, Northampton did not meet the standards. It was designed in collaboration with patients and their feedback from having used the environment. The environment included a television and furniture which patients felt had helped to keep them calm. The room had two doors to enter and exit the room. The second door led into a staff room. Staff did not have the correct key to unlock the door when asked. Staff would not have been able to attend quickly in an emergency if the main entrance to the room was blocked. The room did not have an observation window or clear lines of sight to observe a patient at all times. Convex mirrors and CCTV were not in use to mitigate this risk. Staff were required to sit in the room with patients to be able to observe them effectively and safely. Staff told us if a patient became aggressive they would sit outside the room to observe the patient, with the door left ajar, which also compromised patient privacy and dignity. We read records that showed patients had attempted to abscond from the Health-Based Place of Safety. Staff restrained patients who had become aggressive and had made attempts to abscond from the suite. Staff transferred these patients to a nearby seclusion room for safety. However, this was on seven occasions out of 197 over a six-month period. Staff safely and effectively managed such situations.

The Health-Based Place of Safety at St Mary's Hospital, Kettering did not meet standards. It did not have an observation panel or CCTV in use. Staff were required to enter the room to check the safety of patients using the washing and toileting facilities. Neither Health-Based Place of Safety facility had secure access to fresh air.

The Warren 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 either male or female patients. There was a female only lounge.

Staff working within the crisis resolution and home treatment teams in Northampton had access to personal alarms. When activated, the alarms sounded and were visible on a board located in reception. Staff working within crisis resolution and home treatment teams in Kettering, had access to two alarmed rooms on site. Staff were also able to use rooms within hubs across the county.

Staff working at The Warren crisis house did not have access to room alarms or personal alarms. Managers told us the risk was mitigated by carrying mobile phones. Staff 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).

The Warren crisis house did not have a dedicated clinic room. Patients kept their own medication in a locked cupboard in their bedrooms.

The psychiatric 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 within the same building.

The Health-Based Places of Safety did not have dedicated clinic rooms. Staff utilised clinic equipment from the nearby wards.

All teams had access to emergency equipment, which was in date, regularly tested and ready for use.

All areas visited during this inspection were clean. However, staff at The Warren crisis house did not adhere to all infection control principles. We found a shared storage box of patient's toothbrushes in the female bathroom, and bath sponges and body puffs left in the shower. The manager told us they had sent a staff member to buy individual storage boxes. However, when we returned two days later the toothbrushes, sponges and body puffs were still in the same place all together and had not been separated, nor made identifiable to the patients

Safe staffing [1]

The core service had enough nursing staff of relevant grades to keep patients safe. Managers reported that they were able to adjust staffing levels to take account of patient presentation at The Warren crisis house, psychiatric 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 planned activities and sessions took place.

Managers made arrangements to cover staff sickness and absence.

Managers limited their use of bank and agency staff and requested staff familiar with the service where possible.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The core service had enough medical staff. Managers could use locums when they needed additional support or to cover staff sickness or absence. Managers made sure all locum staff had a full induction and understood the service.

The below chart shows the breakdown of staff in post WTE in this core service from 1 April 2018 to 31 March 2019.

[1] 20190607 Cross Sector Staffing Profile Analysis Tool AT001.xlsx; Vacancy benchmarking tool ; Turnover benchmarking tool ; Sickness benchmarking tool

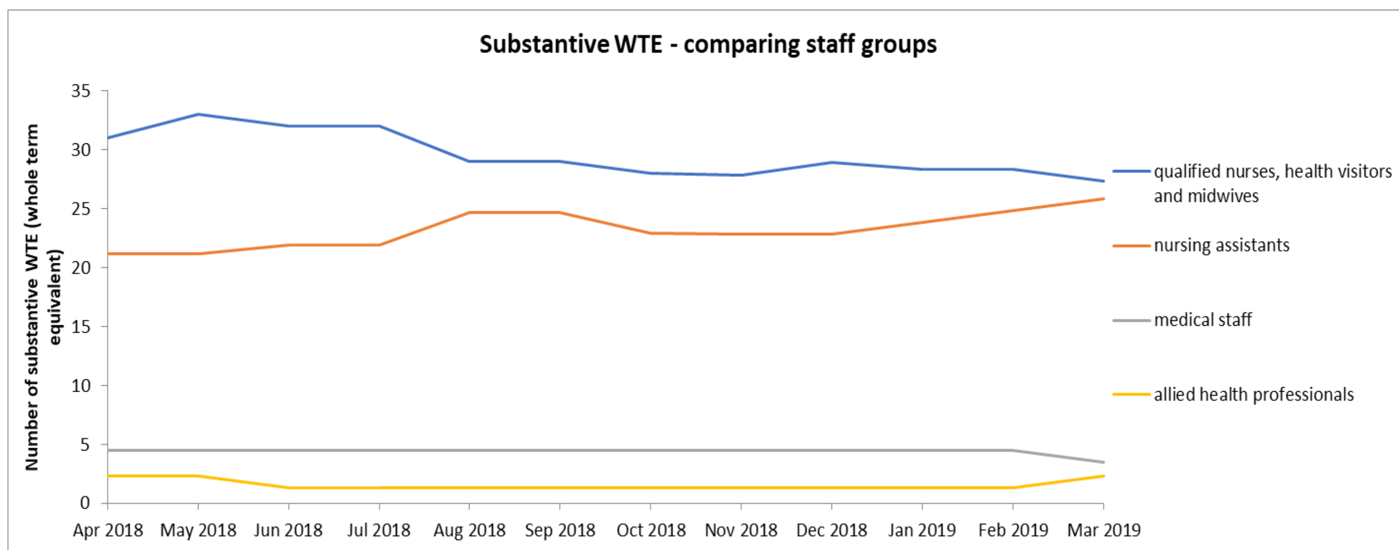

Figure 19

Annual staffing metrics

	Core service annual staffing metrics (1 April 2018 – 31 March 2019)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual "unfilled" hours (% of available hours)**
All staff	80.2	17%	3%	6.1%			
Qualified nurses	25.5	-14%	0%	8.9%	17582 (21%)	6408 (8%)	136 (<1%)
Nursing assistants	27.5	13%	0%	4.3%	20445 (36%)	11 (<1%)	676 (1%)
Medical staff	2.6	-70%	23%	0.4%			
Allied Health Professionals	4.6	68%	0%	0.4%			

All staff

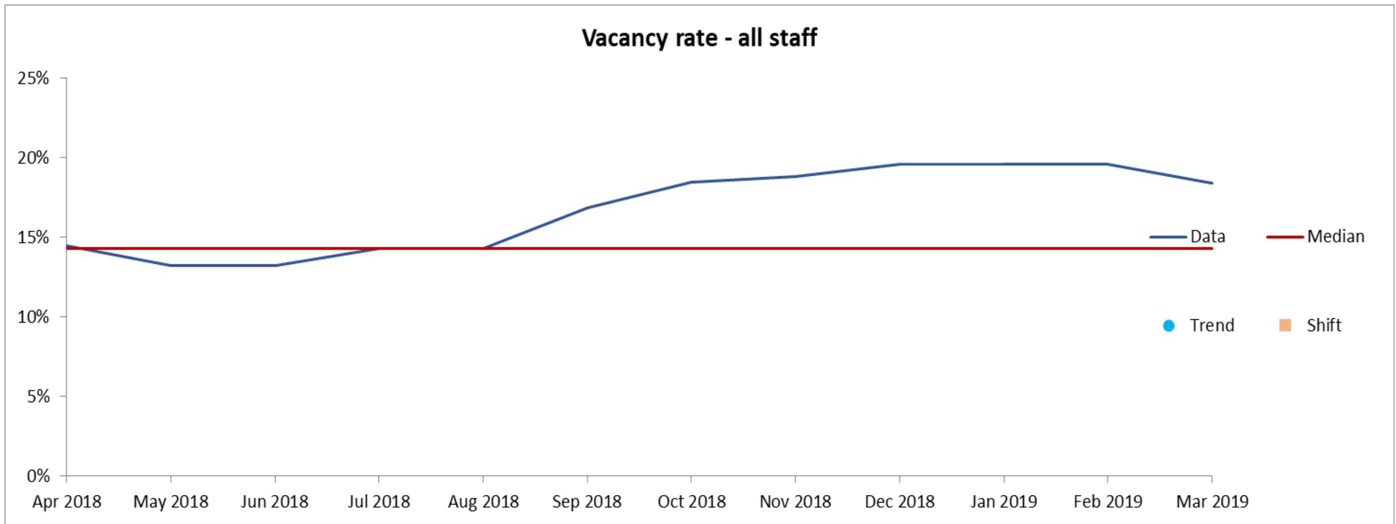

Figure 20

The vacancy rate for all staff when compared to other similar core services nationally, they were reporting in the highest 25%.

The annual turnover rate for all staff was in the lowest 25% when compared to other similar core services nationally.

Qualified nurses

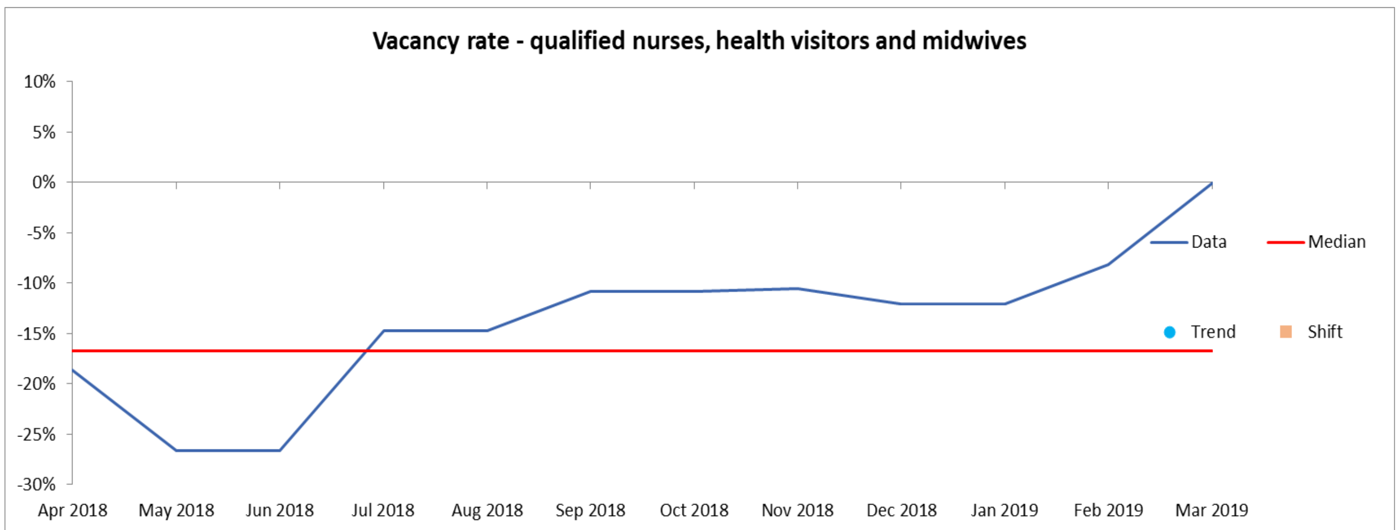

Figure 21

The vacancy rate for qualified nurses when compared to other similar core services nationally, they were reporting in the lowest 25%.

The annual turnover rate for qualified nurses were in the lowest 25% when compared to other similar core services nationally.

The average sickness rate for qualified nurses was in the highest 25% when compared to other similar core services nationally.

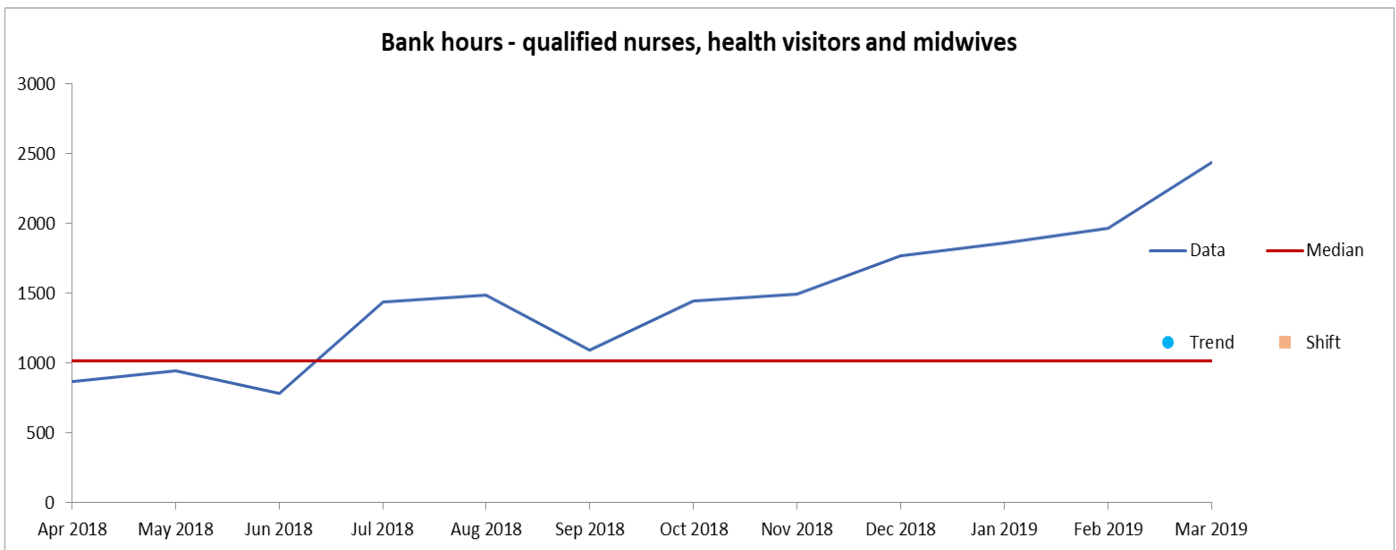

Figure 22

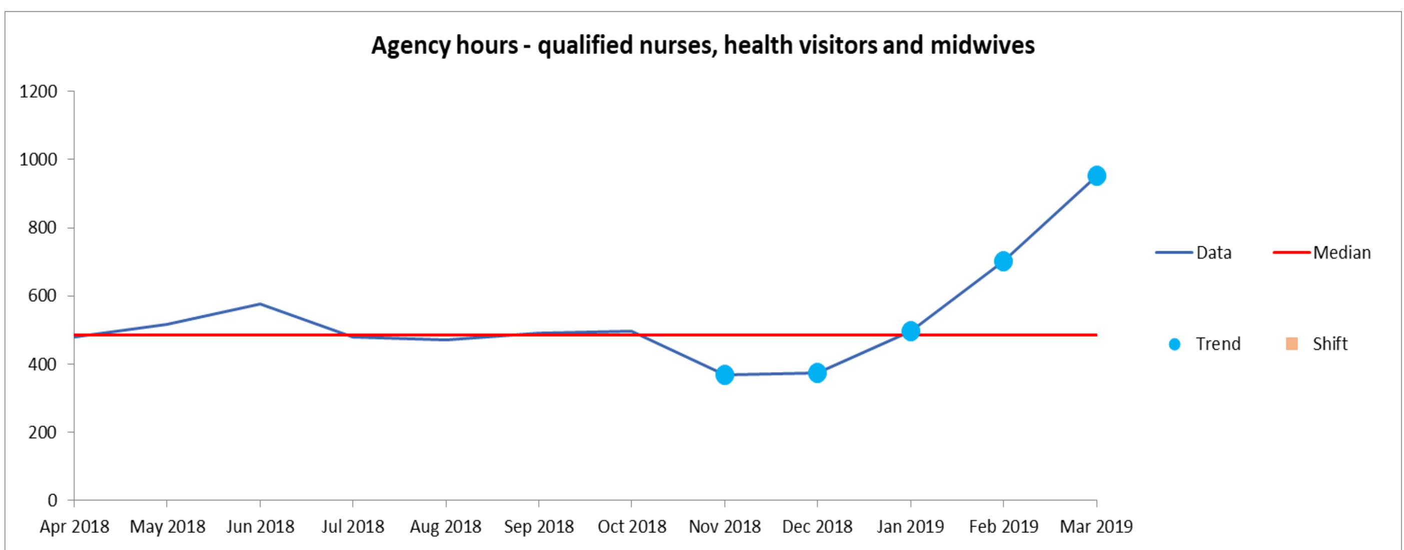

Figure 23

Agency hours over the last 12 months for qualified nurses showed an upward trend from November 2018 to March 2019 (see figure 5).

Nursing Assistants

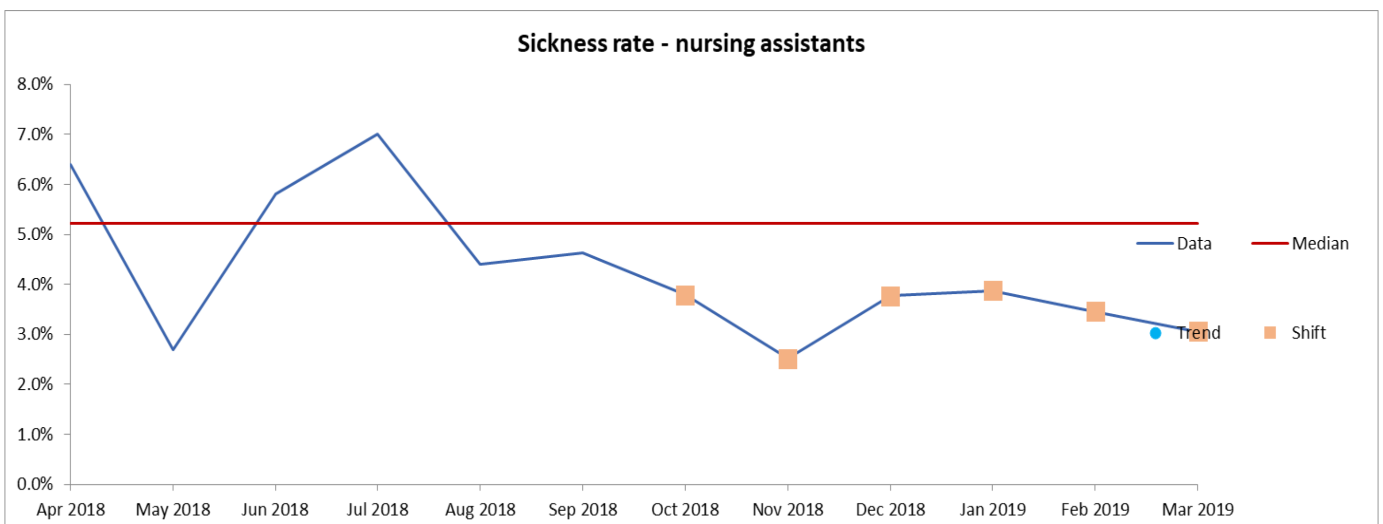

Figure 24

The annual turnover rate for nursing assistants was in the lowest 25% when compared to other similar core services nationally.

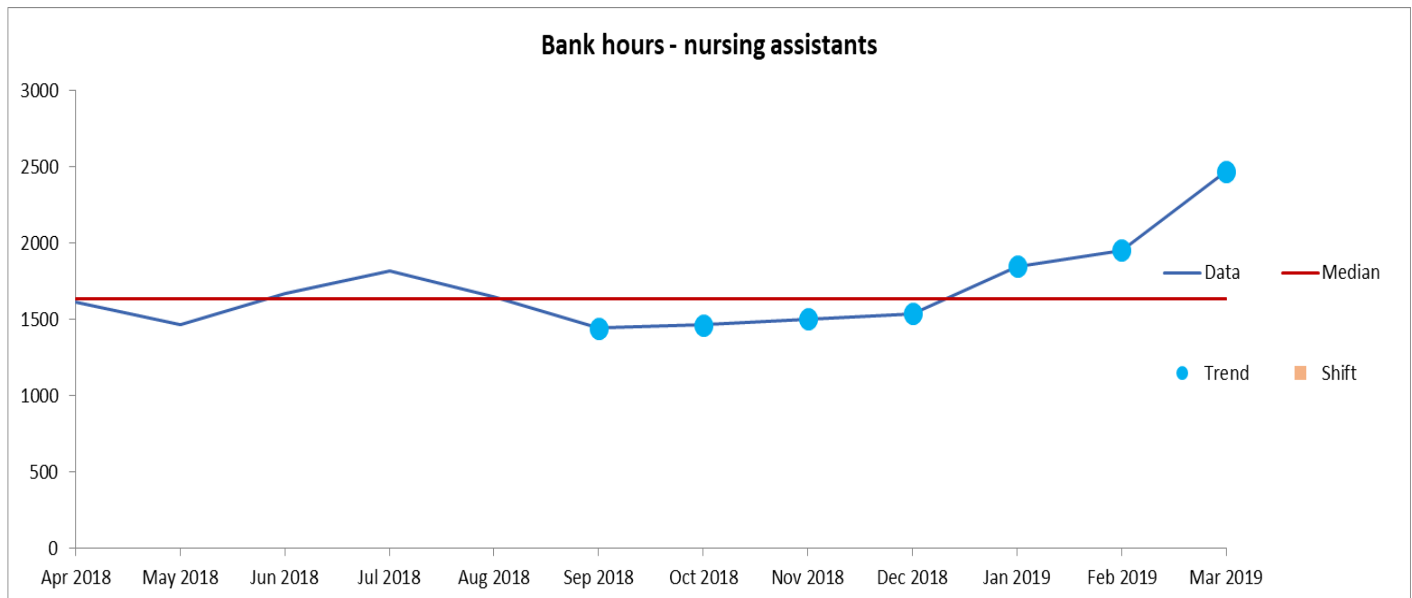

Figure 25

Monthly bank hours for nursing assistants across the 12 months showed an upward trend from September 2018 to March 2019 (see figure 7).

Medical

Vacancy rates for medical staff when compared to other similar core services nationally, were reporting in the lowest 25%, whereas allied health professionals were in the highest 25% nationally.

Turnover rates for medical staff when compared to other similar core services nationally, were reporting in the highest 25%, whereas allied health professionals were in the lowest 25% nationally.

Allied Health Professionals

The average sickness rate for allied health professionals was in the lowest 25% when compared to other similar core services nationally.

Mandatory training

The compliance for mandatory and statutory training courses at 31 March 2019 was 83%. Of the training courses listed nine failed to achieve the trust target and of those, one failed to score above 75%.

The trust set a target of 90% for completion of mandatory and statutory training.

Training is reported on month by month basis.

The trust did not submit training data for staff who had completed prevention, management of violence and aggression training.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✗	Higher ↑	No change →	Lower ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Moving and Handling - Level 2 - 1 Year	3	3	100%	✓
Safeguarding Children (Version 2) - Level 1 - 3 Years	4	4	100%	✓
Safeguarding Adults - Level 1 - 3 Years	4	4	100%	✓
Resuscitation - Level 2 - Adult Basic Life Support - No Specified Renewal	6	6	100%	✓
Resuscitation - Level 2 - Paediatric Basic Life Support - No Specified Renewal	6	6	100%	✓
Resuscitation - Level 1 - No Specified Renewal	6	6	100%	✓
Safeguarding Children (Version 2) - Level 2 - 3 Years	78	71	91%	✓
Safeguarding Adults - Level 2 - 3 Years	78	71	91%	✓
Moving and Handling - Level 1 - 3 Years	82	73	89%	✗
Information Governance and Data Security - 1 Year	82	70	85%	✗
Infection Prevention and Control - Level 1 - 3 Years	6	5	83%	✗
Resuscitation - Level 1 - 1 Year	76	62	82%	✗
Health, Safety and Welfare - 3 Years	82	64	78%	✗
Fire Safety - 1 Year	82	64	78%	✗
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year	76	59	78%	✗
Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year	76	59	78%	✗
Infection Prevention and Control - Level 2 - 1 Year	76	53	70%	✗
Total	**823**	**680**	**83%**	

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 44 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. We saw that staff discussed risk at daily handovers and in multidisciplinary meetings. 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. The crisis resolution and home treatment teams updated an electronic board throughout the day with patients fluctuating risk.

Staff increased the observations of patients when required to support patients in reducing the risk they posed.

Staff at the crisis and telephone support service (CATTS) dealt with risks from those who accessed the telephone support line by signposting, advising and referring onto other services were required.

Crisis resolution and home treatment teams allocated shift coordinators who monitored staff whereabouts. Staff recorded their daily visits on a white board so that their whereabouts were clear. Staff used a code word if a situation of concern occurred during a home visit. Staff we spoke with were aware of the trust's lone working policy. Staff risk assessed areas they visited as well as risk assessing patients. If a patient was not known to the crisis resolution and home treatment teams then two staff members would carry out home visits. Staff contacted GP surgeries and other services known to the patient prior to carrying out home visits. Alternatively, the patient could be seen in one of the hubs or at the GP surgery. Initial assessments were not carried out at a patient's home except for specific circumstances, such as post-partum, late stage pregnancy or due to a physical disability.

We looked at six seclusion records at the Health Based Place of Safety at Berrywood Hospital, Northampton for patients who had been detained under section 136 of the Mental Health Act 1983 between March and August 2019. Each seclusion record comprised a seclusion start form, observation record sheets, reviews, observations and a termination form. All records were complete and detailed the reason for seclusion. Each form included the date and time seclusion started and the time of termination. Medical and nursing reviews were completed regularly. Staff told us patients had required seclusion due to showing increased violence and aggression towards staff, which they could not manage safely in the Health-Based Places of Safety.

Safeguarding

All staff received training in safeguarding that was appropriate for their role. Staff showed detailed knowledge of safeguarding and described how they identified and made a safeguarding referral. Managers and staff reported a good relationship with the local authority safeguarding teams.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

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 adult at risk 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 adult at risk, 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 April 2018 and 31 March 2019, of which seven concerned adults and no children. The number of safeguarding referrals reported during this inspection could not be compared to the last inspection as the data was reported at trust wide level.

Number of referrals		
Adults	**Children**	**Total referrals**
7	**0**	**7**

The number of adult safeguarding referrals ranged from none to two per month.

The trust has submitted details of no serious case reviews commenced or published in the last 12 months (1 April 2018 and 31 March 2019) that relate to this service.

Staff access to essential information

The trust used an electronic patient recording system that all staff could access. All information needed to deliver patient care was available. The Health-Based Places of Safety did not have direct access to a computer. Staff observing patients used paper records to document notes then transferred them onto the electronic recording system. Paper copies were then destroyed.

Letters sent to GPs were located within the patient's electronic file.

Medicines management

Medicines were stored securely in accordance with the provider policy. There were no dedicated clinic rooms across the core service. At psychiatric liaison mental health services medicines were dispensed via Accident and Emergency. At the Health-Based Places of Safety, medicines were dispensed from the adjacent wards. At the crisis house, patients bought in and stored their own medicines in their bedroom safe. Staff prompted and supported patients to take the required medicines. The crisis resolution and home treatment teams shared the clinic room with other services.

We reviewed 18 prescription charts for the crisis resolution and home treatment teams and found all were completed thoroughly. Consent forms were completed within 48 hours and scanned on to the electronic recording system. Medicines were reviewed daily and discussed as part of the morning multi-disciplinary team meeting. A pharmacist attended the multi-disciplinary meeting when required and reviewed prescription charts weekly.

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 18 records we reviewed showed that patients had been given medicines information sheets.

All patients we spoke with told us that staff regularly explained their medicines, possible side effects and impact on any physical health issues.

Track record on safety

Between 1 April 2018 and 31 March 2019 there was one serious incident reported by this service. The incident type was 'apparent/actual/suspected self-inflicted harm meeting SI criteria and resulted in an unexpected death. Prior to inspection we were made aware of a second serious incident in

July 2019, that resulted in an unexpected death due to apparent / actual/suspected self-inflicted harm. Both incidents were linked to the UCAT service.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with one reported.

A ‘never event’ is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported no never events during this reporting period.

The number of serious incidents reported during this inspection was lower than the four reported at the last inspection.

	Number of incidents reported	
Type of incident reported (SIRI)	**Apparent/actual/suspected self-inflicted harm meeting SI criteria**	**Total**
UCAT PCLW (south)	1	1

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 staff had access to an online electronic system to report and record incidents.

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 improvements as a result of learning. One example being that shift co-ordinators at the crisis resolution and home treatment teams attended courageous conversations training. A further example was that the outside bins at the crisis house had been secured and window locks replaced. We saw evidence that staff discussed incidents and lessons learnt at the weekly team meetings across the core service.

Managers held debrief meetings with staff and patients after incidents. Staff told us that they received support following incidents.

Staff across the core service attended regular supervision, training and reflective practice sessions (STAR).

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went 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. There were no ‘prevention of future death’ reports for this core service.

Is the service effective?

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of each patient on referral and / or admission. We looked at 44 care plans across this core service. Care plans were up to date,

personalised, holistic, recovery orientated and included physical health checks. We saw evidence of patient involvement within care plans.

Care plans at The Warren crisis house captured patients 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.

The psychiatric liaison mental health services issued all patients with an information leaflet and completed a personalised action plan in collaboration with the patient upon discharge.

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.

Staff ensured patients had a full physical health assessment. Physical health monitoring was taking place across all services with timely correspondence and discussion with the patient's GP.

Best practice in treatment and care

Staff provided a range of care and treatment suitable for the patients in the service. Patients had access to a range of psychological therapies. Examples included problem identification and achievable goal setting, management of emotional distress, building emotional resilience and understanding and managing emotions group. Interventions included support for housing, employment and substance misuse.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes including Health of the Nation Outcome Scale (HoNOS) outcome measures.

Staff supported patients to live healthier lives – for example, through participation in smoking cessation schemes, healthy eating advice, and referral for support with issues relating to substance misuse.

This service participated in three clinical audits as part of their clinical audit programme 2018 – 2019.

Audit name	Audit scope	Date completed	Key actions following the audit
Baseline audit to assess the compliance of UCAT (South) with recommended physical health monitoring for patients who were commenced, or their antipsychotic was changed whilst under their care	UCAT South	31/07/2018	• Every patient commenced/or their antipsychotic changed or increased by a UCAT medic requires Physical health monitoring which should be part of their management plan and needs to be done either at Physical health clinic at Campbell house or via GP • The request for Physical health monitoring should be documented clearly in patient's case notes. If the patient refuses to have blood tests and ECG then this should be documented in their case notes and patient should be offered another physical health monitoring in line with recommended guidelines • If bloods are requested from GP then Physical health Monitoring form should be completed by NHFT staff

Audit name	Audit scope	Date completed	Key actions following the audit
			• Nurse-led clinic in secondary care to undertake recommended physical heath monitoring at recommended periods while patients are on antipsychotic medication for early identification of cardiovascular and diabetes risk factor is a feasible option
Overview of Electronic and Paper Record Keeping Audit – Mental Health & Adult & Child Q1, Q2, Q3, Q4	MH Community Crisis Services	10/04/2019	Teams to improve compliance for areas that are RAG rated as amber by developing team action plans • All teams to develop a Qualitative Record Keeping Audit. • Feedback results through pathway meetings
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	MH Community Crisis Services	Ongoing	• Creation of dedicated role for STORM training, update of trainers arranged, and comprehensive rolling training package being delivered. • Wrote and submitted zero ambition plan for NHS England – awaiting feedback (which was initially presented and approved at Trust Board) • Supported development of "Common sense Confidentiality" leaflet to support involvement of family/friends in planning of care • Delivered a number of ½ day briefing sessions on work of Suicide Prevention group and suicide prevention more broadly • Support development of suicide prevention course through recovery college • Continued participation in Countywide suicide prevention group, with plans to launch public-facing multi-agency campaign later in year

Skilled staff to deliver care

The core service had access to a full range of specialists to meet the needs of the patients. Teams included doctors, nurses, psychologists, psychiatrists, occupational therapists and support workers. Teams had access to social work support.

Staff we spoke with were experienced and knowledgeable and had the essential skills to meet the needs of the patient 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.

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. Examples included cognitive behavioural therapy training for a support worker, child and adolescence mental health training for all staff working in the psychiatric liaison mental health service, and training to become a Psychiatric Liaison Accreditation Network (PLAN) peer reviewer.

Managers supported non-medical staff through regular supervision of their work. All staff we spoke with described good quality and regular supervision. This took place in a one to one setting and group supervision, training and reflective practice (STAR) sessions.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers supported staff with personal and wellbeing issues through supervision. We saw examples of additional support offered in staff supervision files.

The trust's target rate for appraisal compliance was 90%. At the end of last year (1 April 2018 and 31 March 2019), the overall appraisal rate for non-medical staff within this service was 88%. This year so far, the overall appraisal rates was 91% (as at 24 May 2019). The wards with the lowest appraisal rate at 24 May 2019 were The Warren with an appraisal rate of 86%, and section 136 Suite at 75%.

The rate of appraisal compliance for non-medical staff reported during this inspection was lower than the 93% reported at the last inspection.

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 (as at 24 May 2019)**	**% appraisals (previous year 1 April 2018 - 31 March 2019)**
Crisis Helpline	4	4	100%	100%
EMAS Car	2	2	100%	100%
UCAT North	19	18	95%	100%
CRHT Team – South	14	13	93%	76%
The Warren	14	12	86%	85%
Section 136 Suite	4	3	75%	100%
Core service total	**57**	**52**	**91**%	**88**%
Trust wide	**3719**	**3413**	**92%**	**92%**

At the end of last year (1 April 2018 to 31 March 2019), the overall appraisal rate for medical staff within this service was 100%. This year so far, the overall appraisal rates this was 75% (as at 24 May 2019). The wards with the lowest appraisal rate at 24 May 2019 were rapid resolution medical with an appraisal rate of 0%.

The rate of appraisal compliance for medical staff reported during this inspection could not be compared to the previous inspection as the data was not comparable.

Ward name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals (24 May 2019)	% appraisals (previous year 1 April 2018-31 March 2019)
CRHT Team North	1	1	100%	100%
CRHT Team South	2	2	100%	100%
Rapid Resolution Medical	1	0	0%	100%
Core service total	**4**	**3**	**75**%	**100**%
Trust wide	**90**	**78**	**87**%	**80**%

The trust's target of clinical supervision for non-medical staff is 90% of the sessions required. Between 1 April 2018 and 31 March 2019, the average rate across all five teams in this service was 249%.

The rate of clinical supervision reported during this inspection was higher than the 186% reported at the last inspection.

Figures submitted by the trust showed compliance rates of over 100% in some teams. The trust captured various forms of meetings which they classed as supervision, including clinical, managerial, group supervision, reflective practice and safeguarding supervision. However, we were assured that team met regularly for clinical supervision.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide. In addition, the trust has advised that the trust policy requires a minimum of 2 supervision sessions/quarter which would explain the higher supervision rates in the table below.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Crisis - Crisis Resolution & Home Treatment Team	210	649	309%
Crisis - Crisis Resolution & Home Treatment (Hosp)	84	231	275%
Section 136 South	22	40	182%
Adult CMHT - Triage Car	10	17	170%
The Warren	82	79	96%
Core service total	**408**	**1016**	**249%**
Trust Total	**6128**	**12673**	**207%**

The trust's target of clinical supervision for medical staff was 90% of the sessions required. Between 1 April 2018 and 31 March 2019, the average rate across all two teams in this service was 129%.

The rate of clinical supervision reported during this inspection could not be compared to the last inspection as there was no data for medical staff.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide. In addition, the trust has advised that the trust policy requires a minimum of 2 supervision sessions/quarter which would explain the higher supervision rates in the table below.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Crisis - Crisis Resolution & Home Treatment Team	8	12	150%
Crisis - Crisis Resolution & Home Treatment (Hosp)	16	19	119%
Core service total	**24**	**31**	**129%**
Trust Total	**202**	**319**	**158%**

Multi-disciplinary and interagency team work

Staff held regular multidisciplinary team meetings to discuss patients and improve their care. All teams had daily handover meetings. We attended and observed a handover meeting and found they were effective in sharing information about patients and any changes in their risk level or care needs.

We saw evidence of good working relationships with external professionals and other organisations including GPs, local authority social services, housing, benefits, substance misuse services and local support groups.

Staff had good working relationships with other teams in the organisation. Regular cross sector meetings took place with other services and there were regular meetings with inpatient wards to discuss patients and plans for their care.

The psychiatric liaison mental health service had good links with the liaison psychiatry service for older people and could refer to the team for dementia assessments. Psychiatric liaison mental health services held joint team meetings with accident and emergency staff and ran training for general hospital staff, which included mental health awareness and suicide prevention.

The psychiatric liaison mental health service had an integrated pathway with child and adolescent mental health services (CAMHs). Psychiatric liaison mental health staff could assess young people who attended accident and emergency with low levels of self- harm and book an appointment with CAMHs for the following day. For any young person who was deemed high risk CAMHs would be called immediately.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

The trust did not provide any data relating to Mental Health Act training prior to inspection.

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 knew how to contact the approved mental health professional (AMHP) service. Psychiatric liaison mental health services 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.

The trust had clear, accessible, relevant and up-to-date policies and procedures that reflected relevant legislation and the Mental Health Act Code of Practice.

Referral for Mental Health Act assessment occurred on the patient's arrival at the Health-Based Place of Safety or as soon as a patient was medically fit for assessment. There were effective local arrangements in place to ensure a section 12 approved doctor and Approved Mental Health Professionals attended promptly to complete assessments.

For the majority, the Health-Based Places of Safety met the 24-hour target for detention under Section 136 of the Mental Health Act. The trust received a total number of 197 patients detained under section 136 of the Mental Health Act between March and August 2019. Ten were not assessed within the 24-hour target, which equated to under 6%. On two of the occasions an approved medical clinician extended the section 136. One assessment did not take place as 24 hours lapsed, and the patient left. Staff had not recorded specific reasons for the remaining seven.

Mental Health Act administration staff assisted with arranging assessments for patients detained under section 136 of the Mental Health Act 1983 during working hours Monday to Friday. A nurse was available to arrange assessments during out of hours. Staff spoke highly of the support received from the Mental Health Act administration team. There were good working relationships between the Mental Health Act administration team, the wards and crisis teams.

Informal patients at crisis house could leave at will; patients we spoke with confirmed this.

Good practice in applying the Mental Capacity Act

The trust did not provide any data regarding Mental Capacity Act training prior to inspection.

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 assessments and routinely thereafter. All patients at the crisis house had capacity to consent to an informal admission and management of their medication. This was documented in their care records.

There were no Deprivation of Liberty Safeguards applications made in the last six months across the service.

The trust had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and had access to it.

Staff gave patients every possible assistance 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 with regard to significant decisions.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with exceptional kindness and compassion. Patients we spoke with at the crisis cafes told us they felt the service had been "lifesaving" and had prevented them from attending accident and emergency or calling the crisis telephone support service. Patients said staff were truly caring, respectful, supportive and sensitive to their needs. Patients told us staff always listened to their choices and went the "extra mile". Patients consistently told us that the care they received exceeded their expectations. For example, staff arranging transport for patients to attend the crisis cafes, buying additional clothing for patients at The Warren crisis house and the psychiatric liaison mental health service supporting patients attending voluntary community services.

We observed staff interacting with patients and family members in a respectful, kind and supportive manner. Staff attitudes and behaviours when interacting with patients were exceptionally responsive and provided appropriate emotional and practical support.

Staff at the crisis house were extremely passionate, dedicated and highly motivated and showed a high level of understanding of patients' individual needs. Staff supported patients holistically to overcome their crisis. Staff worked closely with patients, including supporting them in day to day activities. Patients emotional and social needs were highly valued by staff and were embedded in their care and treatment. Feedback from the crisis house was constantly positive. Patients said staff worked well together and were kind, caring, welcoming and understanding, the facilities were excellent and that patients felt hopeful for a positive future.

Staff and patients knew each other on a first name basis, which reinforced respect for each other. Staff had a full awareness of patients' individual needs and preferences and were able to discuss patients in-depth. Staff showed a high degree of understanding of patients emotional and psychological needs.

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.

We reviewed 47 records of feedback for patients who had resided at the crisis house between January and August 2019, all were overwhelmingly positive. Patients commended staff on their team work, said they felt welcomed by staff, the facilities were excellent, and staff were caring, supportive, kind and compassionate.

The crisis and resolution home treatment team at Campbell House, Northampton, displayed patient feedback for August 2019 which showed 89%% of patients would recommend the service and gave a star rating of 4.8 out of five. Patients said they felt well cared for, staff were understanding and supportive.

The Psychiatric liaison mental health service provided patient feedback for June 2019 which two people had responded to. Feedback showed 100% of patients would recommend the service and gave a star rating of five out of five.

The trust calculated that between April 2018 and March 2019 between £454,240.80 and £776,405.96 was saved by the trust due to the use of the crisis cafés. Between February 2018 and March 2019 there were 786 crisis cafés held across the county, which were attended a total of

5,048 times. Overall, 801 people were signposted to other support services and 3,876 people reported that using the crisis cafés had prevented them from attending another service such as accident and emergency, the crisis resolution and home treatment teams or their GP.

Involvement in care

Involvement of patients

At the crisis house and Health-Based Places of Safety, staff orientated patients to the environment upon admission. Staff supported newly admitted patients and provided reassurance and support. Following patient feedback both Health-Based Places of Safety had a chalkboard located on a wall in each room with details about treatment, meal times and why they had been taken to the Health-Based Place of Safety.

The crisis house supplied male and female specific welcome packs for each admission. These packs contained information relating to dietary needs, visiting times, religion, faith and culture and Patient Advice and Liaison services.

There was a strong commitment by staff to include and collaborate with patients. We reviewed 44 care and treatment records and saw evidence in care records of patient involvement in care plans across all locations.

Staff always communicated with patients openly and honestly. Staff involved patients in discussions and decisions 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.

The Warren crisis house was developed and set up with patient involvement and co-production through service user reference groups involving patients and carers. This co-production was central to the culture and development of the service. Meetings were carried on regularly following the house set up and patients had the opportunity to continue to shape the crisis house. Examples included facilitating informal morning meetings to discuss what patients needed support with that day, menu planning and cooking, and developing 'my plan', which was a more structured, individualised plan of care for each patient.

County wide Crisis Cafes were designed and developed in collaboration with service users and their carers, to make sure that they met the needs of the people who used them. The crisis cafés were based at six locations across Northamptonshire and ran 15 times a week at evenings and weekends in collaboration with a partner agency. Crisis cafés were available for anyone 18 years old or over who found themselves in a crisis or needed support with their mental health. The crisis cafés had become overwhelmingly popular and alongside the crisis house, had reduced the number of admissions to acute mental health wards and attendances at accident and emergency.

Staff involved patients in decisions about the service including patients supporting with recruitment and interviewing recruitment of staff at the crisis house.

Involvement of families and carers

Patients we spoke with told us that their carers were consistently 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. The crisis resolution and home

treatment teams were able to allocate two staff members to a home visit, so that one staff member could offer support to the family member where required.

Staff routinely 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 and staff could refer carers to the trust carers group.

Is the service responsive?

Access and waiting times

The mental health crisis service was available 24-hours a day and was easy to access – including through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care.

We were impressed with the care pathway and range of services available to people in the county who were in crisis. The involvement of other organisations and the local community was integral to how the teams planned services and ensured that services met people's needs. The crisis care pathway offered a range of services and support systems for people to access treatment. Services included a 24/7 crisis telephone line, crisis cafes which were open at different locations every evening and at weekends, the crisis house, the crisis resolution and home treatment teams and the Psychiatric liaison mental health service. The trust had plans to open another crisis house in the near future due to the success of The Warren. The range and availability of countywide services allowed people to access services in a way and at a time that suited them.

The trust provided data which showed across the crisis resolution and home treatment teams, 86% of patients were contacted within four hours of referral. Managers told us when people had not been contacted within four hours it was due to patient preference.

We saw how crisis cafes and the Warren had significantly impacted on prevention of admission to hospital. Data provided by the trust showed 5,048 people had used the Crisis Cafes between February 2018 and March 2019, 89% of which would have used urgent or emergency services had the cafés not been available. Overall, 801 people were signposted to other services after discharge.

Since it opened in 2017, there had been 900 patient stays at The Warren crisis house. Overall, 530 of these avoided acute mental health hospital admissions. The trust provided data which showed between March and August 2019 The Warren had 162 admissions with an average length of stay of six days. During this period The Warren avoided an average 16% of acute mental health hospital admissions.

Between 01 June and 31 August 2019, the crisis telephone support service received 12,877 calls. Calls lasted from less than 10 seconds to 71 minutes in length. the crisis telephone support service provided a 24-hour a day telephone support service for people receiving support in Northamptonshire for mental health problems, their carers, families and friends. The team offered evidence-based techniques that people using the service could use to manage feelings and worked with people to help manage problems without having to access other services.

We saw examples of effective collaborative working between crisis and inpatient services. The crisis resolution and home treatment teams had skilled staff available to assess patients immediately 24 hours a day seven days a week. A member of the crisis resolution and home treatment teams visited acute mental health wards to offer discharge support to patients. The psychiatric liaison mental health services accompanied patients to acute mental health wards if and when required.

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 carrying out home visits in crisis resolution and home treatment teams offered morning, afternoon or evening appointments and gave patients two-hour time slots. Appointments ran on time and staff informed patients when they did not. Patients we spoke with told us they had not experienced any appointments being cancelled.

Staff supported patients when they were referred, transferred between services, or needed physical health care. Staff at the psychiatric liaison mental health services were able to give additional support to patients, including attending local voluntary and third-sector community services with patients to support in developing confidence. The service had a few patients who frequently attended accident and emergency with a mental health problem who had specific support plans developed in collaboration with staff. Additional support options included attending the recovery cafes and utilising the recovery college courses.

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

Name of hospital site or location	**Name of Team**	**Please state service type.**	**Days from referral to initial assessment**		**Days from referral to treatment**	
			Target	**Actual (median)**	**Target**	**Actual (median)**
Trust Headquarters	Crisis Resolution / Home Treatment	Crisis Resolution / Home Treatment	4 hours	0	4 hours	0
Trust Headquarters	Crisis Resolution / Home Treatment	Crisis Resolution / Home Treatment	Same Day if referred from GP (before 6pm)	0	Same Day if referred from GP (before 6pm)	0
Trust Headquarters	Triage Car	Triage Car	126	0	126	0

The facilities promote comfort, dignity and privacy

Patients could lie down in the Health-Based Places of Safety and had access to toilets and washing facilities. Staff accessed clean clothes and bedding for patients if needed and offered a range of food and drinks. The trust was smoke free and had policies and procedures in place to support patients with this. Patients in the Health-Based Places of Safety accessed electronic cigarettes if needed and patients at the crisis house could smoke in the community.

The Health-Based Place of Safety at St Mary's Hospital, Kettering and Berrywood Hospital Northampton did not offer patients direct access to fresh air. We were informed that patients were able to enter the adjoining acute mental health admission wards to use the garden area. This could only be facilitated when acute patients were not using the garden or lounge area of the ward.

The crisis house had free Wi-Fi and computers on site for patients. Patients were also able to access new clothing and toiletries. Staff at the crisis house asked patients about food preferences. Staff made arrangements for patients with specific diets such as vegetarian, halal and non-dairy. Patients cooked their own meals with support from staff. Special dietary requirements, and allergies were catered for in the Health-Based Place of Safety.

Patients' engagement with the wider community

Most patients who accessed crisis services lived in the community. Staff ensured patients had access to opportunities for education and work, and supported patients, for example attending external services with patients to support patients develop confidence

Staff helped patients to stay in contact with families and carers. They encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service supported and made adjustments for people with disabilities, communication needs or other specific needs.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. Across all services we found information leaflets available. These leaflets were available in languages spoken by the patients and local community. Staff were able to access hearing loops, language interpreters and sign language interpreters if required.

Crisis cafés ran from six locations across Northamptonshire 15 times a week during evenings and weekends. The crisis cafés were able to offer patients who wanted to attend the cafés with no transport a taxi. Due to popularity of the cafés, plans were in place open another crisis café day in other locations in November 2019.

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 knew how to make a complaint.

Managers actively reviewed complaints and responded within the trust timescale. improvements had been made as a result of complaints across the services.

This service received 15 complaints between 1 April 2018 to 31 March 2019. One of these were upheld, six were partially upheld and six were not upheld. None were referred to the Ombudsman.

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Ongoing	Withdrawn
Crisis Line	1		1			
Section 136 S4outh	2		2			
UCAT Home Treatment (North)	4		2	2		
UCAT Home Treatment (South)	8	1	1	4	1	1

This service received 128 compliments during the last 12 months from 1 April 2018 to 31 March 2019 which accounted for 7% of all compliments received by the trust as a whole (1752).

Is the service well-led?

Leadership

All leaders had the right skills and abilities to run a service that provided a high level of care. Leaders within the service had a robust and thorough understanding of the service, the skills, knowledge and experience to perform their roles. Leaders could explain clearly how the teams were working together to provide high quality care.

Staff we spoke with said that the leaders and senior managers were highly visible, extremely approachable and always available to them. Staff felt fully supported in their roles by leaders, both professionally and personally.

Leaders told us that they had numerous development opportunities and that they felt valued and supported in their roles.

Vision and Strategy

The trusts' vision was 'to be a leading provider of outstanding care'. Staff knew and understood the trust vision and values and what it meant to them in their day to day work and in the work of their team. Staff easily and proudly described the values, which were; people first, respect and compassion, improving lives, dedication and equality.

The trust senior leadership team had successfully communicated the vision and values to the frontline staff in this service. All staff were extremely passionate, caring, focused on putting patients first and patient recovery oriented. During the inspection we observed staff displaying the values in their interactions with colleagues and patients.

Leaders involved staff collaboratively in discussions about the strategy for their service, especially where the service was changing. For example, recruitment and future plans for the development of the crisis care pathway.

Leaders had a clear oversight of budgets and could explain how they were working to deliver high quality care within the budgets available. The provision of safe community spaces for those in crisis at the crisis cafés and The Warren crisis house resulted in significant financial system savings.

Culture

A values-based culture was embedded in the service. Staff felt respected and supported by leaders. Staff told us how they could raise any issues with their line managers who were highly visible. Staff could raise concerns without fear of retribution. Staff understood the whistle-blowing policy and who the speak up guardian was. Staff reported that the provider promoted equality and diversity in its day-to-day work. The core services had freedom to speak up champions embedded within the teams.

Staff we spoke with felt positive and passionate about their roles and the client group they were supporting. Staff felt valued by the leaders within the service. Staff repeatedly told us how proud they were to work for the trust and within their teams.

The trust continued to repeatedly recognise the hard work staff put in to the service. We saw evidence of internal promotion throughout the core service and staff could be put forward for staff quality awards. These took place throughout the year so that staff could enter several categories. Each of the winners were then entered into a contender list for the annual awards ceremony held towards the end of the year.

The service had won a number of national and local awards. These awards had significantly contributed to the high levels of morale in the services and how proud staff were to work for the team and the trust.

Staff had access to support for their own physical and emotional health needs through an occupational health service. Leaders addressed sickness and absence appropriately and supported staff to return to work. Between 1 April 2018 – 31 March 2019, three percent of staff had left the core service. The annual turnover rate for nursing assistants was in the lowest 25% when compared to other similar core services nationally.

Governance

Governance policies, procedures and protocols were embedded within the core service and were regularly reviewed.

Team meetings, handovers and joint meetings had a clear framework of what must be discussed. This ensured that essential information, such as learning from incidents and complaints, was shared and discussed and learning was disseminated to staff. The Health-Based Places of Safety had a space in the ward team meeting agenda to discuss patient presentation and any risks or concerns. In addition, there were regular supervision, training and reflective practice (STAR) days.

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 carried out weekly, monthly and quarterly internal and external audits. These covered all aspects of service. Leaders followed up on any actions from audits with staff as needed.

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 had a commitment to managing risk in a positive way.

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 basis to ensure

it was always appropriately staffed. Due to the nature of the service staff maintained contact with each other and external services to ensure the needs of the patients were met.

The services had contingency plans in place for emergencies, for example, adverse weather conditions or a flu outbreak.

Information Management

All teams we visited used effective and robust systems to collect data from wards and directorates. The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements to services. The information systems were integrated and secure. For example – the trust collected data from the crisis cafés which showed between February 2018 and March 2019 there were 786 crisis cafés held across the county, which were attended a total of 5,048 times. Overall, 3,876 people reported that using the crisis cafés had prevented them from attending another service such as accident and emergency, the crisis resolution and home treatment teams or their GP. Collecting this data had enabled the trust to develop plans to run the crisis cafés in other locations, on other days to meet demand.

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.

There were effective, multi-agency arrangements to agree and monitor the governance of the mental health crisis services and the Health-Based Places of Safety. Managers of the service worked actively with partner agencies to ensure that people in the area received help when they experienced a mental health crisis; regardless of the setting.

Staff made notifications to external bodies as needed.

The trust had an active social media campaign where crisis services were promoted and advertised to the public.

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.

Staff worked hard to ensure they gathered feedback on their services. I want great care continued to be used as a method for seeking feedback on services. 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 via forms and surveys.

Managers and staff had access to feedback from patients, carers and staff and used it to make improvements. 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 who were involved in the service development.

The mental health crisis care pathways were committed to improving crisis services for the public to ensure current and future services were informed by the feedback of service users and carers. A service user and carer group was being established by the crisis care concordat which service users and carers chaired and were encouraged to attend, to share their views and experiences of the crisis care pathway.

Learning, continuous improvement and innovation

The core service had continued to develop and improve following our last inspection. The psychiatric liaison assessment rooms in both Northampton and Kettering general hospitals had been recently updated and reviewed against the Psychiatric Liaison Accreditation Network (PLAN) core standards. The assessment rooms met the standards and the service had been awarded its accreditation certificate at the time of our inspection. The crisis care pathway had continued to develop with the introduction of the crisis cafés and a new crisis house was planned to open late 2019.

Leaders had clear direction to further improve treatment and patient experience within the crisis pathway.

The service aimed to support individuals in the community to avoid admission to a hospital setting. The crisis house was a supportive, caring and alternative environment to hospital and the crisis cafés had been overwhelmingly positive, both reducing the number of admissions to wards and attendances at accident and emergency.

Staff were encouraged to be creative and innovative and were utilised within the staffing team to make use of their existing skills. For example, a staff member with experience in learning disabilities giving additional support to a patient and helping them with a range of difficulties. Staff also told us they had been able to develop new processes and ideas, such as ensuring that patients accessing the crisis resolution and treatment teams were seen by the same three crisis workers during their treatment.

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 trust provided services which have been awarded an accreditation together with the relevant dates of accreditation. However, none of the information pertained to this core service.

The trust was awarded the (Health Service Journal) HSJ trust of the year award in 2018 and were finalists for HSJ patient safety awards for the changing culture award in 2019. The trust had also been shortlisted for three Healthcare People Management Awards, for effective use of diversity, staff wellbeing, and HR Director of the Year 2019.

The crisis pathway had won and been shortlisted for several awards between 2018 and 2019. These included the HSJ Patient safety awards winner 2019; this was awarded for a mental health initiative of the year for crisis community services; the crisis cafes and crisis house delivery secured this award. Again, the crisis pathway was awarded the NHS Parliamentary Awards 2019 Regional winner for Excellence in Mental Health category. Crisis community services (crisis house) had been shortlisted in March 2019 for the HSJ value awards 2020 for Mental Health

Services for initiatives which have delivered efficient and sustainable mental health services, delivering value whilst demonstrating excellent patient outcomes.

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

Facts and data about this service

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Trust Headquarters	Adult ADHD & Asperger's Team	-	Mixed
Trust Headquarters	Community Team for people with a learning disability and opportunities for you	-	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean environment

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Managers ensured that staff were able to maintain a safe environment. Staff did regular risk assessments of the care environments. Staff had undertaken a ligature risk assessment in the last 12 months.

Interview rooms were fitted with alarms and there were staff on site to respond to alarms. Staff had access to alarms in all interview rooms, in the event of an emergency.

Managers had ensured that the clinic room on the respite ward was fully equipped with accessible resuscitation equipment and emergency drugs. Staff conducted regular checks of the clinic including resuscitation equipment, oxygen and room temperatures.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. Patients and carers informed us that all areas were generally clean.

Staff adhered to infection control principles, including handwashing. Staff were trained in infection control. Staff and patients had access to alcohol gels and used these.

Staff maintained equipment well and kept it clean. Staff cleaned all equipment (including bean bags) after each use. Staff ensured that any 'clean' stickers were visible and in date. The trust had

a clean desk policy. Staff ensured that desks had been cleaned after use, and clean stickers displayed. Staff provided evidence that equipment had been calibrated and well maintained.

Safe staffing [2]

The below chart shows the breakdown of staff in post WTE in this core service from 1 April 2018 to 31 March 2019.

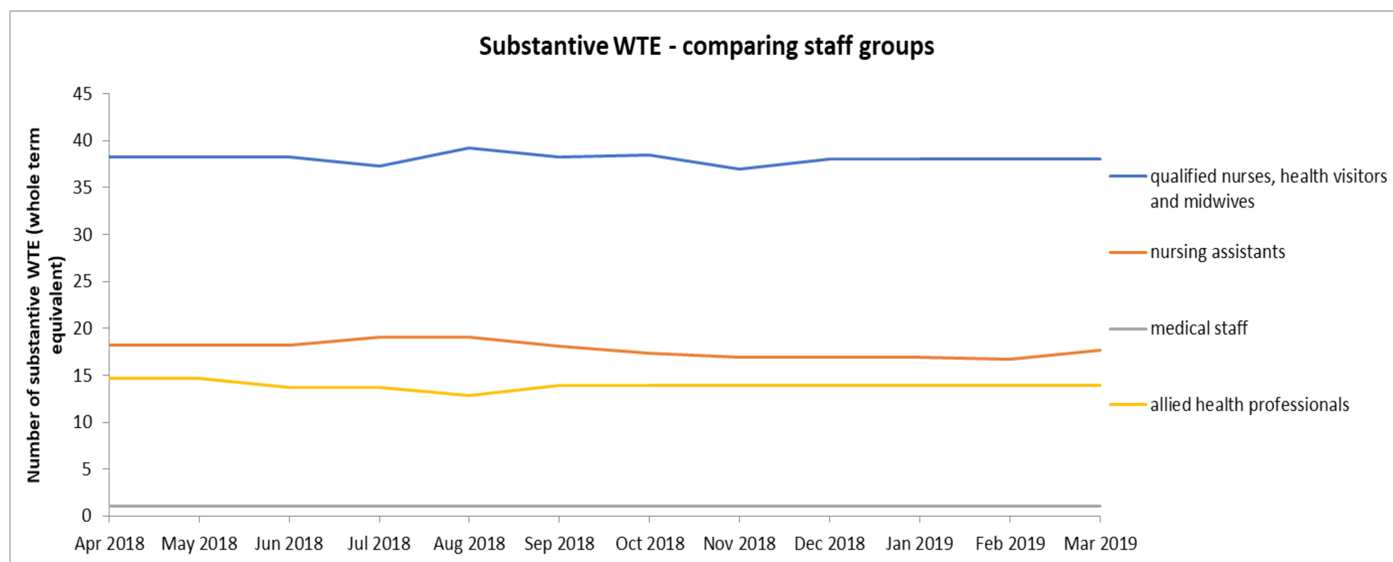

Figure 26

Annual staffing metrics

	Core service annual staffing metrics (1 April 2018 - 31 March 2019)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual "unfilled" hours (% of available hours)**
All staff	106.1	13%	11%	3.8%			
Qualified nurses	41.8	9%	18%	4.8%	949 (2%)	0 (0%)	0 (0%)
Nursing assistants	22.6	22%	15%	1.8%	4727 (18%)	0 (0%)	0 (0%)
Medical staff	2.0	4%	0%	0.0%	0 (0%)	3634 (72%)	536 (11%)
Allied Health Professionals	16.8	16%	7%	1.1%			

Vacancy

[2] Cross sector staffing profile analysis tool ; Vacancy Benchmark Tool ; Turnover Benchmarking Tool ; Sickness Benchmarking Tool

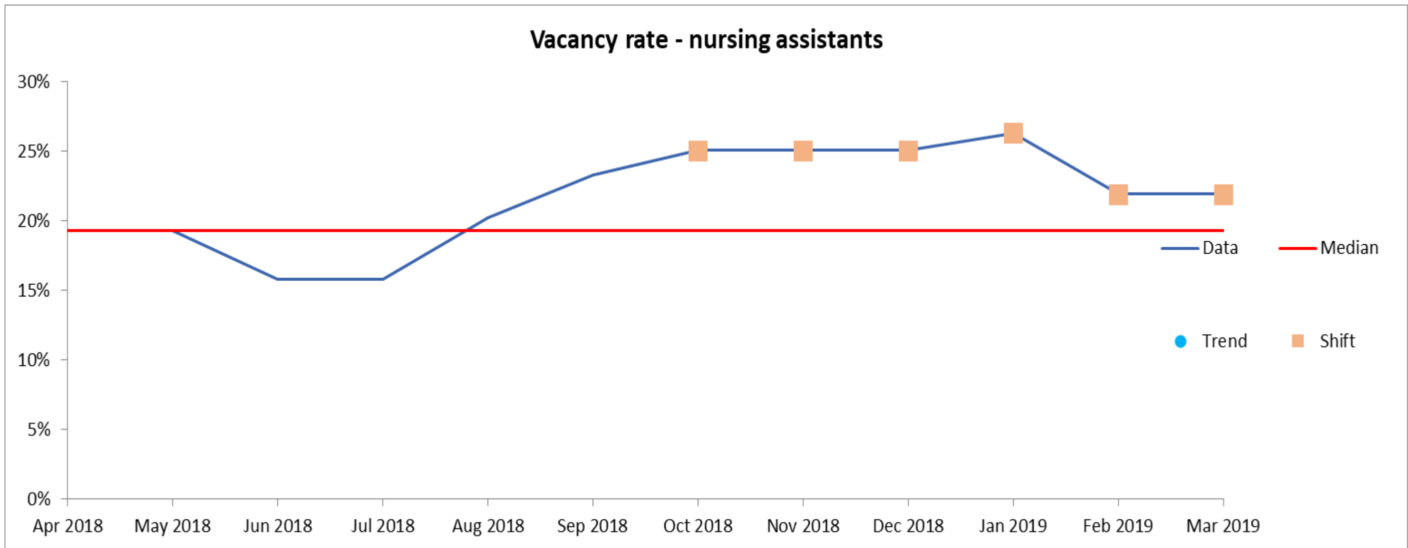

Figure 27

Vacancy rates over the last 12 months for nursing assistants showed a shift from October 2018 to March 2019 (see figure 2), this could be an indicator of change. In addition, the average vacancy rate for nursing assistants was in the highest 25% when compared to other similar core services nationally. Managers had recently undertaken a review of the staff skills, competencies and disciplines required within the service. This highlighted the need for more occupational therapy input. Managers have implemented the findings and have appointed two news occupational therapists' skill and grade mix review and had used vacant posts in order to change the service's staffing structure.

There was not enough variation in the data for medical staff and allied health professionals to show whether there was a shift or trends in the data. However, the average vacancy rates for both staff types were in the highest 25% when compared to other similar core services nationally.

Turnover

There was not enough variation in the data for qualified nurses and medical staff to show whether there was a shift or trends in the data. However, the average vacancy rates for qualified nurses was in the highest 25% and medical staff were in the lowest 25% when compared to other similar core services nationally.

Sickness

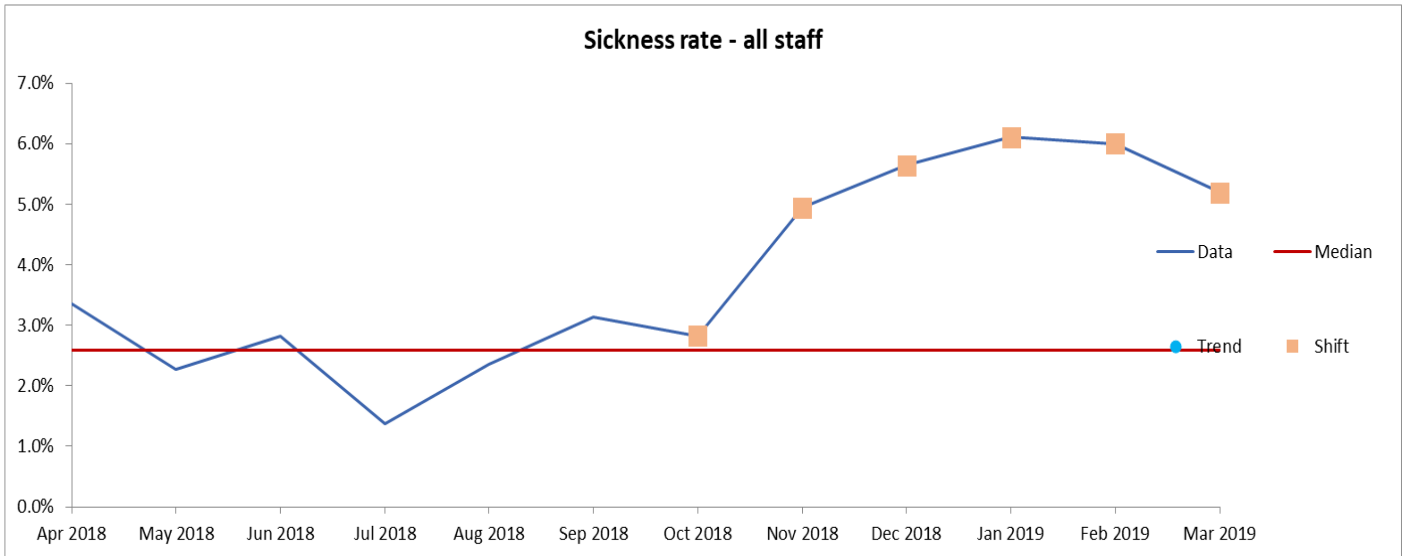

Figure 28

Monthly sickness rates over the last 12 months for all staff showed a shift from October 2018 to March 2019 (see figure 3).

During our visit we were told that two staff members were on long term sick. This had adversely affected the sickness rate for the service.

There was not enough variation in the data for nursing assistants, medical staff and allied health professional staff to show whether there was a shift or trends in the data. However, the average vacancy rates for the three staff types were in the lowest 25% when compared to other similar core services nationally.

Bank Hours

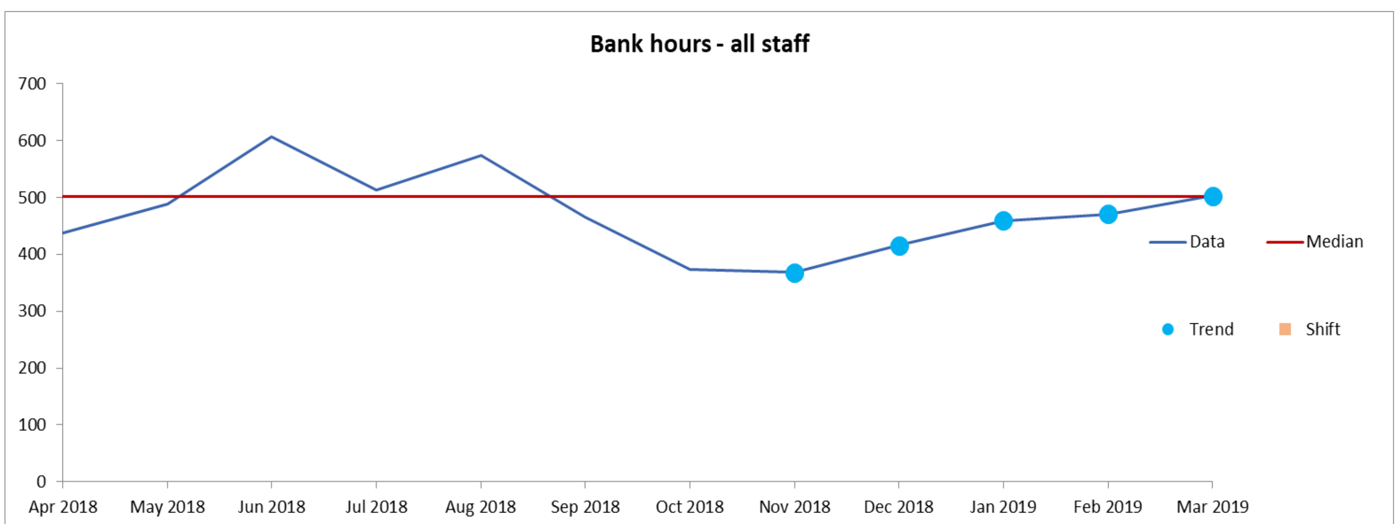

Figure 29

Monthly bank hours over the last 12 months for all staff showed an upward trend from November 2018 to March 2019 (see figure 4).

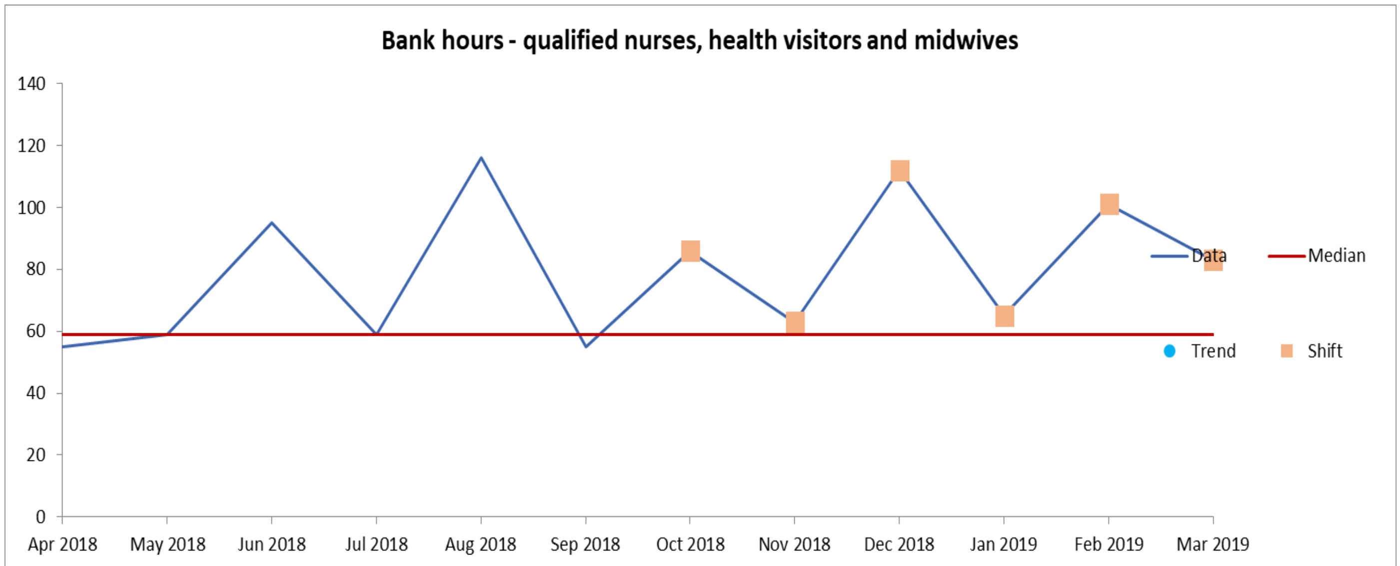

Figure 30

Monthly bank hours over the last 12 months for qualified nurses showed a shift from October 2018 to March 2019 (see figure 5).

Staff told us that bank and agency were not used in the community teams. Managers used bank and agency on 1 Willows Close - the respite ward.

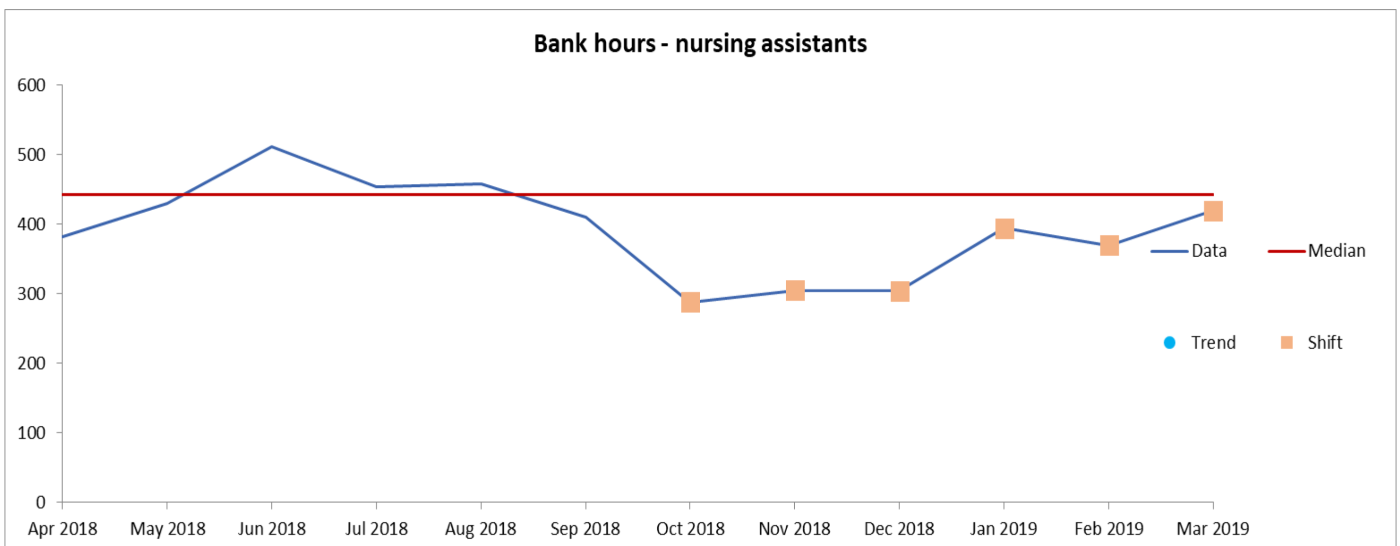

Figure 31

Monthly bank hours over the last 12 months for nursing assistants showed a shift from October 2018 to March 2019 (see figure 6).

The service had enough staff, who knew the patients and received basic training to keep them safe from avoidable harm.

The provider had determined safe staffing levels, by calculating the number and grade of members of the multidisciplinary team required using a systematic approach. Staffing levels took account of patient need and the shift system on the respite ward.

The number, profession and grade of staff in post matched the provider's staffing plan. Managers had recently completed a staffing review, which resulted in an increase in the numbers of

occupational therapists in the team. Managers had reviewed the service funding and appointed two more occupational therapists following the review.

Managers had ensured that the number of patients on the caseload of the teams, and of individual members of staff, was not too high. Staff were able to give each patient the time they needed.

Managers assessed the size of the caseloads of individual staff regularly and helped staff manage the size of their caseloads. Managers reviewed staff caseloads both at supervision and within team meetings. The learning disability community team and learning disability intensive support team had a maximum caseload of 30 patients per staff member. Staff in the opportunities for you team held caseloads of 4 patients. The ADHD team held a ‘team caseload’ shared between all team members. The caseload between 01 April 2018 and 31 March 2019 was an average of 152.

Managers had introduced a buddy system in the team. Staff told us that this ensured cover arrangements were in place for sickness, leave and vacant posts. This ensured patients received consistent care in a safe way.

Managers told us that bank and agency staff were not used in the intensive support community team, due to the levels of skills required to work in this area. Managers on the respite ward and the other community teams used locum / bank / agency staff who knew the patients well.

The service had rapid access to a psychiatrist when required. Staff and carers told us that staff had visited patients within 24 hours following receipt of an emergency referral. Carers also told us that psychiatrists could be accessed quickly when requested.

Mandatory training

Staff had received and were up to date with appropriate mandatory training. The compliance for mandatory and statutory training courses at 31 March 2019 was 93%. Of the training courses listed one failed to achieve the trust target and of those, none failed to score below 75%. The trust set a target of 90% for completion of mandatory and statutory training.

Training is reported on a month on month basis.

The training compliance reported for this core service during this inspection could not be compared to the previous year as the data was not comparable.

The trust did not submit training data for staff who had completed prevention, management of violence and aggression training.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✗	Higher ↑	No change →	Lower ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Safeguarding Children (Version 2) - Level 1 - 3 Years	2	2	100%	✓
Resuscitation - Level 1 - No Specified Renewal	8	8	100%	✓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Infection Prevention and Control - Level 1 - 3 Years	10	10	100%	✓
Resuscitation - Level 2 - Adult Basic Life Support - No Specified Renewal	8	8	100%	✓
Safeguarding Adults - Level 1 - 3 Years	2	2	100%	✓
Resuscitation - Level 2 - Paediatric Basic Life Support - No Specified Renewal	8	8	100%	✓
Fire Safety - 1 Year	83	80	96%	✓
Infection Prevention and Control - Level 2 - 1 Year	73	70	96%	✓
Information Governance and Data Security - 1 Year	83	79	95%	✓
Health, Safety and Welfare - 3 Years	83	77	93%	✓
Safeguarding Children (Version 2) - Level 2 - 3 Years	82	76	93%	✓
Safeguarding Adults - Level 2 - 3 Years	82	76	93%	✓
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year	75	69	92%	✓
Resuscitation - Level 1 - 1 Year	75	69	92%	✓
Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year	75	69	92%	✓
Moving and Handling - Level 1 - 3 Years	83	76	92%	✓
Moving and Handling - Level 2 - 1 Year	38	33	87%	✗
Total	**870**	**812**	**93%**	

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff assessed and managed risks to patients and themselves well. Staff used a recognised risk assessment tool which was part of the electronic health record. Staff responded promptly to any sudden deterioration in a patient's health. Staff completed clear plans of how to deal with a sudden deterioration in the patient. When appropriate, staff worked with patients and their families and carers to develop and make good use of crisis plans and advance decisions.

We reviewed 32 patient risk assessments. Staff completed a thorough risk assessment of every patient at initial assessment. Staff updated these regularly, including after most incidents. We found only one risk assessment which staff had not updated following an incident.

Management of patient risk

Staff responded promptly to sudden deterioration in a patient's health and dealt with any specific risk issues. Staff completed risk management plans for all patients and positive behaviour support plans for patients where required. Staff ensured that patients, and where appropriate carers, were central in the development of both risk management and behaviour support plans. Staff formulated all risk management plans in the multi-disciplinary meeting. Staff used a recognised tool when formulating risk management plans. Staff were aware of the individual plans and followed these for any specific risk issues.

Staff identified and responded to changing risks to or posed by patients. Staff reviewed risk management and positive behaviour support plans during the multidisciplinary and clinical meetings.

Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff rated patient risk as red, amber or green, depending on the level of risk the patient presented.

The service had developed good personal safety protocols, including lone working practices which staff adhered to. Staff had access to lone working bags which contained a torch, alarm and a copy of the lone working policy. Staff also had an agreed code phrase to alert a colleague that they needed urgent assistance.

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 adult at risk 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 adult at risk, 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 nine safeguarding referrals between 1 April 2018 and 31 March 2019, of which nine concerned adults and no children. The number of safeguarding referrals reported during this inspection could not be compared to the last inspection as the data was provided at trust level only.

Number of referrals		
Adults	**Children**	**Total referrals**
9	0	9

The number of adult safeguarding referrals ranged from one to three per month.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had face to face and on-line training on how to recognise and report abuse, and they knew how to apply it. Staff also received specific children's safeguarding supervision four times per year.

Staff showed knowledge of safeguarding and described how they identified and made a safeguarding referral and did that when appropriate. Staff had easy access to the trust safeguarding team, who were accessible to all staff.

Staff could give examples of how to protect 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. Staff discussed safeguarding issues in team meetings. During our inspection we attended a safeguarding meeting. Staff ensured that the meeting was well organised, comprehensive, needs led and resulted in agreed actions. This included working in partnership with other agencies. Managers and staff had good links with other agencies including social services, the multiagency safeguarding hub (MASH), acute hospitals and schools.

Staff access to essential information

The systems to manage and share information that was across services and supported integrated care for people who used the service. Staff had access to essential information needed to deliver effective care. Staff kept detailed records of patients' care and treatment.

The trust used an electronic patient record system. Staff were able to access medication and physical health information when needed. Staff ensured that any paper records were scanned onto the electronic system and destroyed after they were uploaded. Staff informed us that this did not cause them any difficulty in entering or accessing information.

Records were clear, up-to-date and easily available to all staff providing care. All information needed to deliver patient care was available to all relevant staff (including bank and agency staff) when they needed it and was in an accessible form. This included when patients moved between teams and organisations.

People were able to transition seamlessly between services because there was advance planning and information sharing between teams. Staff had developed transition pathways from children to adult services and had produced an easy read transition leaflet for patients and carers. Staff told us that information regarding transitions between the trust and local acute trusts were e-mailed through to the relevant teams.

Medicines management

Staff followed systems and processes when safely prescribing, administering and recording medicines We observed staff did not always store and record controlled drugs in line with national guidance and local policy. We found one Controlled Drug (CD) not stored in the CD cabinet and not recorded in the CD register. This was immediately rectified during inspection.

Staff followed current national practice to check patients had the correct medicines. Staff had fully completed medication administration charts (MARS) charts for all patients. Staff liaised closely with families to ensure that all medicine administration was continued in the way it was done at home. Medicine administration did not conform to strict times and was tailored specifically to patient's needs in a patient centred way. Care plans clearly detailed the necessary information required to ensure that all staff were fully informed of the times and administration needs of medicines to individual patients.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. All prescribing was handled by the patient's GP. The service worked closely with families to raise any queries about medicines.

The community teams did not administer patient's medication. Staff attended medication reviews run by psychiatrists and monitored the side effects of medications, including the effects of medications on patient's physical health.

Track record on safety

The trust has submitted details of no serious case reviews commenced or published in the last 12 months (1 April 2018 and 31 March 2019) that relate to this service.

The service had a good track record on safety. Between 1 April 2018 and 31 March 2019 there was one serious incident reported by this service. Of the total number of incidents reported, the most common type of incident was ‘Diagnostic incident including delay meeting SI criteria (including failure to act on test results)’ with one. There were no reported unexpected deaths for this core service.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was not comparable with STEIS with none reported. The reason for the discrepancy was due to trust downgrading the incident *(Monitoring from the rollout of ICE on SystemOne suggested that a significant number of pathology results have not been verified / completed within the patient record. Downgraded).*

A ‘never event’ is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported no never events during this reporting period.

The number of serious incidents reported during this inspection was the same as the one reported at the last inspection. Which related to CTPLD North and was for ‘disruptive / aggressive / violent behaviour meeting SI criteria’.

	Number of incidents reported	
Type of incident reported (SIRI)	**Diagnostic incident including delay meeting SI criteria (including failure to act on test results)**	**Total**
Medical - Adult Mental Health	1	1

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. All staff knew what incidents to report, how to report them, reported what they should, and reported them appropriately. Any staff member could report an incident.

Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers received all incident reports for information and sign off.

Staff described an open culture of reporting. Staff understood the duty of candour. Staff were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff met to discuss feedback from incidents in team meetings. Staff received feedback from investigation of incidents, both internal and external to the service. Managers ensured that all staff had the opportunity to discuss feedback and identified learning.

Managers communicated the outcome of investigations via team meetings, supervision sessions, de-briefing meetings and team e-mails. Staff also had access to learning via the trust intranet site. Staff were able to evidence that changes had been made because of feedback. Staff provided information about improvements in safety specific to this service. Staff had discussed a recent

information governance incident and had reviewed the process for checking and updating patient records.

Managers offered staff debriefing and support after an incident. Staff described management as supportive and always available to provide support.

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. This service received no 'prevention of future death' reports.

Is the service effective?

Assessment of needs and planning of care

Staff took a function-based approach to assessing the needs of all patients. During our inspection, we looked at 32 care records. There was evidence of a holistic approach to the assessment, planning and delivering of patient care.

Staff completed comprehensive mental health assessments of each patient. Staff completed full behavioural, motivational and cognitive assessments. Staff used a range of evidence-based assessment tools, including the autistic diagnostic observational scale (ADOS) and the Weschler intelligence scale for children.

Staff worked with patients, families and carers to develop individual easy read care plans following initial assessment. Staff ensured that care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. Staff ensured that care plans were up to date, reviewed regularly through multidisciplinary discussion and updated as needed.

Staff ensured that patients had good access to physical healthcare within the trust and from other providers. Staff ensured that any necessary assessment of the patient's physical health had been undertaken. Staff routinely assessed patient's nutrition, diabetes, epilepsy, and bladder and bowel function. Staff identified that a key part of their role was in improving the physical health and addressing the risk of metabolic syndrome in patients with a learning disability. Staff held a metabolic clinic using a recognised physical health tool and held a monthly weight clinic. This service had been recognised with a national award. The Health Service Journal (HSJ) Patient Safety Award 2018 winner for LD initiative of the year. This award recognised the project the LD team worked on to treat sexual offending of men with mild learning disabilities.

Staff on the respite ward completed the modified early warning scale (MEWS) for recording patients' physical observations within 24 hours of admission, and regularly thereafter. Staff in community teams ensured that all patients had received an annual health check with their general practitioner. Staff ensured they communicated with the GP in relation to any physical health concerns.

Staff delivered de-sensitisation work with patients who had difficulty accessing services. This included supporting patients to have blood tests and supporting patients to live healthier lives.

Best practice in treatment and care

Staff understood and applied National Institute for health and Care Excellence (NICE) guidelines in relation to behaviours which challenged. During our inspection, we examined 32 healthcare records. Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by and were delivered in line with National Institute for Health and Care Excellence guidance and best practice. For example, we saw pathways for epilepsy, guidance for nutritional support in adults, stoma care, challenging behaviour and autism.

Staff ensured support for families, early identification and assessment, psychological and environmental interventions, medications, and interventions for co-existing health and sleep problems. Staff provided support for employment, housing and benefits, and interventions that enabled patients to acquire living skills.

Staff ensured that patients' physical healthcare needs were being met, including an annual health check by their general practitioner, and access to specialists when needed. Staff supported both patients and carers in attending appointments with outside agencies, including dental appointments and supporting patients when they had blood taken.

Staff supported patients to live healthier lives – for example, through managing cardiovascular risks, dealing with issues relating to substance misuse, and promoting exercise including 'walks for health'.

Staff used a wide range of recognised rating scales to assess and record severity of illness and outcomes of care and treatment. Staff used the health of the children's global assessment scale, the goal attainment scale, the Health of the Nation Outcome Scale (HoNOS) for learning disabilities and the three-change checklist. Staff discussed patient outcomes in the patient outcomes group.

Staff focused on reducing mortality levels by stopping the over medication of people with a learning disability, autism or both with psychotropic medicines (STOMP), and supporting treatment and appropriate medication in paediatrics (STAMP).

Staff used technology to support patients effectively. For example, via the use of iPad applications for helping patients to communicate their emotions and to provide feedback about their care.

Staff participated in clinical audits including record keeping handwashing, treatment for constipation, treatment and care planning for epilepsy, and a dysphagia pathway audit.

This service participated in one clinical audits as part of their clinical audit programme 2018 – 2019.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Overview of Electronic and Paper Record Keeping	LD Community Services	MH - Community mental health services for people	Clinical	07/04/2019	Teams to improve compliance for areas that are RAG rated as amber by

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Audit – Mental Health & Adult & Child Q1, Q2, Q3, Q4		with a learning disability or autism			developing team action plans • All teams to develop a Qualitative Record Keeping Audit. • Feedback results through pathway meetings

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Patients had access to doctors, nurses, occupational therapists, clinical psychologists, pharmacists, physiotherapists, speech and language therapists, and peer support workers.

Managers provided an induction programme for new staff. Staff attended a two-day trust induction and local induction. The local induction covered local fire procedures, training requirements, local policies and procedures and orientation to the team and patient caseload.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. Managers recognised that the continuing development of the staff skills, competence and knowledge as being integral in providing high quality care.

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 and had the range of skills needed to provide high quality care.

Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development). Managers also ensured that staff had an annual appraisal of their work performance and opportunities to update and further develop their skills, which managers reviewed six-monthly. Figures submitted by the trust shoed compliance rates of over 100% in some teams. The trust captured various forms of meetings which they classed as supervision, including clinical, managerial, group supervision, reflective practice and safeguarding supervision. However, we were assured that team met regularly for clinical supervision.

The trust's target rate for appraisal compliance was 90%. At the end of last year (1 April 2018 and 31 March 2019), the overall appraisal rate for non-medical staff within this service was 89%. This year so far, the overall appraisal rates was 92% (as at 24 May 2019). The team with the lowest appraisal rate at 24 May 2019 were Northampton CTPLD with an appraisal rate of 76%.

The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 80% reported at the last inspection.

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 (as at 24 May 2019)	% appraisals (previous year 1 April 2018-31 March 2019)
Kettering/Corby CTLD	28	28	100%	90%
Opportunities for You	3	3	100%	100%
Intensive Support Service	19	19	100%	100%
ADHD and Asperger's Team	20	19	95%	100%
CTPLDs Psychology	12	11	92%	64%
Northampton CTPLD	29	22	76%	82%
Core service total	111	102	**92%**	**89%**
Trust wide	**3719**	**3413**	**92%**	**92%**

At the end of last year (1 April 2018 to 31 March 2019), the overall appraisal rate for medical staff within this service was 100%. This year so far, the overall appraisal rates this was 50% (as at 25 May 2019).

The rate of appraisal compliance for medical staff reported during this inspection could not be compared to the last inspection as the data was not comparable.

Ward name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals (as at 24 May 2019)	% appraisals (previous year 1 April 2018-31 March 2019)
LD Medical Staff	2	1	50%	100%
Core service total	**2**	**1**	**50%**	**100%**
Trust wide	**90**	**78**	**87%**	**80%**

Between 1 April 2018 and 31 March 2019, the average supervision rate for non-medical staff across all five teams in this service was 207%.

The rate of clinical supervision reported during this inspection was higher than the 100% reported at the last inspection.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide. In addition, the trust has advised that the trust policy requires a minimum of 2 supervision sessions/quarter which would explain the higher supervision rates in the table below.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
ADHD and Asperger's Team -Transition (NES)	122	154	126%
Adult CTPLD - North	172	176	102%
LD Intensive Support Team	124	161	130%
LD Psychology Team	50	125	250%
Opportunities for You (Internal SLA)	24	25	104%
Core service total	**492**	**641**	**130%**
Trust Total	**6128**	**12673**	**207%**

The trust’s target of clinical supervision for medical staff is 90% of the sessions required. Between 1 April 2018 and 31 March 2019 there was no data pertaining to medical staff.

Managers dealt with poor staff performance promptly and effectively.

The trust had a strong culture of recruiting, engaging and investing in volunteers who had positive impact on services. Managers recruited volunteers to this service when required and trained and supported them for their roles. Managers had appointed two peer support workers in the community team, who co-produced documents and literature for the service.

Multi-disciplinary and interagency team work

The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation. Staff in the community teams had good working links, with effective handovers to primary care, social services, and other teams external to the organisation.

Staff from different disciplines worked together as a team to benefit patients. Staff supported each other to make sure patients had no gaps in their care. Staff had formed effective joined up working with social care, schools (including school nurses), acute liaison nurses and other providers.

Managers ensured that staff had access to regular and effective multidisciplinary team meetings. Managers had ensured that meetings had a set agenda, which included safeguarding, incidents, lessons learned, staff well-being and clinical case discussions.

Staff attended effective handover meetings within the team, where information about patients where shared. Staff effectively communicated information about patients prior to going on holiday, via the use of a buddy system, on a daily basis in the community team and between shifts on the respite ward.

The community mental health teams had effective working relationships, including good handovers, with other teams within the organisation including the forensic and crisis teams.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. The trust's target for Mental health Act training was 90%. The trust submitted data on inspection which showed that 94% of staff had had training in the Mental Health Act. Staff were trained in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. At the time of our inspection no patients were detained under the Mental Health Act.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice if required. Staff knew who their Mental Health Act administrators were.

The provider 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.

Good practice in applying the Mental Capacity Act

The trust did not provide any data relating to Mental Capacity Act training prior to inspection. The trust's target for Mental Capacity Act training was 90%. The trust submitted data at inspection, which showed that 53% of staff had received training in the Mental Capacity Act. Some staff were trained in and had a good understanding of the Mental Capacity Act 2005, particularly the five statutory principles.

The provider 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 provider regarding the Mental Capacity Act.

Staff took all practical steps to support patients to understand and manage their care, treatment or condition, and enabled patients to make their own decisions. Staff and patients had co-produced easy read leaflets regarding consent. Staff used a range of nonverbal methods and made use of sensory equipment for patients who had difficulty communicating.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis with regard to significant decisions. For children the service considered Gillick competence (a test in medical law to decide whether a child of 16 years or younger is competent to consent to medical examination or treatment without the need for parental permission or knowledge).

When patients lacked capacity, staff worked with the patient's support network to ensure best interest decisions were made when relevant. Staff recognised the importance of the person's wishes, feelings, culture and history. Staff discussed patient's best interest assessments at each multidisciplinary meeting.

The service has arrangements to monitor adherence to the Mental Capacity Act.

The trust audited the application of the Mental Capacity Act. Managers took action on any learning that resulted from it.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff always treated patients with compassion and kindness. 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. Staff were highly motivated and regularly went the extra mile to support people who used services.

Staff clearly understood the individual needs of patients and consistently supported patients to understand and manage their care, treatment or condition. Staff directed patients to other services when appropriate and, where required, and supported them to access those services.

Feedback from patients, carers and relative was actively encouraged. The trust continued to use 'I want great care' as a method to gather feedback on the service. Feedback continued to be positive about the way staff treated and cared for patients. Patients and carers said staff treated the patients well and behaved appropriately towards them. Carers told us that staff were caring, supportive, interested, knowledgeable, professional and understanding. Carers described staff as "incredible", "fantastic", "good in all aspects", "were very knowledgeable and supportive". Carers also told us that staff had gone 'above and beyond their expectations. One carer told us that "staff have improved their quality of life significantly". Another carer told us that before accessing the team, the care experience 'was a nightmare' and that they had 'never felt so supported' as they do now.

We were impressed by the very strong person-centred culture in the service. Staff thoroughly understood the individual needs of patients, including their personal, cultural, social and religious needs. Staff were highly motivated and inspired to offer care that was particularly kind and promoted patient's dignity. Carers told us that staff were able to identify early signs of discomfort in patients who were unable to communicate and responded to these signs.

Staff said 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.

Involvement in care

Involvement of patients

Staff considered patients as active partners in their care. Staff involved patients in care planning and risk assessment and had evidenced patient involvement within care plans. Staff ensured that patients and carers participated in care programme approach reviews and had access to an easy read copy of their care plan.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. One carer told us that staff had 'listened, observed and were aware of her son's individual needs'. Staff found social activities for a patient who had become socially isolated.

Staff involved patients when appropriate in decisions about the service – for example, in the recruitment of staff. Patients were regularly involved in staff recruitment and had been involved in interviewing staff. Patients had also assisted staff in the production of information leaflets.

Staff always empowered patients to have a voice and realise their potential. Staff embraced individual preference and needs and reflected this on how care was delivered. Staff enabled patients to give feedback on the service they received via surveys using ‘I want great care’.

Staff enabled patients to make advance decisions and to refuse treatment, sometimes called a living will when appropriate.

Staff ensured that patients could always access advocacy through a local advocacy service.

Involvement of families and carers

Staff were fully committed to working in partnership with carers and families and made this a reality. Staff informed and involved families and carers fully in assessment, in the design of care and treatment interventions, and provided them with support when needed. All carers interviewed were extremely positive regarding the care and treatment staff had provided. Carers made a number of positive comments including “I’ve never been so supported” and “I wish I had had this years ago”. Another carer told us that staff were “worth their weight in gold”, adding “I can breathe again, it’s the type of support I’ve never experienced before”.

Staff continually updated and involved carers in the patient’s care. Staff in community services facilitated positive behaviours workshops for families. Staff told us that the development of the attachment pathway had assisted to facilitate work with families. Staff on the respite ward facilitated a carers engagement group and gave all families and carers an information pack.

Staff enabled families and carers to give feedback on the service they received via surveys including ‘I want great care’ and survey monkey.

Staff generally provided carers with information about how to access a carer’s assessment. However, one carer told us that they had not been advised by staff how to access an assessment.

Is the service responsive?

Access and waiting times

The service was easy to access. The service had a clear criterion for which patients would be offered a service. Managers had ensured that the referral criteria did not exclude patients who would have benefitted from care and had identified who could be placed on the waiting list. The criteria did not exclude patients who needed treatment and would benefit from it. The trust had changed its age range for this service. At our last inspection, the service catered for those aged from 18 to 65. At this inspection the service catered for those aged from 14 to 65. The provider had produced figures showing that the numbers of patients receiving interventions had increased by 70% for adults and 170% for children.

The provider had set a target for time from referral to triage /assessment and from assessment to treatment in each of the services. The target from referral to assessment for the community teams was 18 weeks.

Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff were able to see urgent referrals quickly and nonurgent referrals within an acceptable time. Staff in the intensive support team visited patients in crisis on the same day as the referral.

The team responded promptly and adequately when patients telephoned the service. Staff from the intensive support team would see patients on the same day. Staff advised and encouraged patients to contact the trust's crisis cafes and crisis team out of normal working hours.

The team tried to engage with people who found it difficult or were reluctant to engage with mental health services.

Staff followed up patients who missed appointments. Staff tried to make telephone and face to face follow-up contact with people who did not attend appointments. Staff offered patients flexibility in the times of appointments wherever possible.

Staff cancelled appointments only when necessary and when they did, they explained why and helped patients to access treatment as soon as possible. Staff discussed any cancelled stays to the respite ward with families when there had been an emergency admission. Staff then rearranged the date in collaboration with the patient's families. Staff ensured that appointments usually ran on time and people were kept informed when they did not.

The trust had identified the below services in the table as measured on 'referral to initial assessment' and 'referral to treatment'. The service met the referral to assessment target in three of the targets listed.

The service met most of the referral to treatment target in three of the targets listed.

The number of days from referral to initial assessment and referral to treatment during this inspection was higher than that reported at the time of the last inspection for the ADHD & Asperger's team (244 and 73).

Name of hospital site or location	Name of Team	Please state service type.	Days from referral to initial assessment		Days from referral to treatment	
			Target	Actual (median)	Target	Actual (median)
Trust Headquarters	ADHD & Asperger's	ADHD & Asperger's	126	244	126	244
Trust Headquarters	LD Community	LD Community	126	6	126	6
Trust Headquarters	LD Intensive Support	LD Intensive Support	126	2	126	2
Trust Headquarters	Opportunities for You (Internal SLA)	Opportunities for You (Internal SLA)	126	68	126	68

Patient waiting times for children with a learning disability had reduced from 397 days to 195 days. At the time of our inspection 31 children were awaiting initial assessment, five of which had been waiting over the trust target time of 18 weeks.

The provider had improved on the number of patients awaiting psychology assessment. At the time of our inspection, we identified 45 patients waiting for psychological interventions. Patient waiting times for psychology had reduced from 322 days (during our previous inspection), to 159 days.

The attention deficit hyperactivity (ADHD) and Asperger's services for adults and children had not met the trust target for referral to assessment and referral to treatment. The average (median) waiting time for this service was 244 days (34 weeks) against a trust target of 126 days (18 weeks).

The trust provided figures to show that at the time of inspection, 102 children waited longer than 18 weeks on this pathway. Ninety-five patients waited more than 20 weeks. However, the trust had made further investment in April 2019 to provide additional medical cover to reduce the waiting list. In addition, a new interactive digital solution had been procured to support the diagnosis of patients and provide ongoing support and advice. The trust had set a target of achieving waiting times within national targets by the end of January 2020.

The trust provided figures to show that at the time of inspection, 484 patients waited longer that 18 weeks on the adult ADHD pathway. 462 patients waited more than 20 weeks. However, each referral was assessed for risk and each patient given details of support and crisis help available whilst they waited for assessment or treatment. The trust told us they would see a reduction in waiting times from November 2019 but continued to be monitored with the number of patients who waited for assessment and treatment to be halved by February 2020.

There was a holistic approach to planning patient's discharge, transition or transfer to other services. Staff supported patients during referrals and transfers between services. For example, if they required temporary treatment in an acute hospital. The service had employed liaison nurses who worked in the local acute hospitals, who ensured that the needs of patients were known and understood.

The teams had effective working relationships, including good handovers, with other teams within the organisation, including the forensic team, child and adolescent teams and inpatient services. Carers told us that staff worked as a coordinated team. One carer told us that there had been an excellent handover to community nurses, regarding the use of visual aids.

The service complied with transfer of care standards including those set in the national Children and Young People Mental Health Transitions Commissioning for Quality and Innovation.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity. The service had a range of rooms and a wide range equipment to support treatment and care. Staff had access to a clinic room on the willows ward to examine patients. We saw sufficient chairs in the waiting areas.

Managers had ensured that an extensive level and variety of equipment was available on the respite ward, included a hoist in every room. Staff also had access to a weighing scale for wheelchairs and hoists. Interview rooms had adequate soundproofing.

Patients' engagement with the wider community

Staff had the skills, or access to people with the skills, to communicate in the way that suited the patient. Staff produced and used visual aids and easy read letters and guidelines and sign language where required.

The service met the needs of all patients, including those with a protected characteristic. Staff helped patients with communication, advocacy, cultural and spiritual support.

Staff ensured when appropriate, that patients had access to education and work opportunities, including the local recovery college. Staff had facilitated patients to attend college and

engagement with the community including access to voluntary work day services. Patients attended occupational therapy groups aimed at promoting meaningful occupation.

Staff supported patients to maintain contact with their families and carers.

Staff encouraged and supported patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community.

Meeting the needs of all people who use the service

The service had made adjustments for disabled patients. Services had disabled access and lifts were available for patients with mobility issues. Staff met individual communication needs.

Staff ensured that patients could obtain easy read information on treatments, service guidelines, local services and patients' rights. Staff ensured that all information provided was in a form accessible to the patient group in easy-read and pictorial formats.

Staff made information leaflets available in languages spoken by patients. Staff could access leaflets in any language. One staff member had developed an equality and diversity booklet, which identified all different religions, beliefs and what staff needed to consider for holistic patient care.

Managers ensured that staff and patients had easy access to interpreters and / or signers where required.

Listening to and learning from concerns and complaints

This service received four complaints between 1 April 2018 to 31 March 2019. Two of these were withdrawn, one was upheld, none were partially upheld, and none were not upheld. None were referred to the Ombudsman. The reason for each of the four complaints were different. The four complaints related to waiting time for treatment, an incorrect diagnosis being sent to GP, the referral of a patient to another team and a patient discharge back to the care of the GP.

Patients, family and carers knew how to complain or raise concerns. Staff provided feedback when patients complained or raised concerns. Staff tried to resolve complaints quickly and effectively at a local level wherever possible.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff received feedback on the outcomes of investigations of complaints and acted on the findings. An example relates to the checking of patient information prior to sending letters to external agencies.

Ward name	Total Complaints	Fully upheld	Ongoing	Withdrawn
ADHD & Asperger's	2		1	1
Adult CTPLD	2	1		1

This service received 30 compliments during the last 12 months from 1 April 2018 to 31 March 2019 which accounted for 2% of all compliments received by the trust as a whole (1752).

Is the service well led?

Leadership

Leaders had the integrity, experience, skills and abilities to run the service. Staff had attended a range of in-house leadership courses including the trust's training 'leadership matters' and had accessed external specialist training.

Leaders had a good understanding of the services they managed. Leaders could explain clearly how the teams were working to provide high quality care. Leaders measured clinical outcomes and reviewed care in multidisciplinary meetings, based on these findings.

Leaders understood the issues, priorities and challenges the service faced and managed them. Leaders were visible in the service and approachable for patients and staff. Leaders supported staff to develop their skills and take on more senior roles.

Leaders were visible in the service. Staff and carers were able to access leaders when required.

Leadership development opportunities were available, including a wide range of opportunities for staff below team manager level.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. This had been developed with all relevant stakeholders. Staff knew and understood the provider's vision and values, and how they were applied in the work of their teams in day to day actions. Leaders ensured that the vision and values were aligned to local plans and the wider health economy.

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. Staff displayed these values during our inspection. Staff were able to describe the aims of the organisation and describe how these were translated within the team.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff had attended workshops on the draft learning disability and autism strategy. Staff had also attended regular team meetings and away days.

Staff explained how they were working to deliver high quality care within the budgets available.

Culture

Staff felt respected, supported and valued. Staff made positive comments about their experience and told us that they felt supported. The trust had a strong focus on staff wellbeing. We heard about the well-being wheel, used in supervision to focus on a work life balance for staff. Staff felt the service promoted equality and diversity and provided opportunities for career development for staff at all levels.

Staff felt positive and very proud about working for the provider and their team. Some staff told us that they looked forward to going to work and that they enjoyed working in the service. However, due to organisational changes, and a change in the staff group since the last inspection, some staff described 'significant niggles' and difficulties in the team. Organisational changes had had an impact on the morale of some staff. Staff told us that recent changes had affected team dynamics and staff stability. Senior leaders and managers acknowledged the impact of organisational

change and had responded by holding a listening event, and promotion of the trust's respect and compassion charter.

Staff told us that they felt able to raise concerns without fear of retribution. Staff told us that managers were approachable and visible in the service.

Staff knew how to use the whistle-blowing process and about the role of the Freedom to Speak Up Guardian. Staff informed us that there were strong links with the speak up guardians. Staff also had access to freedom to speak up champions within the service.

Managers dealt with poor staff performance effectively.

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. Managers actively encouraged staff training and development.

Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. The trust had delivered a black, minority, ethnic (BME) conference and had co-produced a celebration and awareness event with lesbian, gay, bisexual, transgender and questioning (LGBTQ+) service users and community representatives. Some staff had undertaken gender awareness training.

The service's staff sickness and absence rate of five percent was above the provider target of two-point five percent. However, the service had staff on long term sick.

Staff had access to support for their own physical and emotional health needs through an occupational health service.

The provider recognised staff success within the service – for example, through staff awards. Staff in the intensive support team had recently been runners up in the trust award scheme for the monitoring of patient's physical health.

Governance

Leaders ensured there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings. This ensured that essential information, such as learning from incidents and complaints, was shared and discussed. Managers had developed a set agenda for all meetings which staff adhered to.

Staff had implemented recommendations from reviews of incidents, complaints and safeguarding alerts at the service level. The service had not reported any patient deaths over the past 12 months.

Staff undertook or participated in a range of clinical audits relevant to the service. The audits were sufficient to provide assurance and staff acted on the results when needed.

Staff understood arrangements for working with other teams, both within the provider and externally, to meet the needs of the patients. The service liaised well with other services and had good working relationships with key partners including social services, schools, recovery colleges and commissioners.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level. Staff maintained and had access to the 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.

Staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care. Leaders ensured that where cost improvements were taking place, they did not compromise patient care.

Information Management

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. The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements.

Staff used an electronic system which was used by most GP practices. Staff could easily access essential information regarding patient's physical health and medication management. The provider had ensured that information governance systems included confidentiality of patient records, and that they were integrated and secure.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Managers developed performance reports using data looking at numbers of referral, patients currently on caseload, waiting times and compared these against previous months. The provider had ensured that information was in an accessible format, and was timely, accurate and identified areas for improvement.

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, through the intranet, bulletins, newsletters, supervision and team meetings.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Patients and carers could provide feedback electronically via 'I want great care', survey monkey, via involvement questionnaires or directly to staff and managers. 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 including the development of its vision and values, interviewing staff and preparing service strategies.

Patients and staff could meet with members of the provider's senior leadership team and governors to give feedback. The trust has a non-executive director who links in with learning disability services and links in with the service on a regular basis.

The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. It collaborated with commissioners and partner organisations to help improve services for patients.

Learning, continuous improvement and innovation

Staff were committed to continually improving services and had a good understanding of quality improvement methods. Staff were given the time and support to consider opportunities for improvements and innovation and this had led to changes.

Staff had opportunities to participate in research. Staff were researching the effectiveness of interventions for adults with a learning disability.

Staff participated in a range of local audits relevant to the service and learned from them.

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 trust provided a list of teams/wards within the trust which have been awarded an accreditation together with the relevant dates of accreditation. However, there is no data pertaining to this trust.

This service had been recognised with a national award. The Health Service Journal (HSJ) Patient Safety Award 2018 winner for LD initiative of the year. This award recognised the project the LD team worked on to treat sexual offending of men with mild learning disabilities.

MH – 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	Marina ICU	7	Male
Berrywood Hospital	Bay Ward	17	Female
Berrywood Hospital	Cove Ward	17	Male
Berrywood Hospital	Harbour Ward	12	Mixed
St Mary's Hospital	Shearwater ICU	7	Female
St Mary's Hospital	Avocet Ward	16	Male
St Mary's Hospital	Kingfisher Ward	10	Mixed
St Mary's Hospital	Sandpiper Ward	16	Female

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean care environments

Staff did regular risk assessments of the care environment. This included ligature risks and risks related to the physical environment.

The layout of the wards allowed staff to observe most parts of the wards. All wards had a line of sight audit and a heat map that identified blind spots. Where blind spots were identified they were mitigated by zonal nursing and regular nursing observations.

Safety of the ward layout

Over the 12-month period from 1 April 2018 to 31 March 2019 there were no same sex accommodation breaches reported within this service. This was the same as at the last inspection.

All staff had access to alarms. Records reviewed evidenced non-substantive staff signed for a set of keys and an alarm at the start of each shift and returned these at the end of the shift. Patients did not have a nursing call system in their room. However, if an alarm was required to meet the needs of the patients, staff provided portable alarms. We saw an example where the provider was using assistive technology such as motion detectors in a patient's room to alert staff when the patient was awake. The use of the assistive technology was robustly planned for involving senior managers, commissioners and the multidisciplinary team to ensure staff were working in the least restrictive way to meet the patients' needs.

Managers completed ligature risk assessments on each ward and updated these regularly. Where building works had been completed, for example the addition of sensory rooms on some wards, potential anchor points were added to the risk assessment. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Staff were able to identify ligature points and knew were the ligature cutters were located.

Maintenance, cleanliness and infection control

Wards were safe, clean, well equipped and well-furnished. However, some wards needed updating. Some wards were tired and needed painting. We were told a capital bid had been submitted to the senior leadership team to procure funding. Managers were awaiting the outcome. We found some minor maintenance issues at Kettering hospital site during the tour of the care environment. The trust actioned these immediately.

Staff adhered to infection control principles, including handwashing. Staff had access to personal protective equipment in accordance with infection control code of practice. Wards had posters located in key areas reminding staff to wash their hands. We found 89% of staff had completed the trusts infection control training.

PLACE assessments aim to provide a clear message from patients on how the care environment may be improved. They are undertaken by teams of local people alongside healthcare staff. Areas

assessed include privacy and dignity, food, cleanliness, building maintenance, and the suitability of the environment for people living with disabilities and dementia.

The sites which deliver acute wards for adults of working age and psychiatric intensive care units within Northamptonshire Healthcare NHS Foundation Trust were compared to other sites of the same type. The scores they received for 'cleanliness' and 'condition, appearance, and maintenance' were found to be about the same as the England average.

Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly. The house keeping teams were visible on the wards and were spoken highly of by staff and patients.

Seclusion room

Seclusion rooms allowed clear observation and had two-way communication systems. All had toilet facilities and a clock visible on the external wall.

Clinic room and equipment

Wards had a fully equipped clinic room with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff maintained equipment well and kept it visibly clean.

Safe staffing

The trust had established and calculated the number and grade of qualified and unqualified staff required to achieve their safer staff requirements.

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

The below chart shows the breakdown of staff in post WTE in this core service from 1 April 2018 to 31 March 2019.

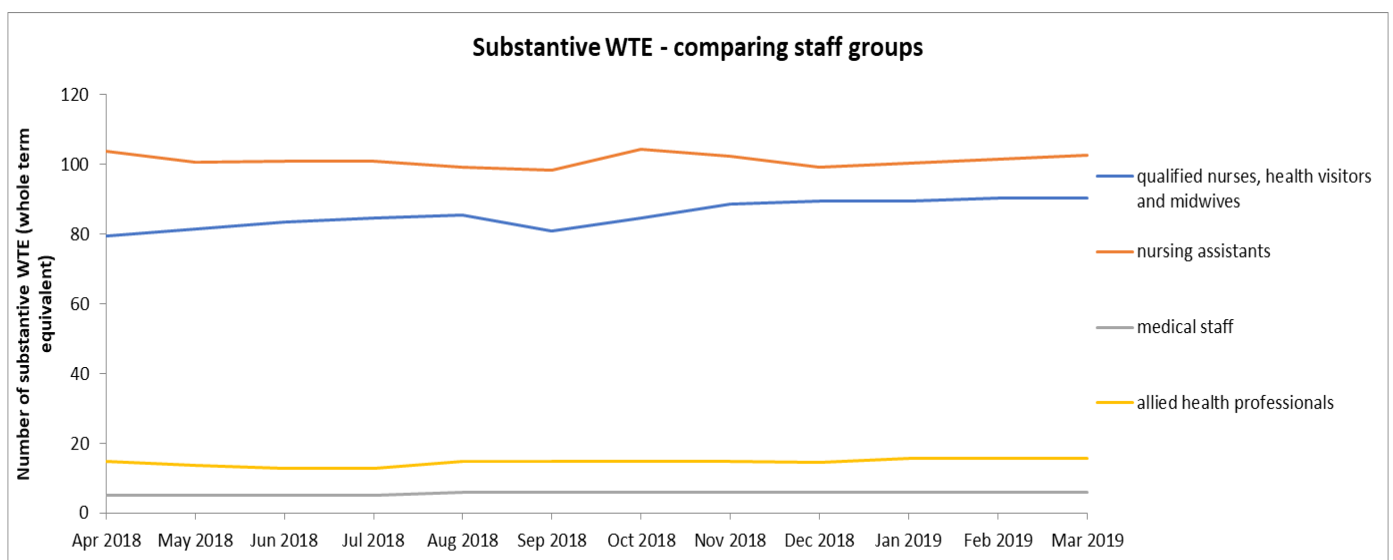

Figure 32

The below table covers staff fill rates for qualified nurses and care staff during February, March and April 2019.

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 (%)
	February 2019				March 2019				April 2019			
Kingfisher Ward	104.0	103.1	100.0	116.2	107.0	96.9	103.2	107.7	98.4	120.7	100.2	128.3
Avocet Ward	97.3	120.6	100.0	107.2	100.2	102.5	98.4	114.5	102.1	120.9	106.7	141.7
Sandpiper Ward	99.3	103.9	98.3	99.8	93.3	106.8	98.4	103.2	95.7	98.7	95.4	141.7
Harbour Ward	111.8	113.9	98.2	174.7	112.0	86.5	101.2	118.5	101.3	102.4	101.8	107.7
Cove Ward	100.9	93.4	88.6	110.7	93.4	105.0	90.1	127.0	89.4	113.0	92.0	110.5
Bay Ward	91.8	114.9	92.8	136.0	85.3	113.6	91.9	123.5	94.1	113.9	93.0	117.7
Marina ICU	95.8	101.4	98.6	98.6	90.3	94.6	96.9	101.6	93.7	95.0	94.4	99.6
Shearwater ICU	94.4	99.2	96.6	105.5	94.6	151.4	91.5	113.0	97.3	101.5	100.3	100.0

In the trust's board report for May 2019 they reported that:

'Due to both planned & unplanned leave (short term sickness and maternity leave) and vacancies (HCA 1.44wte), Harbour ward had a lower day care staff fill rate of 86.5%. However, this was mitigated by a qualified day fill rate of 112.0%.'

'Bay ward had a lower day qualified fill rate of 85.3% due to vacancies (3.3 wte). The lower fill rate was mitigated by increased ward matron clinical input and the use of experienced substantive and bank HCA's (113.6%).'

Cove ward reported 88.6% for night nurses in February 2019 and 89.4% for day nurses in April 2019. No narrative was provided for Cove ward to explain the lower fill rates for this ward.

Ward managers told us the trust had calculated the number and grade of nurses and healthcare assistants required based on the acuity and bed occupancy. Ward managers were able to increase staffing levels if required.

We reviewed a random sample of the electronic staffing rota and saw evidence that ward managers had planned staffing levels to be consistent with the providers staffing establishment requirements. There was sufficient staff for patients to take escorted leave and for them to engage with patients during therapeutic and meaningful activities.

Ward managers told us bank and agency staff received an induction to the wards. We spoke with bank staff who were working on the day of inspection who confirmed they had received an induction to the ward.

Patients told us a qualified nurse was always present on the ward. Patients received regular one to one time with their named nurse.

There was enough staff to carry out physical interventions and increase the level of care observations if required.

Annual staffing metrics

	Core service annual staffing metrics (1 April 2018 – 31 March 2019)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual “unfilled” hours (% of available hours)**
All staff	260.1	13%	7%	5.3%			
Qualified nurses	103.2	16%	6%	2.6%	29198 (18%)	8231 (5%)	2783 (2%)
Nursing assistants	121.5	12%	9%	8.7%	72046 (38%)	348 (<1%)	3683 (2%)
Medical staff	5.0	-16%	0%	1.5%	308 (1%)	2039 (7%)	3010 (10%)
Allied Health Professionals	15.2	4%	0%	2.0%			

All Staff

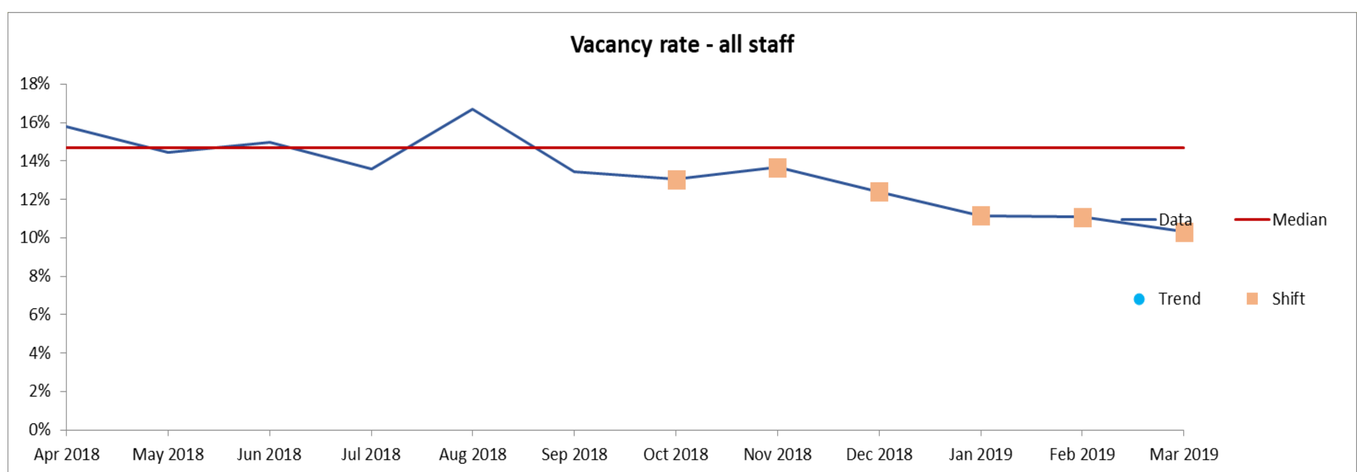

Figure 33

Vacancy rates for all staff over the last 12 months for all staff showed a shift from October 2018 to March 2018 (see figure 2).

Turnover rates for all staff, when benchmarked to similar core services nationally were reporting in the lowest 25%.

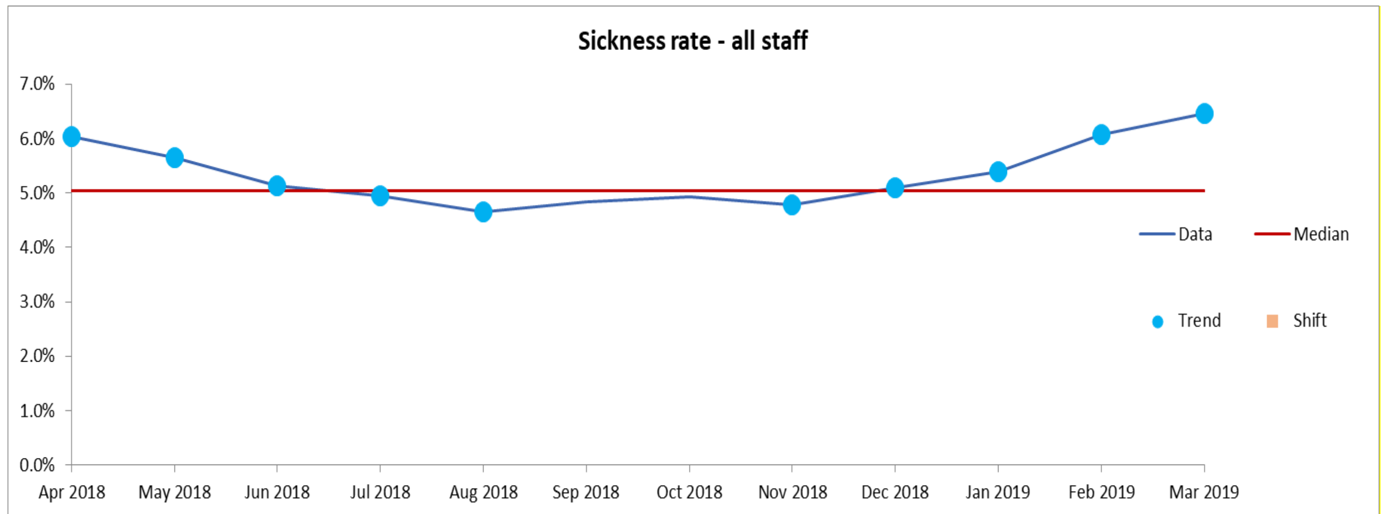

Figure 34

Monthly sickness rates over the last 12 months for all staff showed an upward trend from November 2018 to March 2019 (see figure 3).

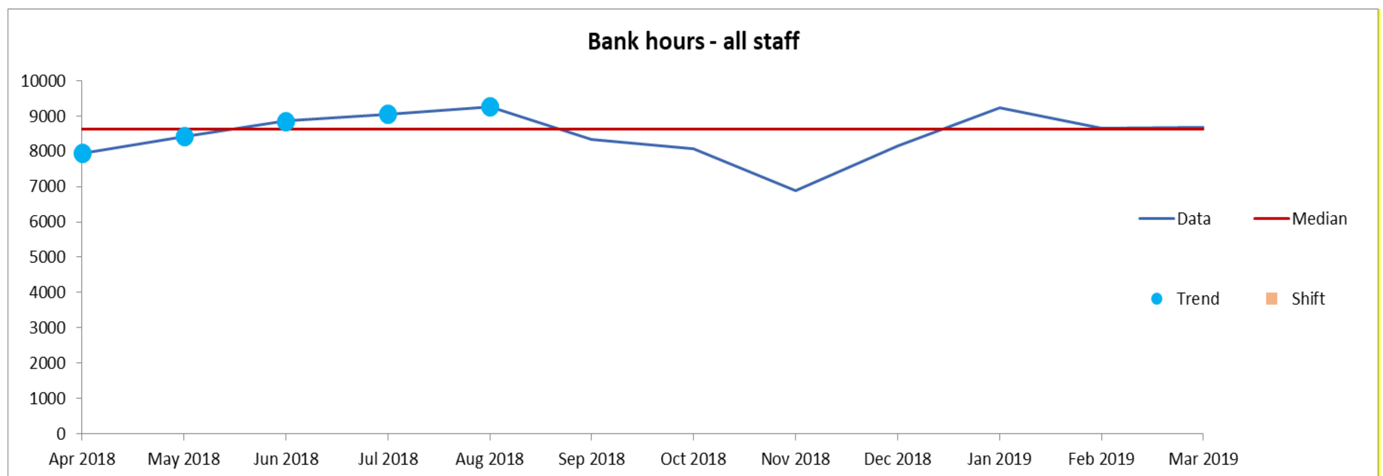

Figure 35

Bank hours over the last 12 months for all staff showed an upward trend from April 2018 to August 2018 (see figure 4).

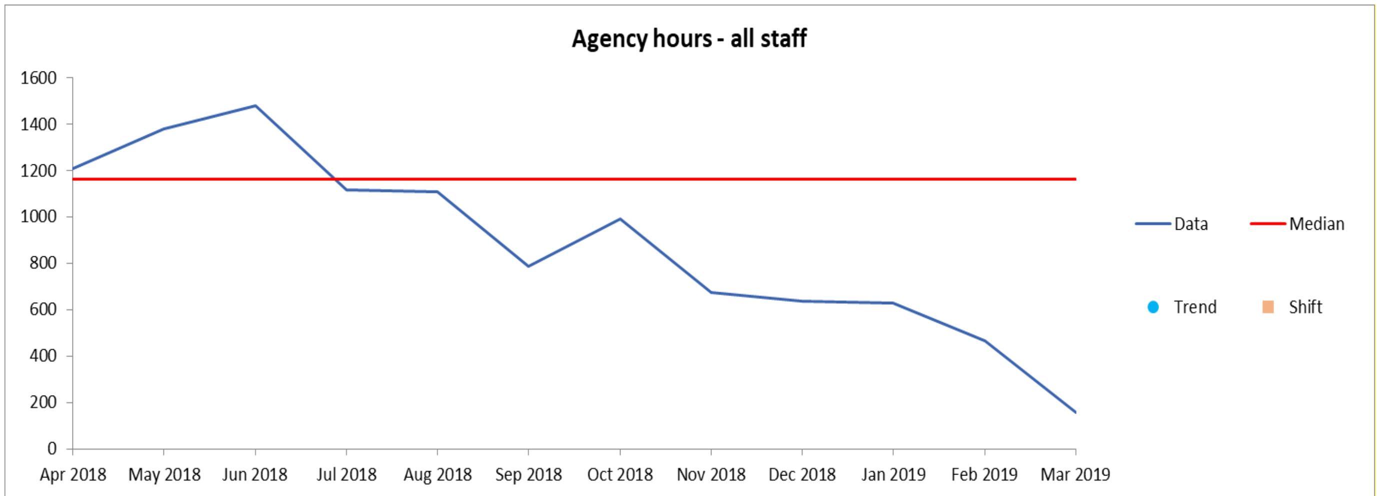

Figure 36

Monthly agency hours over the last 12 months for all staff are not stable and may be subject to ongoing change (see figure 5).

Qualified nurses

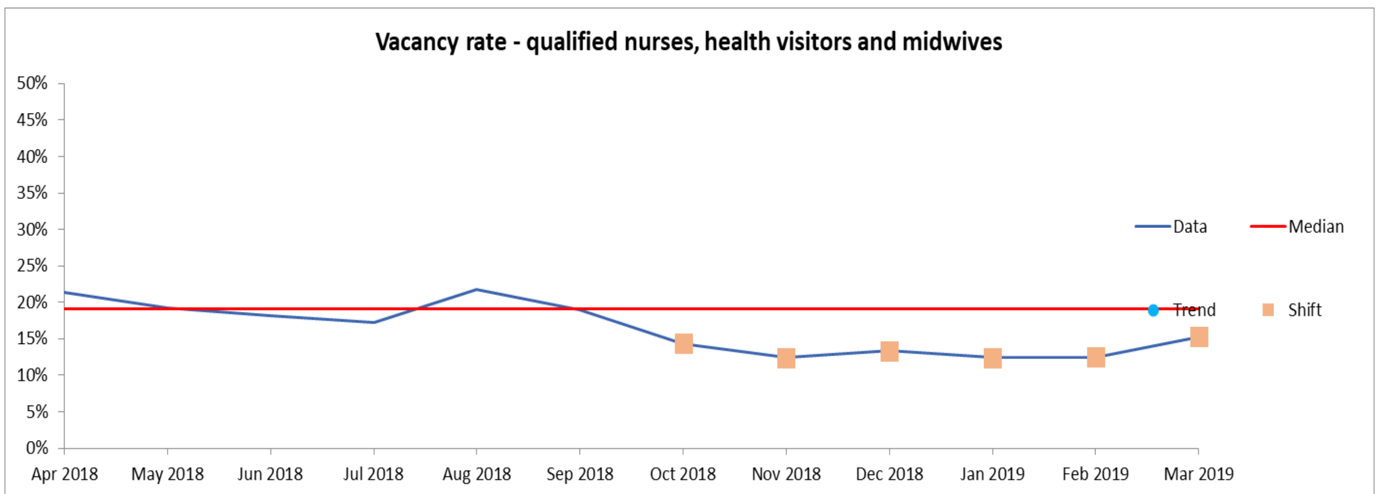

Figure 37

Vacancy rates for qualified nurses showed a shift from October 2018 to March 2019 (see figure 6).

Sickness rates for qualified nurses were in the lowest 25% when benchmarking to similar core services nationally.

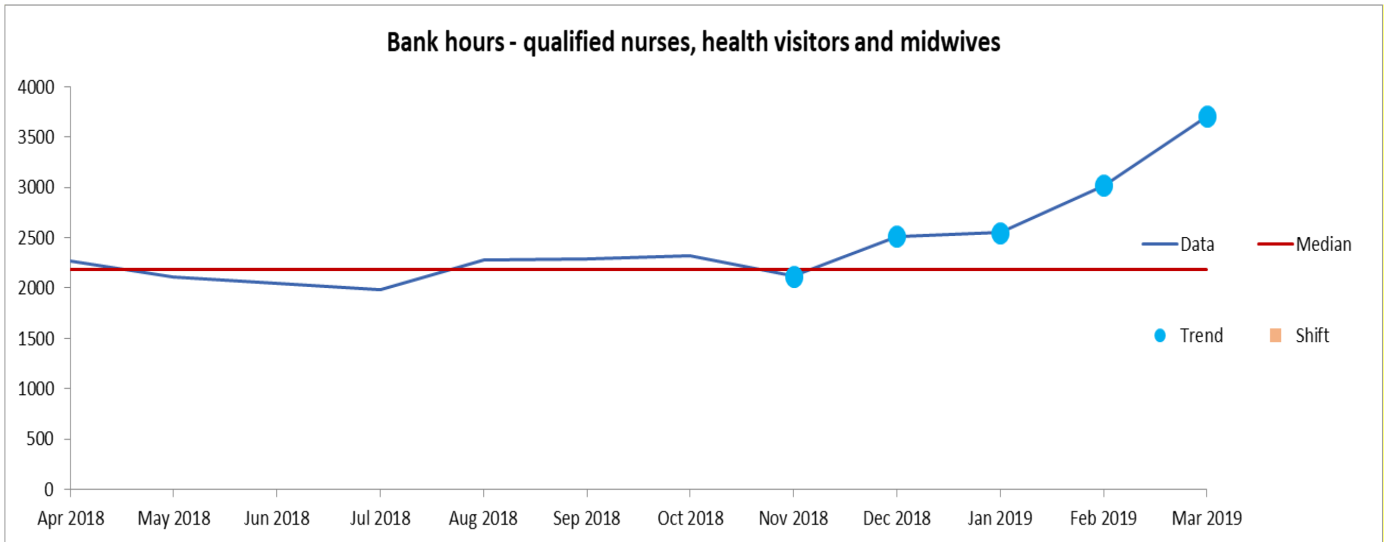

Figure 38

- Bank hours over the last 12 months for qualified nurses showed an upward trend from November 2018 to March 2019 (see figure 7).

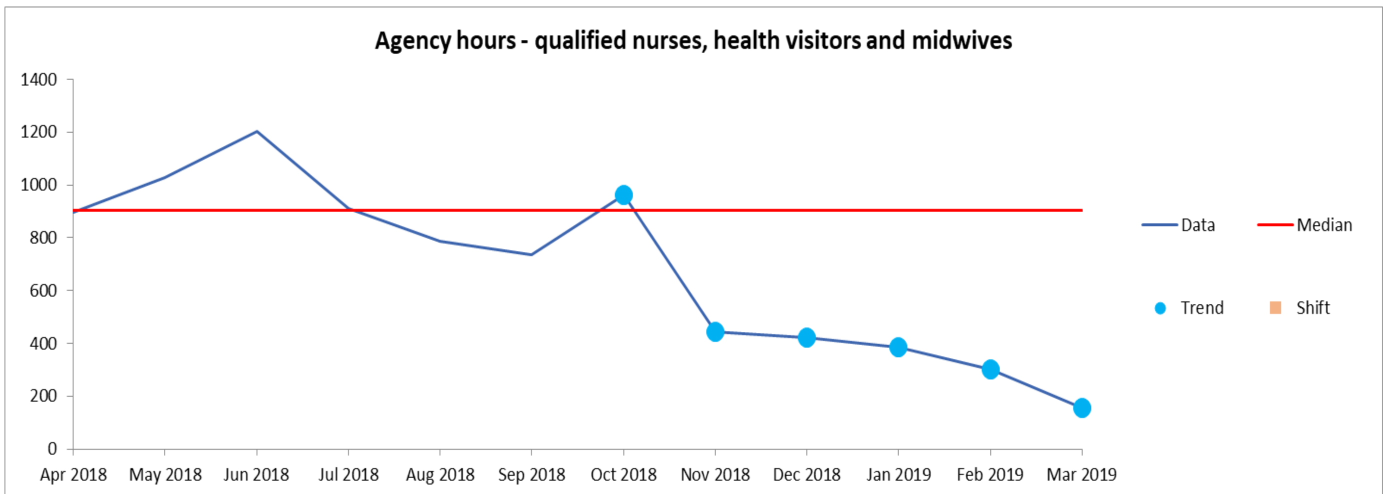

Figure 39

- Qualified nurse’s agency hours showed a downward trend from October 2018 to March 2019 (see figure 8).

Nursing Assistants

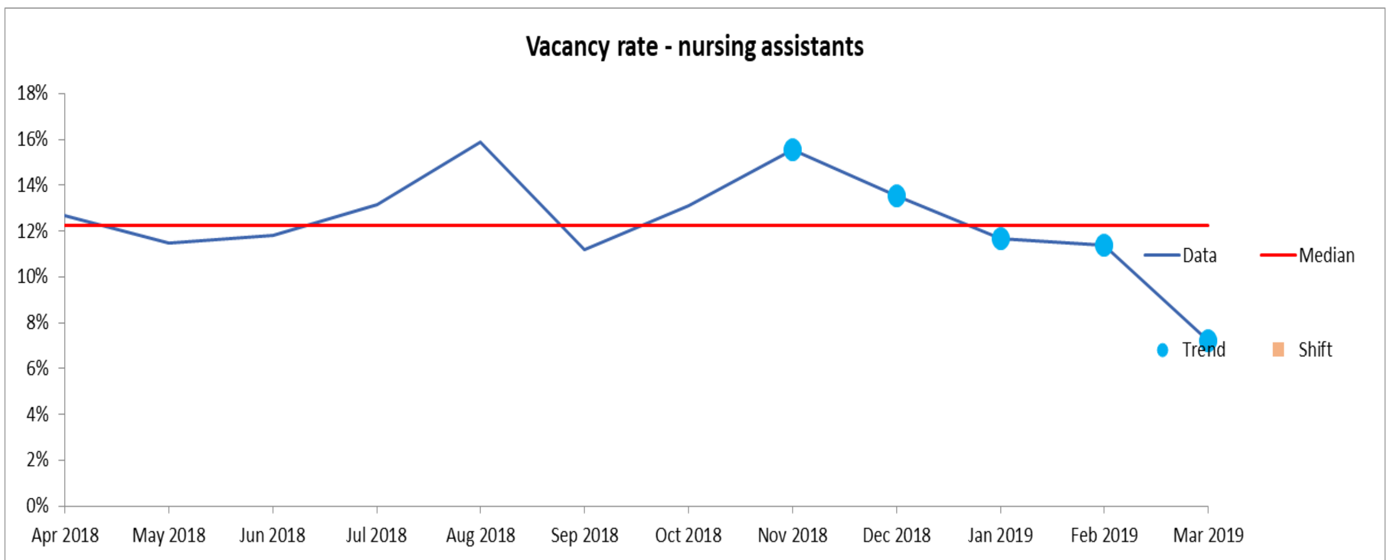

Figure 40

Monthly vacancy rates for nursing assistants showed a downward trend from November 2018 to March 2019 (see figure 9).

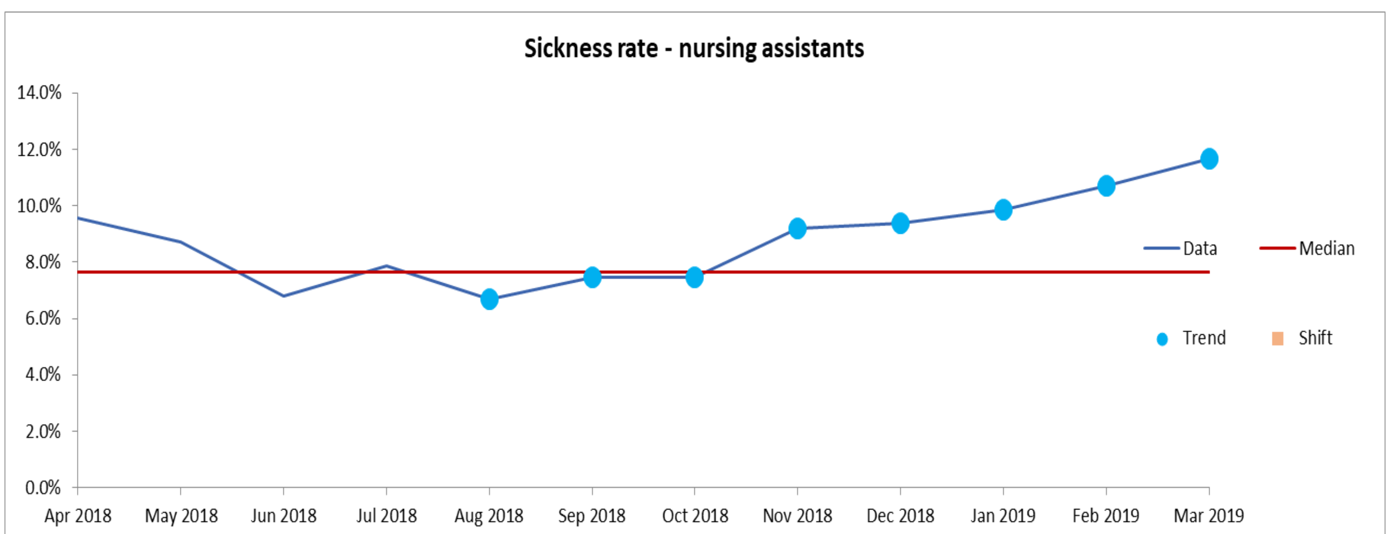

Figure 41

- Sickness rates for nursing assistants over the last 12 months showed an upward trend from August 2018 to March 2019 (see figure 10).

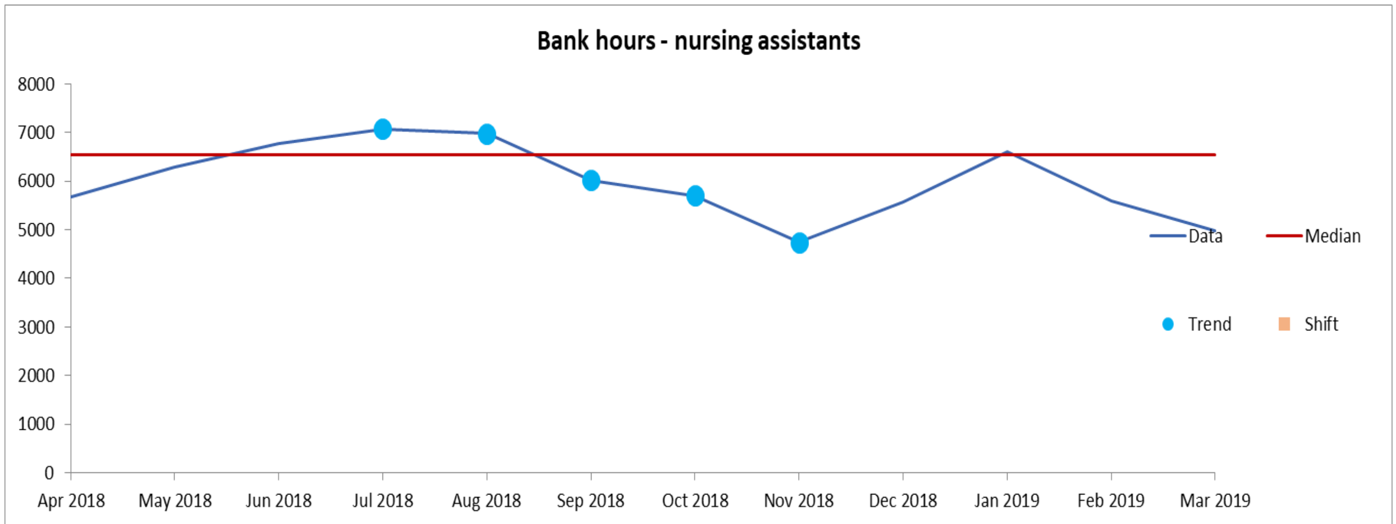

Figure 42

Monthly bank hours over the last 12 months for nursing assistants showed a downward trend from July 2018 to November 2018 (see figure 11).

When necessary ward managers were able to use bank staff to fill vacant shifts. Bank shifts were filled by substantive staff in the first instance and if they were not able to work the shift ward managers used the electronic system to request further bank staff.

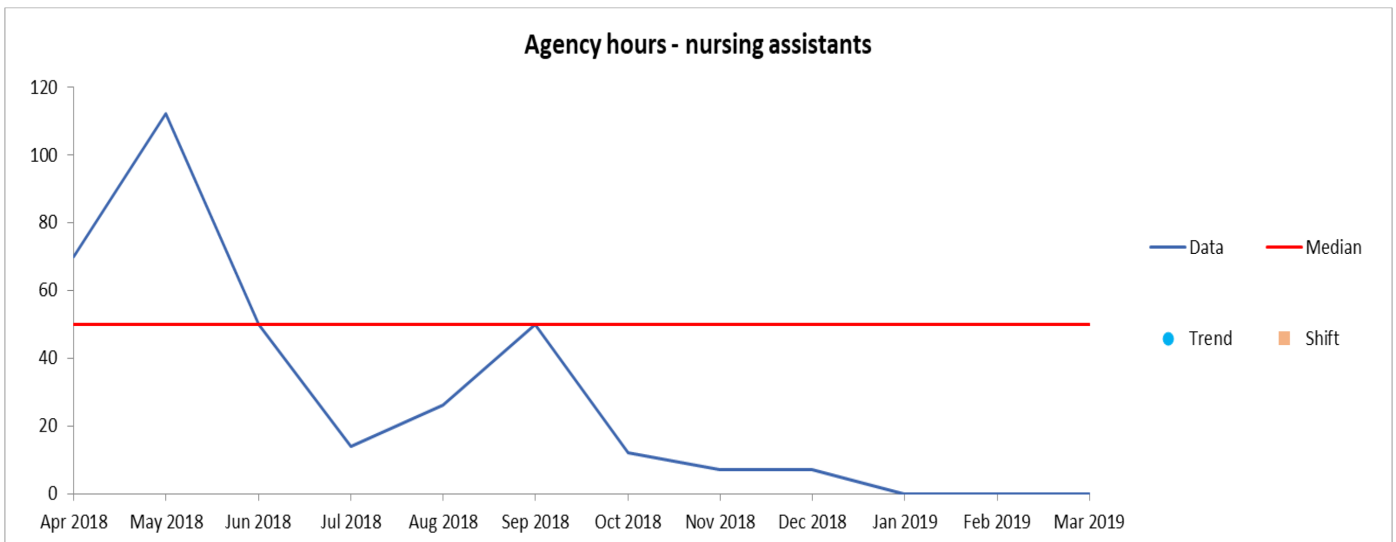

Figure 43

Agency hours for nursing assistants over the last 12 months are not stable and may be subject to ongoing change (see figure 12).

Medical

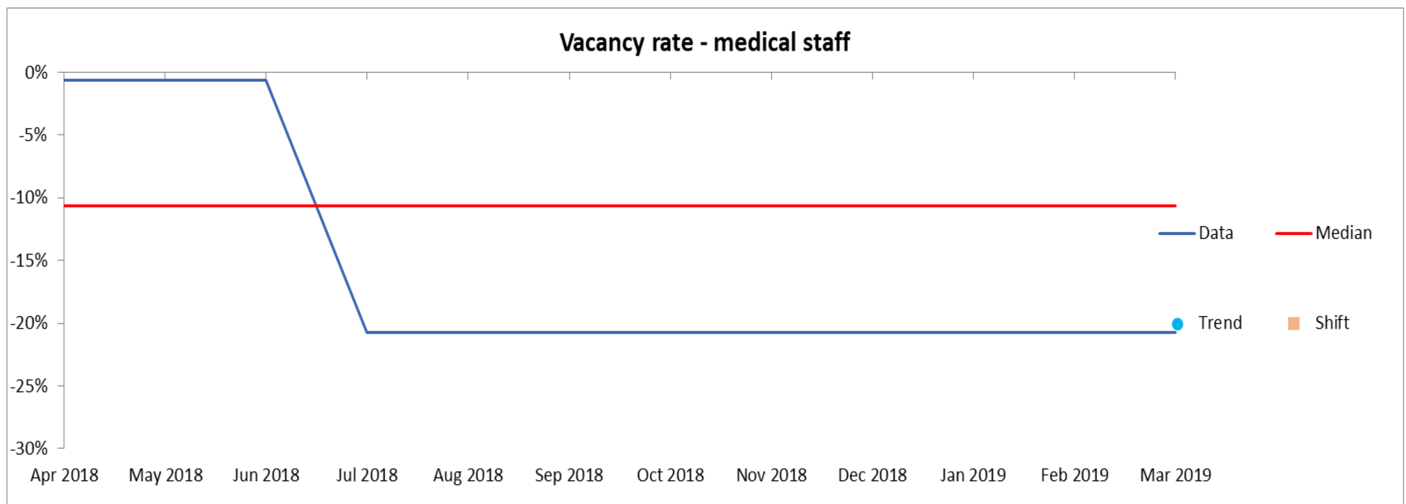

Figure 44

Vacancy rates for medical and are not stable and may be subject to ongoing change (see figure 13). When benchmarking to similar core services nationally, medical and dental staff was in the highest 25%.

Turnover rates for medical staff was in the lowest 25% when benchmarking to similar core services nationally.

Allied Health Professionals

Vacancy, turnover and sickness rates for allied health professionals over the last 12 months appear to be stable. When benchmarking to similar core services nationally, turnover was in the lowest 25%.

Medical staff

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency.

Mandatory training

Staff had received and were up to date with appropriate mandatory training. Overall, staff in this service had undertaken 90% of the various elements of training that the trust had set as mandatory.

The trust set a target of 90% for completion of mandatory and statutory training. The compliance for mandatory and statutory training courses at 31 March 2019 was 90%. Of the training courses listed eight failed to achieve the trust target and of those, all scored above 75%.

We are unable to compare to the previous year as the training data was provided in another format and the course (training modules) were not consistent and not all courses have been listed.

The trust did not submit training data for staff who had completed prevention, management of violence and aggression training.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✗	Higher ↑	No change →	Lower ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Resuscitation - Level 1 - No Specified Renewal	2	2	100%	✓
Safeguarding Children (Version 2) - Level 1 - 3 Years	7	7	100%	✓
Safeguarding Adults - Level 1 - 3 Years	7	7	100%	✓
Resuscitation - Level 2 - Adult Basic Life Support - No Specified Renewal	2	2	100%	✓
Resuscitation - Level 2 - Paediatric Basic Life Support - No Specified Renewal	2	2	100%	✓
Infection Prevention and Control - Level 1 - 3 Years	9	9	100%	✓
Safeguarding Adults - Level 2 - 3 Years	226	218	96%	✓
Safeguarding Children (Version 2) - Level 2 - 3 Years	226	218	96%	✓
Health, Safety and Welfare - 3 Years	233	223	96%	✓
Information Governance and Data Security - 1 Year	233	221	95%	✗
Moving and Handling - Level 1 - 3 Years	233	220	94%	✓
Infection Prevention and Control - Level 2 - 1 Year	224	200	89%	✗
Resuscitation - Level 1 - 1 Year	231	201	87%	✗
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year	147	127	86%	✗
Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year	147	127	86%	✗
Fire Safety - 1 Year	233	194	83%	✗
Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year	84	68	81%	✗
Moving and Handling - Level 2 - 1 Year	212	165	78%	✗
Total	**2458**	**2211**	**90%**	

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

We reviewed 43 care records and saw all patients had a risk assessment complete on admission. Clinical staff used a recognised risk assessment tool which was reviewed regularly including after incidents.

Management of patient risk

Staff were aware of and dealt with any specific risk issues, such as falls or pressure ulcers. Where a patient risk was identified the multidisciplinary team managed the risk appropriately. Staff we spoke with told us the trust encouraged staff to take positive risks which ensured staff did not over restrict patients.

We saw evidence that staff identified and recorded changing risk on the electronic recording system.

Ward based staff was aware of the patient's observation policy which was adhered too.

Staff considered blanket restrictions and took positive risks. For example, all patients had access to their own mobile phones unless the risk was deemed too high. We saw the service took actions in line with best practice guidelines by implementing the smoke free policy and offered smoking cessation to patients who smoked. Patients had access to vapes if they requested to use them.

Informal patients could leave at will. We saw informal notices throughout the wards and on the exit doors detailing informal patients' rights.

Use of restrictive interventions

The total number of restraints was 6% higher in 2018 than the previous year (545 total). Seclusion had increased by 14.5% (241 total). However prone restraint had decreased by 13% since our last inspection, although 46% of all restraints were prone, a decrease from 56% at our last inspection. We saw the trust had a proactive approach to reducing restrictive practices with a specific group targeted to address such issues.

The below table focuses on the last 12 months' worth of data: 1 April 2018 to 31 March 2019.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of mechanical restraint	Of restraints, incidences of rapid tranquilisation
Avocet Ward	16	22	12	10 (45%)	0	5 (23%)
Bay Ward	11	56	17	28 (50%)	0	26 (46%)
Cove Ward	13	37	15	21 (57%)	0	7 (19%)
Harbour Ward	6	43	18	19 (44%)	0	16 (37%)
Kingfisher Ward	9	26	10	7 (27%)	0	3 (12%)
Marina Ward PICU	91	116	28	75 (65%)	5 (4%)	16 (14%)
Sandpiper Ward	11	74	27	19 (26%)	0	14 (19%)
Shearwater ICU	84	171	34	71 (42%)	0	25 (15%)
Core service total	**241**	**545**	**161**	**250 (46%)**	**5 (1%)**	**112 (21%)**

There were 250 incidences of prone restraint, which accounted for 46% of the restraint incidents. Over the 12 months, incidences of restraint ranged from nine to 34 per month. The number of incidences (250) had decreased from the previous 12-month period (269).

There were 112 incidences of rapid tranquilisation over the reporting period. Incidents resulting in rapid tranquilisation for this service ranged from four to 16 per month over (1 April 2018 to 31 March 2019). The number of incidences (112) had decreased from the previous 12-month period (186).

We reviewed a random sample of rapid tranquilisation records. Staff had completed all physical health monitoring following the use of the medication, in line with the National Institute for Health

and Care Excellence guidelines. However, we found on Sandpiper Ward where intramuscular medication was administered as part of treatment, the required physical health monitoring post administrating had not been completed by nurses. We raised this with the ward manager who confirmed it was an error. We were assured the recording error was an isolated incident and the ward manager took robust action to ensure all staff were informed of the error and lessons learnt.

There had been five instances of mechanical restraint over the reporting period (all were on Marina ward across two months). The number of incidents (five) had increased from the number of incidents from the previous 12-month period (none).

The number of restraint incidents reported during this inspection was higher than the 512 reported at the time of the last inspection.

The trust had submitted a paper to board in March 2019, to suggest ways in which the trust would reduce levels of restrictive intervention. The trusts' restraint reduction strategy had considered guidance in a reasoned way and reviewed its ways to reduce restraint further. It highlighted three main reasons for an increase in restraint numbers. Firstly, accurate data collection where a specific form which captured all restraint was quicker for staff to use. Secondly the trust promoted a culture of effective reporting and learning culture where staff were encouraged to actively report incidents in a transparent way. Third, staff acknowledged in some high-risk situations, restraint may represent the only option available when other strategies have failed.

Staff we spoke with told us they only used physical restraint as a last resort and after de-escalation had failed. Ward based staff acknowledged there were peaks of when restraint was used which was due to the complex needs of the patient group. We were assured restraint was used as a last resort.

The trust had recently implemented the use of restraint pods. The pods assisted in ensuring patient and staff safety whilst engaging in manual restraint. The pods were large, soft and portable which were used to safely hold a patient whilst conducting manual restraint preventing patients from being taken to the floor.

There had been 241 instances of seclusion over the reporting period. Over the 12 months, incidents of seclusion ranged from none to 19.

The number of seclusion incidents reported during this inspection was higher than the 206 reported at the time of the last inspection.

We reviewed a random sample of seclusion records and found staff had completed appropriately. This was an improvement from the previous inspection. There have been no instances of long-term segregation over the 12-month reporting period.
The number of segregation incident reported during this inspection was the same as the number reported at the time of the last inspection (none).

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Staff we spoke with at all grades were able to demonstrate how they would identify and raise a safeguarding concern. Staff were able to describe how to protect patients from discrimination and harm, including those with protected characteristics under the Equality Act. Protected

characteristics are: age, disability, sexual orientation, gender reassignment, religion or belief, marriage and civil partnership, and pregnancy, maternity and race.

Wards had safe provisions for children that visited family members away from the ward. There were rooms outside of the ward areas that were used. Children did not have to enter the wards when visiting.

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 adult at risk 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 adult at risk, the organisation will work to ensure the safety of the person. 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 36 safeguarding referrals between 1 April 2018 and 31 March 2019, of which 36 concerned adults and none concerned children. The number of safeguarding referrals reported during this inspection could not be compared to the last inspection as the data was provided at trust wide level only.

Number of referrals		
Adults	**Children**	**Total referrals**
36	0	36

The number of adult safeguarding referrals in month ranged from one to eight referral per month.

The trust submitted details of one serious case reviews commenced or published in the last 12 months (1 April 2018 and 31 March 2019) that related to this service.

Reference Number	Team/Ward/Unit	Recommendations	Actions Taken	Outstanding Actions
DHR: Ref007	Sandpiper ICU, St Marys Hospital	3 recommendations: review of risk assessments, contemporaneous record keeping and professional curiosity being part of everyday practice	Working on actions and sharing with operational teams	On-going work to evidence and audit due Dec 2019

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

The trust used an electronic record system. All staff had access to the system and were able to update and input new patient information in a timely manner. However, on Shearwater ward the

scanner was not working. There was a backlog of patient information that was required to be scanned on to the computer system.

Medicines management

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. Out of date medicines were found in the medicines trolley on Sandpiper ward, one of which had expired in October 2018. It wasn't always clear from records at what time patients had received their medicines. Morning medicine administration could take up to two hours to complete. We saw that medicines were still being administered four hours after the prescribed time on Avocet ward. Lorazepam injection (a sedative) was prescribed for one patient on Sandpiper ward without the relevant certificate of consent being in place. The prescription was discontinued by the doctor during our inspection. In one case when lorazepam injection was administered as part of a treatment plan, the nurses had not monitored physical observations as expected. We found one injection which nurses had administered as part of rapid tranquilisation, recorded as being given orally.

Staff reviewed patient's medicines regularly as part of the multidisciplinary meeting (MDT) and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. However, staff were not always using up to date references to check medicines information upon administration.

Staff followed current national practice to check patients had the correct medicines. All patients' charts we reviewed had a medicines reconciliation completed to ensure that they had their medicines appropriately prescribed.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines on most wards. However, on Cove ward, we identified that 13 of the 17 patients had been prescribed lorazepam, seven of which included prescriptions for both oral and / or injection. Nurses had administered oral lorazepam on two occasions to different patients. The doctor discontinued these prescriptions during our inspection.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance. Staff completed regular monitoring during medicine rounds. The service employed two physical health nurses, who could oversee the physical wellbeing of patients.

Track record on safety

Between 1 April 2018 and 31 March 2019 there were no serious incidents reported by this service.

The number of serious incidents reported during this inspection was lower than the five reported at the last inspection. At the time of inspection and after the trust had submitted data for the inspection, there were two on going serious incident investigations from Cove and Harbour ward. The serious incidents had been commenced due to two patient deaths. The trust was investigating the serious incidents and will provide a written serious incident report once each of the investigations are concluded.

Reporting incidents and learning from when things go wrong

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.

The service had made improvements to learning lessons following incidents. The trust involved relatives in a group which valued feedback about processes of investigation and made changes to improve communication, support and feedback to families.

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 has been one 'prevention of future death' reports sent to Northamptonshire Healthcare NHS Foundation Trust. However, it did not pertain to this core service.

Staff we spoke to were able to demonstrate their role and responsibilities regarding duty of candour.

Is the service effective?

Assessment of needs and planning of care

We reviewed 43 care and treatment records. Staff completed a comprehensive mental health and physical health assessment on each patient upon admission. Clinical staff, through coproduction with the patients and their careers, developed individual care plans. These were reviewed regularly through multidisciplinary discussion and updated by staff as needed. Care plans reflected patients' assessed needs, were personalised, holistic and recovery-oriented.

Staff ensured that all patients regularly received on going physical health checks. Clinical staff regularly monitored weight, pulse, blood pressure and temperature. If any issues were identified staff were able to demonstrate the process of how they would escalate their concerns to the relevant medical professional. The physical healthcare checks completed were so thorough, they delayed the medication rounds and the times recorded when staff gave patients medication.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives.

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence.

The trust had developed a personality disorder pathway. This was a goal focused admission process, with an agreed length of stay with the patient prior to admission. The trust reported that this had a positive impact reducing the average length of stay and avoided crisis admissions to the wards.

Staff used recognised rating scales to assess and record severity and outcomes for example, using HONOS. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. There was evidence staff supported patients to live healthier lives. For example, through participation in smoking cessation schemes, healthy eating advice, and dealing with issues relating to substance misuse. Staff we spoke with knew of the local community drug and alcohol services.

Patient's had access to a psychologist and psychology lead groups in line with National Institute for Health and Care Excellence guidance. Staff and patients told us they felt they had enough access to psychological support.

This service participated in 14 clinical audits as part of their clinical audit programme 2018 – 2019. Staff we spoke to confirmed they took part in the clinical auditing programme for the wards.

Audit name	Audit scope	Date completed	Key actions following the audit
National Early Warning Scores – Mental Health & Adult & Child Q1, Q2, Q3, Q4	Adult Inpatients Acute	01/04/2019	• To ensure continual improvement NEWS audits will remain weekly/monthly • Ward Managers and Modern Matrons to continue to feedback to all clinical staff to ensure: • Those areas who have not achieved 90% to have further training, either on line or face to face to improve concordance with standards which is provided by Clinical Skills Team. • The Quality team have aligned with the Adult and Child pathway and are currently implementing a new audit tool. • The CQF has been visiting ward areas and discussing NEWS with staff and Managers, as well as providing up to date audit data for wards to work from. • The CQF provides DMT with regular updates on progress of outliers. • Areas that have access to an RGN, to share these results and complete an action plan.
Nutritional Assessments (MUST) – Mental Health & Adult & Child Q1, Q2, Q3, Q4	Adult Inpatients Acute	01/04/2019	• Feedback will be offered by the Clinical Quality Facilitators to ward managers • Staff to identify where a patient has refused to engage in MUST scoring
Overview of Electronic and Paper Record Keeping	Adult Inpatients Acute	01/04/2019	Teams to improve compliance for areas that are RAG rated as

Audit name	Audit scope	Date completed	Key actions following the audit
Audit – Mental Health & Adult & Child Q1, Q2, Q3, Q4			amber by developing team action plans • All teams to develop a Qualitative Record Keeping Audit. • Feedback results through pathway meetings
Quarterly Photographic ID Audit	MH Adult Inpatients Acute	01/04/2019	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.
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	MH Adult Inpatients Acute	ongoing	• Creation of dedicated role for STORM training, update of trainers arranged, and comprehensive rolling training package being delivered. • Wrote and submitted zero ambition plan for NHS England – awaiting feedback (which was initially presented and approved at Trust Board) • Supported development of "Common-sense Confidentiality" leaflet to support involvement of family/friends in planning of care • Delivered a number of ½ day briefing sessions on work of Suicide Prevention group and suicide prevention more broadly • Support development of suicide prevention course through recovery college • Continued participation in Countywide suicide prevention group, with plans to launch public-facing multi-agency campaign later in year
Tobacco and Alcohol Audit	MH Adult Inpatients Acute	31/03/2019	Regular updates using a variety of media and meetings around health promotion and good record keeping standards given to all ward areas using Staff Training And Retention (STAR) days, team meetings, e- brief and emails. AUDIT-C Cards posters were distributed to all ward areas

Audit name	Audit scope	Date completed	Key actions following the audit
			NHFT has implemented an automatic smoking referral system within its clinical systems for every patient that is screened as a smoker; however, patients are given the choice to opt out if they are not yet ready to quit. There are trained Smoking Cessation Specialists on the wards.
Compliance with VTE Risk Assessment - Quarterly	MH Adult Inpatients Acute	Ongoing	New VTE policy in place reflecting NICE guidance Clinical Systems VTE template amended and implemented VTE steering group in place Awareness training developed and delivered to nursing staff Drs Induction training around VTE strengthened Weekly compliance conference call in place
Bi-annual Ligature Audit	MH Adult Inpatients Acute	31/03/2019	The Trust now has a tool which has been developed to help staff address the risk of ligatures in a balanced, objective and systematic way. Actions must be taken to eliminate or reduce those risks identified immediately or as soon as reasonably practicable. The Trust actively pursues an objective to eradicate as far as reasonably practicable all potential ligature and anchor points and where this is not practicable to control the risks by monitoring them. The Trust's primary aim is to eliminate all high-risk ligature anchor points that are scored at 81 using the tool. All risk assessment and mitigation plans produced as a result of the ligature audit must be reviewed at least bi-annually or when a change occurs to the environment, the service provided or as the needs of the patient changes. Replacement of bed frames with anti-ligature bed bases.

Audit name	Audit scope	Date completed	Key actions following the audit
Prone Restraint	MH Adult Inpatients Acute	01/05/2019	Continue to measure and monitor specifically our use of prone restraint in the context of our overall use of restraint to ensure prone restraint is being used as a last resort. Continue to search for alternative restraint positions for the higher risk incidents. Continue to publicise the trusts restraint reduction strategy, which includes specific actions relating to the use of prone restraint around the trust Continue to measure and monitor staff and patient injuries related to restraint
Informal Leave Audit	Avocet, Sandpiper and Kingfisher	22/04/2019	Informal Leave form added to May 19 STR days as an agenda item to ensure all staff are aware of the necessity to complete this form accurately. (STR days are whole staff team meetings, which capture the majority of staff over a one-month period).
An evaluation of staff's attitudes towards and experience of co-production in an adult inpatient mental health setting	Adult Inpatients Acute	01/03/2019	
Missed admission bloods	Adult Inpatients Acute	Ongoing	
An evaluation of staff's attitudes towards and experience of co-production in an adult inpatient mental health setting	Adult Inpatients Acute	01/03/2019	
Falls and Fragility Fracture Audit	Adult Inpatients Acute	Ongoing	

Skilled staff to deliver care

Patients had access to a range of disciplines to provide care and treatment. The multidisciplinary team consisted of consultant psychiatrists, doctors, qualified nurses, healthcare support workers, occupational therapists, art therapists and psychology. The hospital also employed a catering team, housekeepers, administrative staff and had a service level agreement in place with maintenance contractors.

The trust had a staff induction policy which included substantive, bank and agency staff. Staff we spoke with told us they had received a corporate induction and ward-based induction in line with the trusts policy. Staff were expected to read key polices, learn about the ward and shadow experienced staff before working independently on the wards.

Ward managers used a range of systems to monitor staff performances. Where areas of improvement or concern were identified managers took appropriate action in a timely manner.

Ward mangers arranged specialist training for ward staff when required. For example, staff received specialist training and support from the community learning disability team to meet the needs of a patient who had a mental health and learning disability diagnosis.

Staff we spoke with throughout the inspection confirmed they had received a supervision and appraisal in line with the trusts policy.

The trust's target rate for appraisal compliance was 90%. At the end of last year (1 April 2018 and 31 March 2019), the overall appraisal rate for non-medical staff within this service was 92%. This year so far, the overall appraisal rates was 93% (as at 24 May 2019). The wards with the lowest appraisal rate at 24 May 2019 were Kingfisher ward with an appraisal rate of 80%, and Avocet ward at 75%.

The rate of appraisal compliance for non-medical staff reported during this inspection was the same as the 93% reported at the last inspection.

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 (as at 24 May 2019)**	**% appraisals (previous year 1 April 2018 – 31 March 2019)**
Cove Admissions (Male)	21	21	100%	95%
Mental Health in-patient OT/Physio Service	29	29	100%	100%
Marina ICU	21	21	100%	95%
AMH Nurse Management Acute Care	10	10	100%	100%
Sandpiper Treatment Ward	23	23	100%	87%
Bay Admissions (Female)	19	19	100%	100%
AMH Inpatients - Psychosis	5	5	100%	100%
Welland Centre	13	12	92%	80%
Shearwater PICU	24	22	92%	88%
Harbour Acute	23	21	91%	100%
Kingfisher Assessment Ward	25	20	80%	75%
Avocet Treatment Ward	24	18	75%	87%
Core service total	**237**	**221**	**93%**	**92%**
Trust wide	**3719**	**3413**	**92%**	**92%**

At the end of last year (1 April 2018 to 31 March 2019), the overall appraisal rate for medical staff within this service was 100%. This year so far, the overall appraisal rates this was 100% (as at 24 May 2019).

The rate of appraisal compliance for medical staff reported during this inspection was higher than the 82% reported at the last inspection.

Ward name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals (as at 24 May 2019)	% appraisals (previous year 1 April 2018 – 31 March 2019)
Shearwater PICU	1	1	100%	100%
Bay Admissions (Female)	1	1	100%	100%
Welland Centre In-Patients	2	2	100%	100%
Cove Admissions (Male)	1	1	100%	100%
Marina ICU	1	1	100%	100%
Core service total	**6**	**6**	**100%**	**100%**
Trust wide	**90**	**78**	**87%**	**80%**

The trust's target of clinical supervision for non-medical staff was 90% of the sessions required. Between 1 April 2018 and 31 March 2019, the average rate across all 12 teams in this service was 169%. Caveat, there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Nurse Management Acute Care	48	143	298%
Cove Ward	142	348	245%
Harbour Ward	144	287	199%
MH in-patient OT/Physio	174	306	176%
Welland centre	64	106	166%
AMH inpatients – psychosis	38	63	166%
Avocet ward	150	240	160%
Bay Ward	128	198	155%
Shearwater PICU	168	249	148%
Sandpiper ward	126	176	140%

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Marina Ward	128	169	132%
Kingfisher Ward	148	174	118%
Core service total	**1458**	**2459**	**169%**
Trust Total	**6128**	**12673**	**207%**

The trust's target of clinical supervision for medical staff was 90% of the sessions required. Between 1 April 2018 and 31 March 2019, the average rate across all three teams in this service was 108%. **Caveat,** there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Marina Ward	8	11	138%
Cove Ward	8	8	100%
Shearwater ICU	8	7	88%
Core service total	**24**	**26**	**108%**
Trust Total	**202**	**319**	**158%**

We reviewed a random sample of staff supervisions and found the supervision were of good quality. Ward managers used a standardised template that covered key areas such as performance and well-being.

Figures submitted by the trust showed compliance rates of over 100% in some teams. The trust captured various forms of meetings which they classed as supervision, including clinical, managerial, group supervision, reflective practice and safeguarding supervision. However, we were assured that team met regularly for clinical supervision.

Multi-disciplinary and interagency team work

Staff held regular and effective multidisciplinary meetings. Clinical staff discussed all patients during these meetings which included a comprehensive review of their needs and progress made. Records showed that patients were encouraged to take part in their review meetings.

Shift handovers happened at the start of every shift. We observed two handovers. They had a set agenda which staff were familiar with. Shift co-ordinators completed the handover sheet. Topics covered during handover included, current patient risk, level of observations and Mental Health Act status.

Staff we spoke with reported they had good relationships with the local authority and mental health teams. Care coordinators, the crisis team and community mental health professionals were invited

to, and where possible, attended discharge meetings, to ensure a smooth transition back in to the community.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

The trust did not provide any data relating to Mental Health Act training prior to inspection.

We reviewed 43 care and treatment records. Some patients were informal, and others were detained under the Mental Health Act. Staff clearly documented patients' legal status within care records.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.

Patients had easy access to information about independent mental health advocacy.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this had been granted. The service displayed a notice to tell informal patients that they could leave the ward freely.

Staff did regular audits to ensure that the Mental Health Act was being applied correctly. There was evidence of learning from those audits.

Mental Health Act administrators were responsible for scrutinising detentions papers and ensuring all legal documents were accurate and up to date.

Good practice in applying the Mental Capacity Act

The trust did not provide any data relating to Mental Capacity Act training prior to inspection.

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

The trust told us that two Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 April 2018 to 31 March 2019.

The greatest number of DoLS applications were made in January 2019 with two.

	Number of 'Standard' DoLS applications made by month												
	Apr 18	**May 18**	**Jun 18**	**Jul 18**	**Aug 18**	**Sep 18**	**Oct 18**	**Nov 18**	**Dec 18**	**Jan 19**	**Feb 19**	**Mar 19**	**Total**
Standard applications made	0	0	0	0	0	0	0	0	0	2	0	0	2
Standard applications approved	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

The trust had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it.

Staff had a good understanding of the Mental Capacity Act, in particular the five statutory principles. Staff we spoke with told us they assumed capacity in line with the Mental Capacity act. Where a patient was found to lack capacity, clinical staff had access to appropriate guidance to provide care and treatment such as applying for deprivation of liberty safeguarding.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We observed staff treat patients with compassion and kindness. They respected patients' privacy and dignity. Staff were engaging in meaningful activities and showed they had a good understanding of the patient's needs. For example, staff were able to meet the needs of a patient who had speech difficulties as a result of a brain injury.

We reviewed 43 care and treatment record and identified two patients who were in the process of gender reassignment. One care record was detailed and referred to the patient by their chosen name and preferred pronoun, however, we found within the other record the patients preferred name and preferred pronoun was not used consistently used.

The sites which delivered acute wards for adults of working age and psychiatric intensive care units within Northamptonshire Healthcare NHS Foundation Trust were compared to other sites of the same type. Scores they received for 'privacy, dignity and wellbeing were found to be about the same as the England average.

Involvement in care

Involvement of patients

Staff involved patients at all stages in the planning of their care. Staff spoken with told us they coproduced care and treatment plans with patients and their carers if necessary. We reviewed 43 care and treatment records. Patients were involved in planning of their care from admission. We saw goals had been set, which were achievable, individualised and personal to their wishes.

Community meetings were held daily which followed a set agenda which included activity preferences and any concerns regarding the service.

Patients were able to provide feedback on the service they received during daily community meetings. Patients were also encouraged to complete a satisfaction survey upon discharge from the service.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. We spoke with five carers who told us they felt involved by the service and that they felt listened too.

Staff enabled families and carers to give feedback on the service they received. For example, via surveys or during care reviews.

Staff provided carers with information about how to access a carer's assessment. Staff sign posted carers to third party services in the community where appropriate. For example, the link

worker was able to sign post carers to access funding for patients who required white goods for their home, to ensure they lived in an adequality furnished property.

Is the service responsive?

Access and discharge

Staff managed beds well. A bed was available when needed and patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

Bed management

The trust provided information regarding average bed occupancies for eight wards in this service between 1 April 2018 to 31 March 2019.

All of the wards within this service reported average bed occupancies ranging above the minimum benchmark of 85% over this period.

Ward name	Average bed occupancy range (1 April 2018 – 31 March 2019)
Avocet Ward	102 % - 123%
Bay Ward	106% - 123%
Cove Ward	102% - 115%
Harbour Ward	102% - 125%
Kingfisher Ward	107% - 137%
Marina Ward PICU	76% - 113%
Sandpiper Ward	92% - 122%
Shearwater ICU NHFT Beds	63% - 98%

The bed manager for the inpatient's wards told us that when patients went home on leave, they would mostly have a bed to return too. The table above details average bed occupancy for all wards. All leave was risk assessed and rag rated, based on likely hood of the leave breaking down. Only beds that were rated as low and medium risks were used to admit patients too, until a bed became available for them to move too. The bed manager was present at all discharge planning meetings, held on Monday and Fridays. Staff managed the flow of beds safely.

When patients were moved or discharged, this happened at an appropriate time of day to ensure the community mental health teams were able to offer after care support.

The trust had seven PICU beds at Marina ward and seven beds at Shearwater. Four of the beds on Shearwater ward were contracted by another trust, and so were not used by Northampton Healthcare NHS Foundation Trust. When a bed was not available for a patient requiring a psychiatric intensive care unit, they were sent out of area to private providers.

The trust provided information for average length of stay (patients discharged in month and current patients) for the period 1 April 2018 to 31 March 2019.

Ward name	Average length of stay range of patient with leave (1 April 2018 – 31 March 2019) (on discharge)
Avocet Ward	20-50
Bay Ward	13-60
Cove Ward	21-44
Harbour Ward	15-38
Kingfisher Ward	14-44
Marina Ward PICU	13-69
Sandpiper Ward	12-33
Shearwater NHFT Beds	9-26

Ward name	Average length of stay range of patient with leave (1 April 2018 – 31 March 2019) (current patients)
Avocet Ward	57-110
Bay Ward	63-110
Cove Ward	41-96
Harbour Ward	37-99
Kingfisher Ward	53-106
Marina Ward PICU	48-106
Sandpiper Ward	67-89
Shearwater NHFT Beds	19-107

This service reported 153 out area placements between 1 April 2018 to 31 March 2019. As of 16 May 2019, this service had no ongoing out of area placements. There were seven placements that lasted one day, and the placement that lasted the longest amounted to 39 days.

Of the 153 out of area placements,138 were due to the trust placing a patient with another provider due to capacity issues. Five related to the patient being placed with another provider due to this better suiting their care or personal needs.

Ten placements were due to a patient being received from another provider.

The number of out of area placements reported during this inspection was lower than the 274 reported at the time of the last inspection.

Number of out of area placements	Number due to specialist needs	Number due to capacity	Number due to being received from another provider	Range of lengths (completed placements)	Number of ongoing placements
153	5	138	10	1-39	0

This service reported 53 readmissions within 28 days between 1 April 2018 to 31 March 2019. Twenty-five of readmissions (47%) were readmissions to the same ward as discharge. The average of days between discharge and readmission was 14 days. There were no instances whereby patients were readmitted on the same day as being discharged. However, there was one patient who was readmitted the day after being discharged.

At the time of the last inspection, for the period 1 February 2017 to 31 January 2018, there were a total of 47 readmissions within 28 days. Of these, 29 were readmissions to the same ward (62%) and the average days between discharge and readmission was 11 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
53	25	47%	1-28	14

Discharge and transfers of care

Between 1 April 2018 to 31 March 2019 there were 1462 discharges within this service. This amounts to 21% of the total discharges from the trust overall (6890).

There was a total of four delayed discharges over the 12-month period.

The number of delayed discharges reported during this inspection was lower than the seven reported at the time of the last inspection. Staff planned for patients' discharge, including good liaison with care managers and co-ordinators.

Staff supported patients during referrals and transfers between services. For example, if they required treatment in an acute hospital, or temporary transfer to a psychiatric intensive care unit. We tracked a patient care record who was admitted to the acute hospital for treatment. We found the trust had robust measures in place to ensure the continuity of care for a patient who was detained under the Mental Health Act.

The service complied with transfer of care standards. If a patient required secure transport the trust had a preferred provider who they used.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom. Patients had somewhere safe to

store personal belongings. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Patients had their own en-suite bedroom that was accessible throughout the day. We saw patients could personalise their bedrooms with decorations and wall art. We also saw some electrical items, such as laptops and radios in patients' rooms. Staff risk assessed these to ensure they were appropriate for the patient to have. Each ward had a secure safe centrally located to keep additional personal possessions safe.

The hospital had a range of rooms and equipment to meet the needs of the patients. These rooms included separate day rooms, a clinic room, a faith room, designated visitor rooms and a dining room. Patients had access to outside space throughout the day.

Patients had access to fresh fruit, and both hot and cold drinks throughout the day. Patients were also able to buy their own snacks and store them in a safe place.

The sites which delivered acute wards for adults of working age and psychiatric intensive care unit within Northamptonshire Healthcare NHS Foundation Trust were compared to other sites of the same type. Scores they received for 'ward food' were found to be about the same as the England average.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

Wards were wheel chair accessible. Staff could access information leaflets in a variety of formats such as easy read. Staff could print leaflets in a different language for people whose first language was not English. Staff also had access to interpreters to ease communication with patients, as needed.

There was a variety of leaflets for patients and visitors. These included how to complain about the service, what to expect during the patient's admission to the ward, co-production, care planning, advocacy information and patients' rights.

The cooks prepared meals that met the dietary needs of the patients. For example, the cooks prepared halal meat and vegetarian dishes to those who requested them. There were information boards in the dining room detailing options available for breakfast, lunch and dinner.

We saw an example where staff supported a patient who was admitted to the wards facilitate a university exam. Staff liaised with the university and it was agreed the patient was able to take their exam whilst admitted in the hospital.

The sites which delivered acute wards for adults of working age and psychiatric intensive care units within Northamptonshire Healthcare NHS Foundation Trust were compared to other sites of the same type. Scores they received for 'disability' and dementia friendliness' were found to be about the same as the England average.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results. Managers shared these with the whole team and wider service. Staff and advocates supported patients to raise concerns when needed.

The trust had systems for the recording and management of complaints. Staff we spoke with were able to describe the process of how to handle a complaint in line with the trust policy. We saw minutes of team meetings where the outcomes and learning from complaints had been discussed.

This service received 26 complaints between 1 April 2018 to 31 March 2019. Two of these were upheld, nine were partially upheld and 14 were not upheld. One complaint was withdrawn. None were referred to the Ombudsman.

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Withdrawn
Avocet	**2**			2	
Bay Admissions (Female)	**6**		5	1	
Cove Admissions (Male)	**2**		1		1
Harbour Acute	**3**	1		2	
Kingfisher	**3**	1		2	
Marina ICU	**2**		1	1	
Sandpiper	**5**		1	4	
Shearwater PICU	**3**		1	2	
Totals	**26**	**2**	**9**	**14**	**1**

This service received 276 compliments during the last 12 months from 1 April 2018 to 31 March 2019 which accounted for 16% of all compliments received by the trust as a whole (1752).

Is the service well led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood the issues, priorities and challenges the service faced and managed them effectively. Leaders were visible in the service and supported staff to develop their skills, take on more senior roles, and responsibilities.

Staff we spoke with knew who the leaders and senior managers were. Staff told us they were approachable and could raise any issues they wanted to escalate.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. This had been developed with all relevant stakeholders. They were aligned to local plans and the wider health economy. Managers made sure staff understood and knew how to apply them.

Staff we spoke with were aware of the organisation's values. Staff told us that they were available on the trust's intranet system and were regularly highlighted in meetings and training.

Culture

Staff felt respected, supported and valued. They felt the service promoted equality and diversity and provided opportunities for career development. They could raise concerns without fear. Staff we spoke with knew the trust had a whistle blowing policy which they would use if they needed to.

Staff annual sickness rate for the service was 5.3%. When benchmarked against national data this is in the lowest 25% nationally. The staff we spoke with told us they could access the trust occupational health service for support, for both physical and mental health issues.

Ward managers used a range of systems to monitor staff performances. Where areas of improvement or concern were identified, managers took appropriate action in a timely manner. Where areas of good performance were noted, this was praised and discussed during annual appraisal and supervisions.

Governance

Leaders ensured there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities. Staff had regular opportunities to meet, discuss and learn from the performance of the service.

Ward managers followed a standard agenda for ward meetings. Items covered at the meetings included incidents, feedback, actions following incidents and performance data.

The trust had a dashboard system in place to monitor mandatory training and ward performance. Ward managers regularly reviewed the dashboard and requested training dates for training that was due to expire. Managers implemented action plans where areas for improvement were identified.

We saw ward managers regularly review the staffing duty rota to ensure safe staffing levels. If a shortfall was identified they would arrange cover using regular bank or agency staff to ensure continuity of care.

Ward managers told us they felt they had a lot of support from her their managers and had autonomy to make daily decisions in their role.

Frontline staff completed clinical audits, for example, environmental and infection control audits.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level. Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care.

Staff were able to contribute to the risk register. If staff identified an area of risk through environmental checks and audits, they were able to escalate this to ward managers, who would ensure control measures were put in place to minimise the risk.

The service had a contingency plan in place for events such as severe adverse weather or power failure.

Information management

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The information systems were integrated and secure.

Staff made notifications to external bodies as needed. For example, raising safeguarding concerns and submitting statutory notifications to the Care Quality Commission.

Engagement

The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.

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.

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

Patients and carers were involved in decision making about changes to the service. For example, at daily community meetings all patients were able to inform ward staff of their preferences and what they wanted the ward to improve on.

Learning, continuous improvement and innovation

All staff were committed to continually improving services and had a good understanding of quality improvement methods. Leaders encouraged innovation and participation in research. For example, two occupational therapists had been researching the use of sensory rooms on acute wards and had successfully secured funding for four wards to have a sensory room installed. They had also submitted a bid to secure funding for the other five wards to install sensory rooms. Where the sensory rooms were installed, staff we spoke with felt they were able to manage the patients challenging behaviours more proactively.

Ward managers were able to provide us with an up to date picture of how the wards were performing and had a good understanding of where improvements were required.

The service had made improvements to learning lessons following incidents. The trust involved relatives in a group which valued feedback about processes of investigation and made changes to improve communication, support and feedback to families.

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 service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Core service	Service accredited	Comments
AIMS – WA (working age adults	Acute wards for adults of working age and psychiatric intensive care units	Cove AIMS peer review took place on 25.8.2018 to 6.3.2021 Bay AIMS peer review took place on 6.3.2018 to 6.9.2019 Harbour AIMS Peer review took place 29.05.2018 to 6.9.2020 Sandpiper - AIMS accreditation peer review took place 21.06.2018 Avocet - AIMS visit and review on the 27.06.2017 - further documentation submitted 30.01.19. Awaiting confirmation and accreditation. Kingfisher - AIMS Accreditation Review visit – 20.06.2017	
AIMS – PICU (assessment and triage wards)	Acute wards for adults of working age and psychiatric intensive care units	Marina accredited 5.9.2017	

MH – Long stay/rehabilitation mental health wards for working age adults

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Berrywood Hospital	Adult inpatient specialist – Meadowbank	12	Male

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean care environments

The service provided safe care in a safe environment. All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

However, the patients self-catering kitchen was not clean. There was no effective system for ensuring that this kitchen was cleaned after every use. This meant that on occasions, such as after meal preparation, patients did not always clean the cooker and microwave thoroughly. Patients did not always clean the sink and there were used dish cloths left on the side.

Safety of the ward layout

The long stay rehabilitation ward for adults of working age was male only. Therefore, over the 12-month period from 1 April 2018 to 31 March 2019 there were no same sex accommodation breaches within this service.

The number of same sex accommodation breaches reported in this inspection was the same as the number reported at the time of the last inspection (nil).

The ward had an up to date ligature risk assessment. All risks identified had been rated mitigated against.

Lines of site were improved by the installation of mirrors.

Maintenance, cleanliness and infection control

While ward areas were well maintained, well-furnished and fit for purpose. The patients self-catering kitchen, was not clean. The cooker, microwave and sink were not clean, and dirty dish cloths were left on the side of the sink. There was no clear system in place for ensuring the patients self-catering kitchen was always cleaned after use.

While there were cleaning records for the ward areas there were no records available for the patients self-catering kitchen.

Staff followed infection control policy, including handwashing.

PLACE assessments aim to provide a clear message from patients on how the care environment may be improved. They are undertaken by teams of local people alongside healthcare staff and assess privacy and dignity, food, cleanliness, building maintenance and the suitability of the environment for people with disabilities and dementia.
The site which deliver long stay/rehabilitation mental health wards for working age adults within Northamptonshire Healthcare NHS Foundation Trust were compared to other sites of the same type and the score it received for ‘cleanliness’ and ‘condition, appearance, and maintenance’ was found to be about the same as the England average.

Seclusion room

Meadowbank ward did not have a seclusion room. If and when a seclusion room was needed, staff accessed the room on the adjacent Wheatfield ward.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment in the clinic room.

Safe staffing[3]

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[3] Safer Staffing analysis ; Cross sector staffing profile analysis tool ; Vacancy Benchmark Tool ; Turnover Benchmarking Tool ; Sickness Benchmarking Tool

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

The below chart shows the breakdown of staff in post WTE in this core service from 1 April 2018 to 31 March 2019.

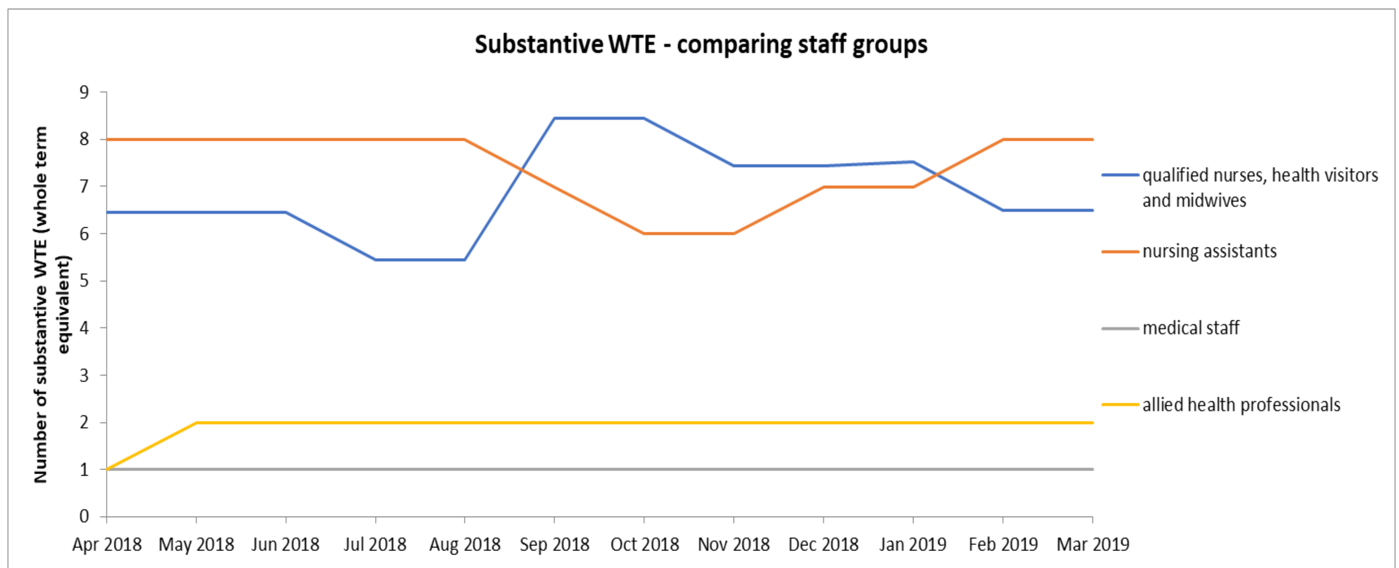


Figure 45

Managers had calculated the number and grade of nurses, and healthcare assistants for each shift, based on staff numbers from April 2017. Managers advised us this was calculated using professional judgement, a review of data, and consideration of how other team members could assist (for example the ward manger, and other multidisciplinary team members). However, the ward bed numbers had increased from eight to twelve since April 2017.

We found no evidence that managers had reviewed staffing establishment since then. Following the bed increase, managers had removed the physical healthcare nurse post from the ward and reassigned an occupational therapy assistant post. There was also high long-term sickness in the staff team. Managers were aware of the skill mix shortfall. To address the issue short-term, they had filled gaps with a variety of bank staff and volunteers. In the month prior to inspection, 27 bank shifts had been filled by 24 different people. Nursing staff carried out other, additional duties that the multidisciplinary team would have covered. The impact of this, was that while patient safety was not compromised, patients' interventions were delivered by a range of bank staff. The delivery of rehabilitative intervention was not comparable to that on the forensic ward (pre-admission ward to Meadowbank) who provided more rehabilitation programmes.

The below table covers staff fill rates for qualified nurses and care staff during February, March and April 2019.

<u>Key</u>:

> 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 (%)

	Feb 19				Mar 19				Apr 19			
Meadowbank	111.4	163.6	100.3	108.1	119.9	164.8	100	100	117.1	158.8	100	103.3

Meadowbank overfilled for day care staff (<125%) across the three-month period. This was due to the need for patient increased observation levels.

Annual staffing metrics

	Core service annual staffing metrics (1 April 2018 to 31 March 2019)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual "unfilled" hours (% of available hours)**
All staff	19.1	4%	16%	5.5%			
Qualified nurses	8.1	15%	29%	6.8%	3539 (26%)	11 (<1%)	159 (1%)
Nursing assistants	7.5	1%	12%	4.9%	1548 (14%)	0 (0%)	91(1%)
Medical staff	0.5	-100%	0%	2.2%			
Allied Health Professionals	2.0	0%	0%	6.3%			

Vacancies

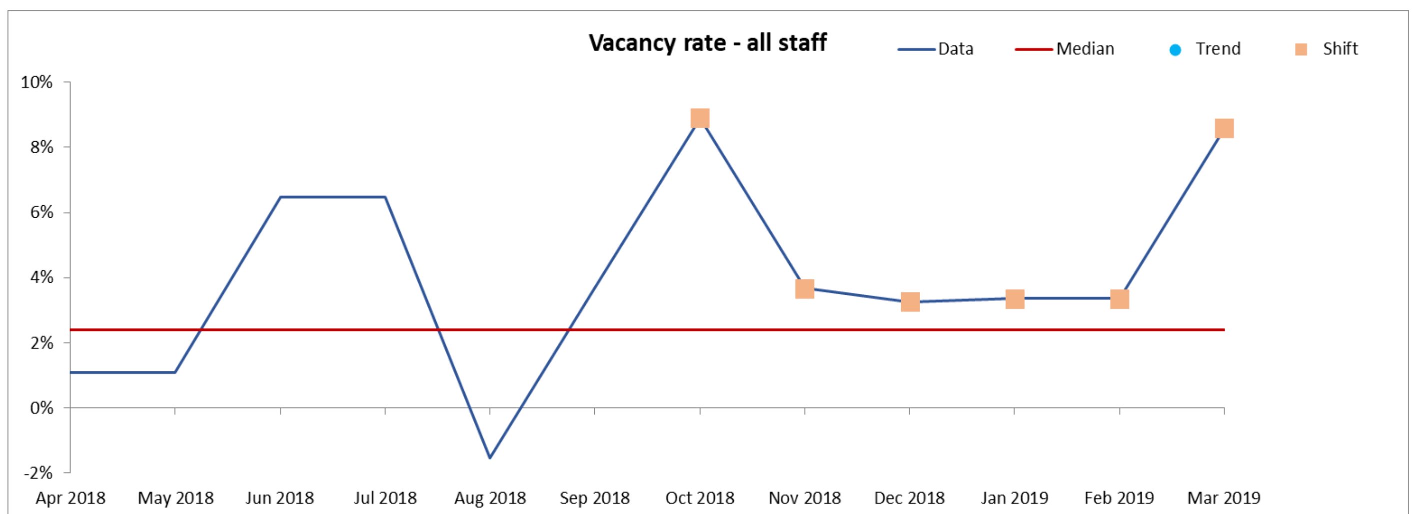


Figure 46

Monthly vacancy rates for all staff showed a shift from October 2018 to March 2019 (see figure 2). In addition, the average vacancy rate for all staff was in the lowest 25% when compared to other similar core services nationally.

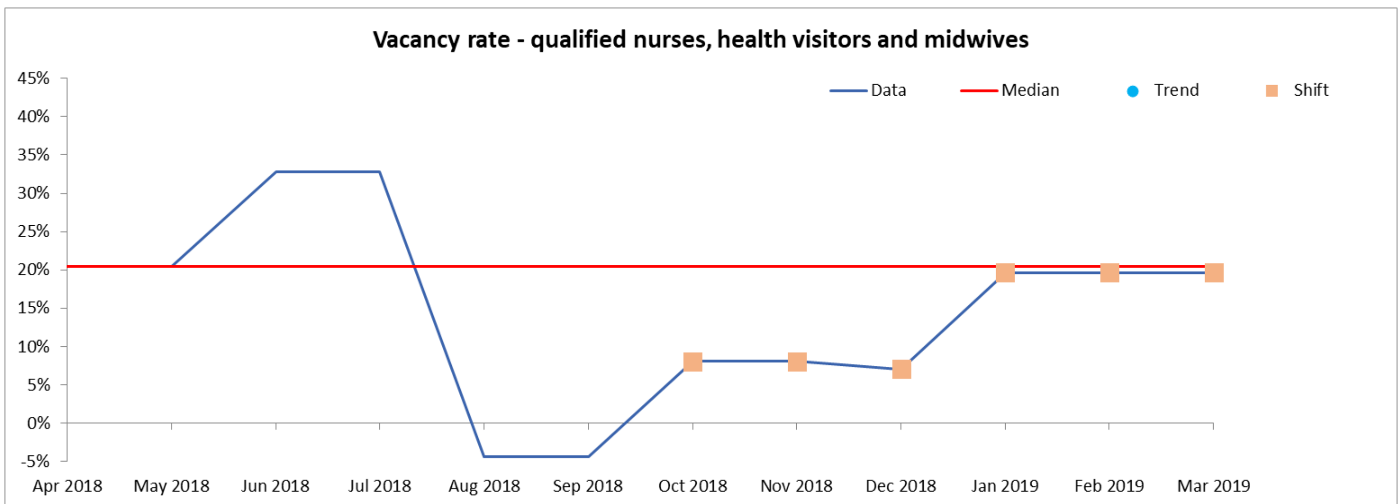


Figure 47

Qualified nurse vacancy rates across the 12 months showed a shift from October 2018 to March 2019 (see figure 3). When comparing to similar core services nationally, nursing assistants, medical and dental staff and allied health professionals were all in the lowest 25%.

At the time of inspection, the service had increasing vacancy rates, due in part to organisational change. The impact of this was an increased use of bank staff.

Turnover

When compared to similar core services nationally, all staff and qualified nurses were reporting in the highest 25%. Though, medical staff and allied health professionals were in the lowest 25%.

Sickness

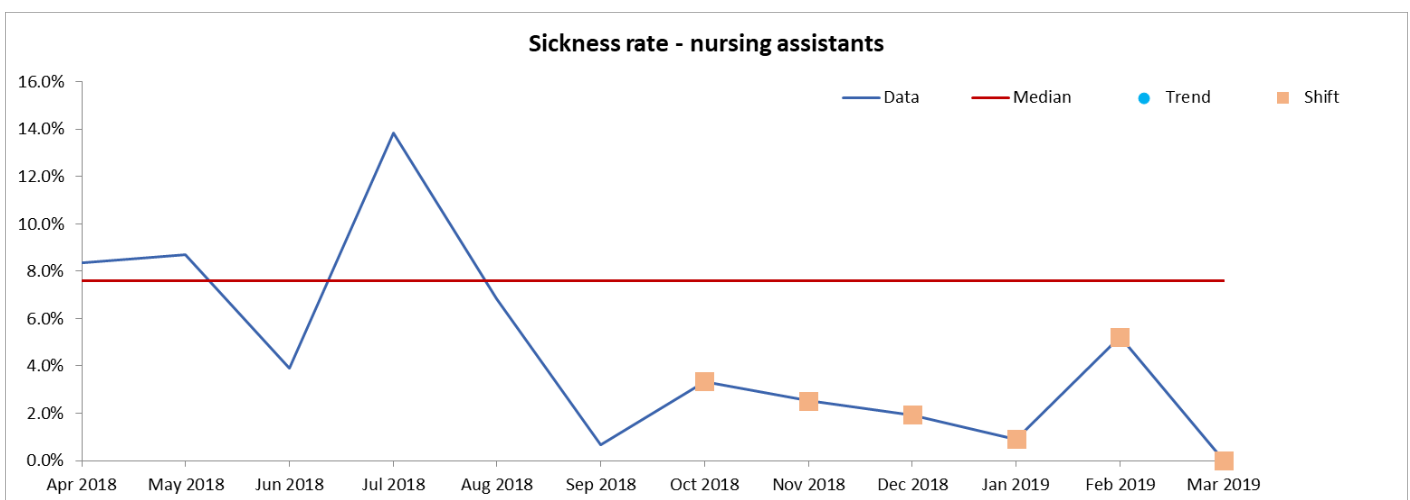


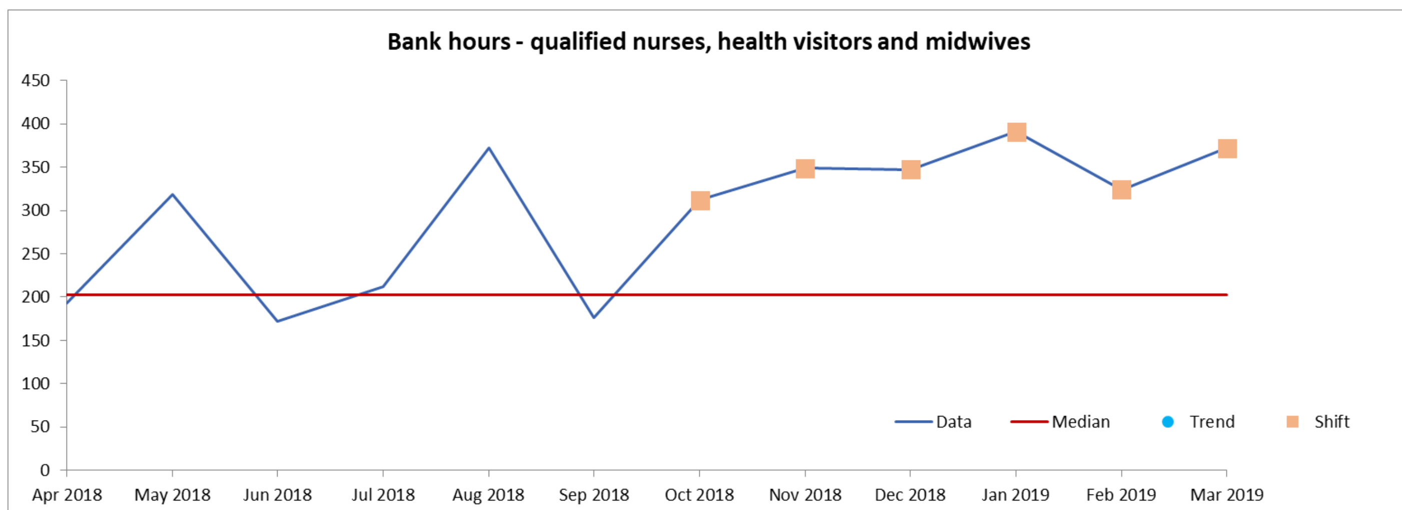
Figure 48

Nursing assistant sickness rates over the last 12 months showed a shift from October 2018 to March 2019 (see figure 4).

At the time of inspection, the long-term sickness rate had increased to 15%. Managers had acknowledged the impact of this on service delivery and were addressing the issue in line with trust policy and procedure.

The average sickness rates for medical staff was in the highest 25% when compared to other similar core services nationally.

Bank Hours



Monthly bank hours over the last 12 months for qualifies nurses showed a shift from October 2018 to March 2019 (see figure 5).

The use of bank staff had increased due to long-term sickness rates. During July 2019, 27 bank shifts were covered by 24 different staff. However, bank staff were usually staff from other wards and were known to the patients. Managers ensured that all bank and agency staff had a full induction and understood the service before starting their shift. There were enough nursing staff to ensure patients had regular one to one sessions with their named nurse.

The service used the early responder service, (staff attending from other wards), to ensure that physical interventions were carried out safely.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night-time medical cover. A doctor was always available to go to the ward quickly in an emergency.

Mandatory training

The compliance for mandatory and statutory training courses at 31 March 2019 was 94%. Of the training courses listed three failed to achieve the trust target and of those, one failed to score above 75%.

The trust set a target of 90% for completion of mandatory and statutory training.

Training is reported on month by month basis.

The training compliance reported for this core service during this inspection was not compared to the previous year as the data was not comparable.

The trust did not submit training data for staff who had completed prevention, management of violence and aggression training.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✗	Higher ↑	No change →	Lower ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Resuscitation - Level 1 - 1 Year	18	18	100%	✓
Safeguarding Adults - Level 2 - 3 Years	18	18	100%	✓
Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year	10	10	100%	✓
Resuscitation - Level 2 - Adult Basic Life Support - No Specified Renewal	1	1	100%	✓
Resuscitation - Level 1 - No Specified Renewal	1	1	100%	✓
Resuscitation - Level 2 - Paediatric Basic Life Support - No Specified Renewal	1	1	100%	✓
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year	10	10	100%	✓
Health, Safety and Welfare - 3 Years	19	19	100%	✓
Safeguarding Adults - Level 1 - 3 Years	1	1	100%	✓
Infection Prevention and Control - Level 1 - 3 Years	1	1	100%	✓
Safeguarding Children (Version 2) - Level 1 - 3 Years	1	1	100%	✓
Safeguarding Children (Version 2) - Level 2 - 3 Years	18	18	100%	✓
Fire Safety - 1 Year	19	18	95%	✓
Information Governance and Data Security - 1 Year	19	18	95%	✗
Moving and Handling - Level 1 - 3 Years	19	18	95%	✓
Infection Prevention and Control - Level 2 - 1 Year	18	17	94%	✓
Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year	8	7	88%	✗
Moving and Handling - Level 2 - 1 Year	16	10	63%	✗
Total	**198**	**187**	**94%**	

Managers were aware of the lower than expected rate for moving and handling and were in the process of addressing this. The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed a risk assessment for each patient when they were admitted and reviewed this regularly, including after any incident.

Staff used the Historical, Clinical, Risk Management-20 (HCR-20) a risk assessment tool that helps mental health professionals estimate a person's probability of violence and risk.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, patients.

Staff could observe patients in all areas of the ward.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

This service had one incidence of restraint (one service user) and one incidence of seclusion between 1 April 2018 and 31 March 2019.
The below table focuses on the last 12 months' worth of data: 1 April 2018 to 31 March 2019.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
Meadowbank	1	1	1	1 (100%)	0 (0%)
Core service total	**1**	**1**	**1**	**1 (100%)**	**0 (0%)**

When staff placed a patient in seclusion, they kept clear records and followed best practice guidelines.

There was only one incident of restraint in this reporting period. This was a prone restraint. The use of prone restraint increased by one, compared to the previous 12-month period of nil.

There were no incidences of rapid tranquilisation over the reporting period.

There have been no instances of mechanical restraint over the reporting period.

The number of restraint incidences reported during this inspection was the same as the one reported at the time of the last inspection.

Over the last reporting period, there had been no episodes of seclusion. There had been one episode of seclusion during this reporting period.

The number of seclusion incidences reported during this inspection was higher than the none reported at the time of the last inspection.
Staff knew they had to follow best practice, including guidance in the Mental Capacity Act Code of Practice, if a patient was put in long-term segregation.

There had been no episodes of long-term segregation during the last reporting period. This was the same as this reporting period, with no episodes of long-term segregation reported.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. Staff training was role appropriate. All staff kept up to date with their safeguarding training.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of, or suffering harm, and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

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 adult at risk 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 adult at risk, 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 no safeguarding referrals between 1 April 2018 and 31 March 2019.

The trust had no serious case reviews commenced or published in the last 12 months (1 April 2018 and 31 March 2019) that relate to this service.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records.

Patient records were stored securely.

Medicines management

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The service had a policy and facilities in place to allow self-administration of medicines if appropriate. Staff risk assessed and supervised patients to enable them to be as independent with their medicines as possible. Arrangements were put in place, such as blister packs. This helped patients with their medicines. Medication adherence was discussed routinely as part of multidisciplinary team reviews.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. All the necessary documents to ensure that medicines were administered legally were in place for the patients we reviewed.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medication on their physical health according to National Institute of Health and Care Excellence guidance and records were completed appropriately.

Track record on safety

The service had a good track record on safety.

Between 1 April 2018 and 31 March 2019 there were no serious incidents reported by this service.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.

Reporting incidents and learning from when things go wrong

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 knew what incidents to report and how to report them. Staff reported all incidents that they should report. Staff reported serious incidents clearly and in line with trust policy. The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were given the opportunity to be involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. Such as the installation of observation mirrors to improve lines of sight, and amendments to the wardrobe doors in bedrooms.

Managers shared learning with their staff about never events that happened elsewhere, through team meetings and staff handovers.

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 assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, were personalised, holistic and recovery-oriented.

Best practice in treatment and care

Staff provided a basic range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies and support for self-care. However, key staffing posts had not been recruited to since an increase in bed numbers in 2017. This impacted on delivery of interventions designed to help with the development of everyday living skills and meaningful occupation for patients. This was due to an absence of occupational therapy and activity therapy staff.

Staff supported patients with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

This service participated in nine clinical audits as part of their clinical audit programme 2018 – 2019.

Audit name	Audit scope	Date completed	Key actions following the audit
National Early Warning Scores – Mental Health & Adult & Child Q1, Q2, Q3, Q4	Meadowbank	02/04/2019	• To ensure continual improvement NEWS audits will remain weekly/monthly • Ward Managers and Modern Matrons to continue to feedback to all clinical staff to ensure: • Those areas who have not achieved 90% to have further training, either on line or face to face to improve concordance with standards which is provided by Clinical Skills Team. • The Quality team have aligned with the Adult and Child pathway and are currently implementing a new audit tool. • The CQF has been visiting ward areas and discussing NEWS with staff and Managers, as well as providing up to date audit data for wards to work from. • The CQF provides DMT with regular updates on progress of outliers.

Audit name	Audit scope	Date completed	Key actions following the audit
			• Areas that have access to an RGN, to share these results and complete an action plan.
Physical Health Monitoring of Community Forensic Patients on Antipsychotics	Dr Shahid Latif	Ongoing	
Nutritional Assessments (MUST) – Mental Health & Adult & Child Q1, Q2, Q3, Q4	Meadowbank	02/04/2019	• Feedback will be offered by the Clinical Quality Facilitators to ward managers • Staff to identify where a patient has refused to engage in MUST scoring
Overview of Electronic and Paper Record Keeping Audit – Mental Health & Adult & Child Q1, Q2, Q3, Q4	Meadowbank	02/04/2019	Teams to improve compliance for areas that are RAG rated as amber by developing team action plans • All teams to develop a Qualitative Record Keeping Audit. • Feedback results through pathway meetings
Quarterly Photographic ID Audit	Meadowbank	02/04/2019	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.
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	Meadowbank	ongoing	• Creation of dedicated role for STORM training, update of trainers arranged, and comprehensive rolling training package being delivered. • Wrote and submitted zero ambition plan for NHS England – awaiting feedback (which was initially presented and approved at Trust Board) • Supported development of “Common sense Confidentiality” leaflet to support involvement of family/friends in planning of care • Delivered a number of ½ day briefing sessions on work of Suicide Prevention group and suicide prevention more broadly • Support development of suicide prevention course through recovery college • Continued participation in Countywide suicide prevention group, with plans

Audit name	Audit scope	Date completed	Key actions following the audit
			to launch public-facing multi-agency campaign later in year
Tobacco and Alcohol Audit	Meadowbank	31/03/2019	Regular updates using a variety of media and meetings around health promotion and good record keeping standards given to all ward areas using Staff Training And Retention (STAR) days, team meetings, e- brief and emails. AUDIT-C Cards posters were distributed to all ward areas NHFT has implemented an automatic smoking referral system within its clinical systems for every patient that is screened as a smoker; however, patients are given the choice to opt out if they are not yet ready to quit. There are trained Smoking Cessation Specialists on the wards.
Bi-annual Ligature Audit	Meadowbank	31/03/2019	The Trust now has a tool which has been developed to help staff address the risk of ligatures in a balanced, objective and systematic way. Actions must be taken to eliminate or reduce those risks identified immediately or as soon as reasonably practicable. The Trust actively pursues an objective to eradicate as far as reasonably practicable all potential ligature and anchor points and where this is not practicable to control the risks by monitoring them. The Trust's primary aim is to eliminate all high-risk ligature anchor points that are scored at 81 using the tool. All risk assessment and mitigation plans produced as a result of the ligature audit must be reviewed at least bi-annually or when a change occurs to the environment, the service provided or as the needs of the patient changes. Replacement of bed frames with anti-ligature bed bases.
Prone Restraint	Meadowbank	01/05/2019	Continue to measure and monitor specifically our use of prone restraint in the context of our overall use of

Audit name	Audit scope	Date completed	Key actions following the audit
			restraint to ensure prone restraint is being used as a last resort. Continue to search for alternative restraint positions for the higher risk incidents. Continue to publicise the trusts restraint reduction strategy, which includes specific actions relating to the use of prone restraint around the trust Continue to measure and monitor staff and patient injuries related to restraint

Skilled staff to deliver care

Managers had not ensured that multidisciplinary staffing establishment met the holistic needs of patients. Managers had not increased staffing following an increase in bed numbers from eight to twelve in April 2017. Managers had not ensured patients had access to experienced and consistent occupational therapy. To address this, managers used two occupational therapists from another ward to carry out patient's rehabilitation assessments as required. In addition, managers used volunteers and healthcare assistants to carry out the day to day intervention programmes with patients. The ward manager (whose professional background was occupational therapy) offered these staff specific training and support to carry out the additional roles. This included how to enable skills acquisition, and how to grade interventions to be effective.

Managers were aware of the impact this situation had on ward staff. A longer-term plan to address the issues through a quality Improvement project had been commenced and was ongoing. Managers supported staff with supervision and through regular, constructive appraisals of their work. Managers were keen to provide opportunities for staff to update and further develop their skills. Managers gave each new member of staff a full induction to the service before they started work.

The trust's target rate for appraisal compliance is 90%. At the end of last year (1 April 2018 and 31 March 2019), the overall appraisal rate for non-medical staff within this service was 100%. This year so far, the overall appraisal rates was 100% (as at 24 May 2019).

The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 94% reported at the last inspection.

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 (as at 24 May 2019)	% appraisals (previous year 1 April 2018-31 March 2019)
Meadowbank	18	18	100%	100%
Core service total	**18**	**18**	**100%**	**100%**
Trust wide	**3719**	**3413**	**92%**	**92%**

The trust's target rate for appraisal compliance is 90%. At the end of last year (1 April 2018 to 31 March 2019), the overall appraisal rate for medical staff within this service was 100%. This year so far, the overall appraisal rates this was 100% (as at 24 May 2019).

The rate of appraisal compliance for medical staff reported during this inspection could not be compared to the previous inspection as the data was not comparable. Data was not provided at ward level.

Ward name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals (as at 24 May 2019)	% appraisals (previous year 1 April 2018-31 March 2019)
Meadowbank	1	1	100%	100%
Core service total	**1**	**1**	**100%**	**100%**
Trust wide	**90**	**78**	**87%**	**80%**

The trust's target of clinical supervision for non-medical staff was 90% of the sessions required. Between 1 April 2018 and 31 March 2019, the compliance for Meadowbank ward was 190%.

The rate of clinical supervision reported during this inspection was higher than the 160% reported at the last inspection.

Figures submitted by the trust showed compliance rates of over 100% in some teams. The trust captured various forms of meetings which they classed as supervision, including clinical, managerial, group supervision, reflective practice and safeguarding supervision. However, we were assured that team met regularly for clinical supervision.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide. In addition, the trust has advised that the trust policy requires a minimum of 2 supervision sessions/quarter which would explain the higher supervision rates in the table below.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Meadowbank ward	118	224	190%
Core service total	**118**	**224**	**190%**
Trust Total	**6128**	**12673**	**207%**

The trust's target of clinical supervision for medical staff was 90% of the sessions required. Between 1 April 2018 and 31 March 2019, the average rate across Meadowbank ward was 225%.

The rate of clinical supervision reported during this inspection could not be compared to the last inspection as the data was not comparable.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide. In addition, the trust has advised that the trust policy requires a minimum of 2 supervision sessions/quarter which would explain the higher supervision rates in the table below.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Meadowbank ward	**8**	**18**	**225%**
Core service total	**8**	**18**	**225%**
Trust Total	**202**	**319**	**158%**

Multi-disciplinary and interagency teamwork

Although most staff felt they worked together as a team to benefit patients, some staff expressed concern that they did not have a full multidisciplinary team on the ward. However, all staff we spoke with agreed that they supported each other to make sure patients had no gaps in their care.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation and with staff from services providing care following a patient's discharge. Staff engaged with them early in the patient's admission to plan discharge.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers ensured that staff explained patients' rights to them.

Staff received and kept up to date with, training on the Mental Health Act and the Mental Health Act Code of Practice. Staff could describe the Code of Practice guiding principles.

At the time of inspection 89% of the workforce in this service had received training in the Mental Health Act. The trust stated that this training was mandatory for all inpatient services and renewed every three years.

The training compliance reported during this inspection was higher than the 82% reported at the last inspection.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. The service had clear, accessible, relevant and up to date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy. Staff automatically referred patients who lacked capacity to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand. Staff repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Staff ensured that section 17 leave was meaningful and linked with individual patients' rehabilitation care plan.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

At the time of inspection 89% of staff in this service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all inpatient services and was renewed every three years.

The training compliance reported during this inspection was higher than the 82% reported at the last inspection.

The trust told us that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 April 2018 to 31 March 2019.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients.

Staff gave patients help, emotional support and advice when they needed it.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly. However, two patients told us that different bank staff who worked on the ward did not provide them with consistency in their care.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

The site which delivers long stay/rehabilitation mental health wards for adults of working age within Northamptonshire Healthcare NHS Foundation Trust was compared to other sites of the same type and the score it received for 'privacy, dignity and wellbeing was found to be about the same as the England average.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Staff and patients had co-produced revised care plans based on my shared care pathway and positive behavioural support plans.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties.

Through a series of co-production groups and activities, staff involved patients in decisions about the service, where possible.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to produce wellness recovery plans and make advanced decisions on their care

Staff ensured that patients had easy access to independent advocates.

Involvement of families and carers

Staff supported, informed and involved families or carers appropriately. Staff ensured carers and families knew about any coproduction groups relevant to them, and when their relatives care planning reviews were taking place.

Staff helped families to give feedback on the service.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

Bed management

The trust provided information regarding average bed occupancies and average length of stay for Meadowbank between 1 April 2018 to 31 March 2019.

Meadowbank reported average bed occupancies ranging above the minimum recommended national benchmark of 85% over this period.

Ward name	Average bed occupancy range (1 April 2018 – 31 March 2019)
Meadowbank Rehab	88% - 100%

The trust provided information for average length of stay for the period 1 April 2018 to 31 March 2019.

Ward name	Average length of stay range (1 April 2018 – 31 March 2019) (On discharge)
Meadowbank Rehab	26-429

Ward name	Average length of stay range (1 April 2018 – 31 March 2019) (current patients)
Meadowbank Rehab	196-306

This service reported no out of area placements between 1 April 2018 to 31 March 2019.

This service reported no readmissions within 28 days between 1 April 2018 to 31 March 2019.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interests of the patient.

Staff did not move or discharge patients at night or very early in the morning.

The psychiatric intensive care unit always had a bed available if a patient needed more intensive care which was not far away from the patient's family and friends.

Discharge and transfers of care

Between 1 April 2018 to 31 March 2019 there were 20 discharges within this service. This amounts to 0.3% of the total discharges from the trust overall (6890).

There were no delayed discharges across the 12-month period.

The proportion of delayed discharges reported during this inspection was the same, as there were also no delayed discharges at the time of the last inspection.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred to or transferred between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe.

There were quiet areas for privacy, and a room where patients could meet with visitors in private. Patients could make phone calls in private. The service had an outside space that patients could access easily.

The food was of a good quality and patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.

The site which delivers long stay/rehabilitation mental health wards for adults of working age within Northamptonshire Healthcare NHS Foundation Trust was compared to other sites of the same type and the score it received for 'ward food' was found to be about the same as the England average.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access and support to opportunities for education and work.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support.

The site which delivers long stay/rehabilitation mental health wards for adults of working age within Northamptonshire Healthcare NHS Foundation Trust was compared to other sites of the same type and the score it received for ‘disability’ and dementia friendliness’ was found to be about the same as the England average.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients knew how to complain or raise concerns. Staff understood the policy on complaints and knew how to handle them.

The service received a low number of complaints reflecting that patients were satisfied with their care.

This service received one complaint between 1 April 2018 to 31 March 2019. The complaint for Meadowbank was still ongoing at the time of the data extract (25 May 2019) and was in relation to all aspects of clinical treatment. At the time of inspection, this complaint had been resolved. We saw a copy of the letter sent to the family as part of responsibility under duty of candour.

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

Staff received feedback from managers after investigations.

This service received four compliments during the last 12 months from 1 April 2018 to 31 March 2019.

Is the service well led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood the issues, priorities and challenges the service faced and managed them effectively. They understood the service they managed, and followed the Life Skills Profile, a recognised model for rehabilitation care. Patients and staff knew who they were and could approach them with any concerns.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Managers ensured the vision and values reflected local plans and the wider health economy. Managers held co production sessions with staff to develop the vision and values and made sure staff understood and knew how to apply them. We saw evidence that staff had included elements of the vision and values in care planning and supervision notes.

Culture

Staff felt respected, supported and valued by their managers despite the organisational changes. All staff we spoke with said their managers were keen for them to develop their clinical and leadership skills. Staff felt the service promoted equality and diversity and provided opportunities for career development. Staff could raise concerns without fear. Two staff gave examples of when they had raised concerns and felt that the managers had listened to them. while they could not improve the situation at that time, they did give explanation of how they hoped to address the situation in the future.

Managers had not ensured that multidisciplinary staffing establishment met the holistic needs of patients. Managers had not increased staffing following an increase in bed numbers from eight to twelve in 2017. This had impacted of staff individual and team morale. However, senior leaders and local managers were aware of the impact this situation had on ward staff. A longer-term plan to address the issues through a quality improvement project had been commenced and was ongoing.

Governance

Leaders ensured there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. Managers ensured they dealt with risks at the appropriate level. Clinical staff contributed to decision-making on service changes through co production groups.

Information Management

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The information systems were integrated and secure.

Engagement

The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.

However, some staff expressed dissatisfaction with the length of time the change process took to develop a cohesive team. Some staff told us they covered duties of the depleted multidisciplinary team as well as their own roles. Managers acknowledged this and were able to show us plans for quality improvements and efforts to engage staff in co-production that would address these concerns.

Learning, continuous improvement and innovation

All staff were committed to continually improving services and had a good understanding of quality improvement methods. Leaders encouraged innovation and participation in research.

NHS trusts can participate in several accreditation schemes whereby the services they provide are reviewed and a decision is made whether 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 service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Core service	Service accredited
AIMS – Rehab (Rehabilitation Wards)	Long stay/rehabilitation mental health wards for adults of working age	Meadowbank accredited 23.05.2017 - 22.05.2020

MH – Secure wards/Forensic inpatient

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Berrywood Hospital	Adult inpatient low secure – Wheatfield Unit	12	Male

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean care environments

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

The ward layout did not allow staff to observe all parts of the ward. There were blind spots in one corridor and in part of the outside area. Managers identified these and mitigated against them by increased staff observations of these areas.

Managers completed a ligature audit within the last twelve months. Managers identified ligature risks and provided photographs of ligature risk areas, with descriptions of how patients would be able to tie a ligature.

Managers displayed bright yellow signs on doors to rooms with limited access reminding staff to lock them.

The ward complied with guidance on eliminating mixed-sex accommodation.

Staff had easy access to alarms.

Maintenance, cleanliness and infection control

PLACE assessments aim to provide a clear message from patients on how the care environment may be improved. They are undertaken by teams of local people alongside healthcare staff and assess privacy and dignity, food, cleanliness, building maintenance and the suitability of the environment for people with disabilities and dementia.

The site which delivers secure wards/forensic inpatients within Northamptonshire Healthcare NHS Foundation Trust was compared to other sites of the same type and the score it received for 'cleanliness' and 'condition, appearance, and maintenance' was found to be about the same as the England average.

Staff made sure cleaning records were up to date and the premises were clean.

Staff followed infection control policy, including handwashing.

Seclusion room

The ward had one seclusion room, which allowed clear observation, two-way communication, had toilet facilities and a visible clock.

Clinic room and equipment

The clinic room was fully equipped with emergency resuscitation equipment and emergency drugs which staff checked regularly.

Staff maintained equipment and kept it clean.

Safe staffing[4]

The service had enough nursing staff of relevant grades to keep patients safe.

The below chart shows the breakdown of staff in post WTE in this core service from 1 April 2018 to 31 March 2019.

[4] Safer Staffing analysis ; Cross sector staffing profile analysis tool ; Vacancy Benchmark Tool ; Turnover Benchmarking Tool ; Sickness Benchmarking Tool

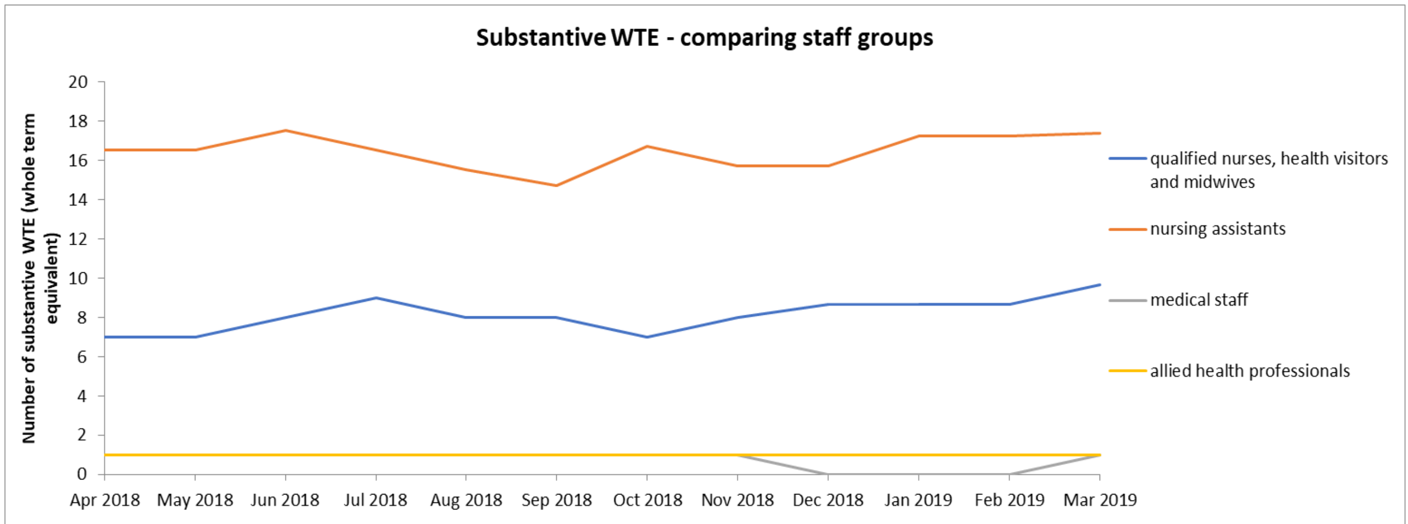


Figure 49

The below table covers staff fill rates for qualified nurses and care staff during February, March and April 2019.

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 (%)
	Feb 19				Mar 19				Apr 19			
Wheatfield unit	101.2	108.1	101.2	101.1	95.2	111.7	101.3	128.5	114.2	113.6	100.3	137.7

Between March and April 2019, the Wheatfield unit overfilled shifts for care staff at night.

Annual staffing metrics

	Core service annual staffing metrics (1 April 2018 – 31 March 2019)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual “unfilled” hours (% of available hours)**
All staff	33	14%	4%	1.9%			
Qualified nurses	10.1	18%	0%	1.9%	2783 (17%)	233 (1%)	410 (3%)

Nursing assistants	17.7	7%	0%	2.1%	6899 (22%)	25 (<1%)	818 (3%)
Medical staff	2.4	69%	100%	0.0%	40 (<1%)	467 (5%)	1275 (13%)
Allied Health Professionals	1.0	0%	0%	2.5%			

Vacancies

The service had low vacancy rates at the time of inspection.

The average vacancy rate for medical staff was in the highest 25% when compared to other similar core services nationally. In addition, allied health professionals in the same period were reporting in the lowest 25% nationally. The service recruited a full-time consultant psychiatrist who commenced in post in June 2019.

Turnover

The service had low turnover rates at the time of inspection.

The average turnover rate for all staff, nursing assistants, qualified nurses and allied health professionals lowest 25% when compared to other similar core services nationally. However, medical staff in the same period were reporting in the highest 25% nationally.

Sickness

Managers supported staff who needed time off for ill health.

Levels of sickness were low at the time of inspection.

The average sickness rate for all staff, nursing assistants, qualified nurses and medical staff reported in the lowest 25% when compared to other similar core services nationally.

Agency hours

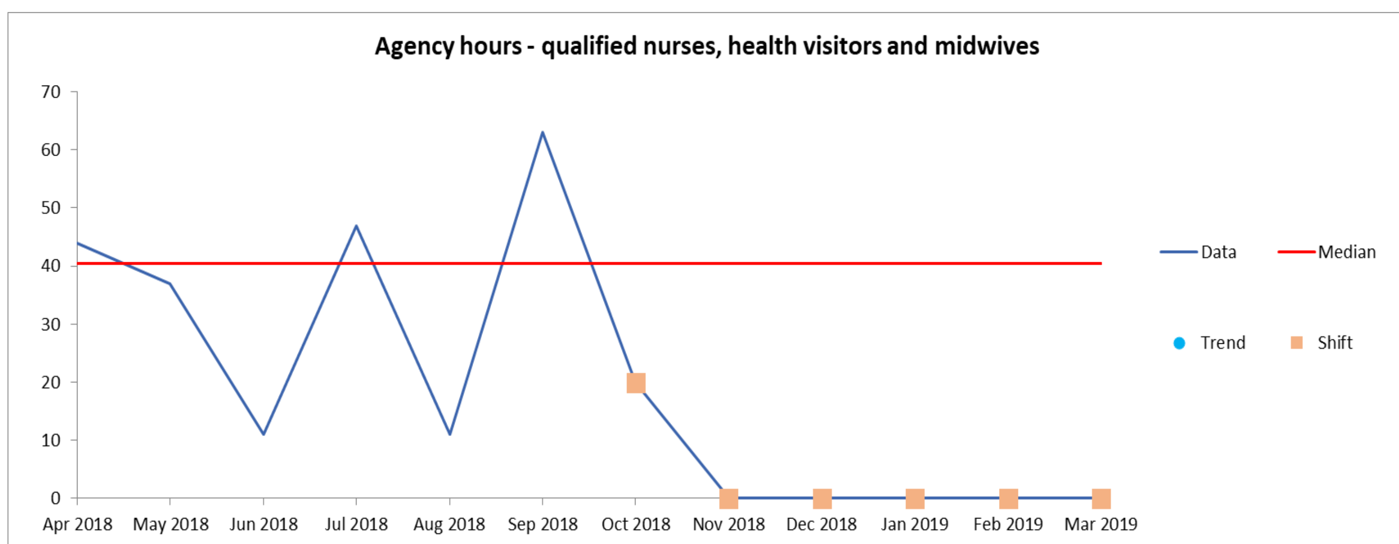


Figure 50

Monthly agency hours over the last 12 months for qualified nurses showed a shift from October 2018 to March 2019 (see figure 2). Managers told us that they had reduced the use of agency staff following recruitment to posts and more effective use of staffing resources across the hospital site.

The ward manager could adjust staffing levels according to the needs of the patients.

Patients had regular one to one sessions with their named nurse.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Most staff completed and kept up to date with their mandatory training.
The compliance for mandatory and statutory training courses at 31 March 2019 was 87%. Of the training courses, submitted prior to inspection, listed seven failed to achieve the trust target and of those, two failed to score above 75%. We reviewed mandatory training data whilst on site and as of 31 July 2019 the service reported a compliance rate for mandatory and statutory training of 93%. The compliance rate for the courses below 75% had increased to 86%.

The trust set a target of 90% for completion of mandatory and statutory training.

Training is reported on a month to month basis.

The training compliance reported for this core service during this inspection could not be compared, as the data was not comparable.

The trust did not submit training data for staff who had completed prevention, management of violence and aggression training.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✗	Higher ↑	No change →	Lower ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Safeguarding Children (Version 2) - Level 1 - 3 Years	1	1	100%	✓
Safeguarding Adults - Level 1 - 3 Years	1	1	100%	✓
Infection Prevention and Control - Level 1 - 3 Years	1	1	100%	✓
Safeguarding Adults - Level 2 - 3 Years	30	29	97%	✓
Fire Safety - 1 Year	31	29	94%	✓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Safeguarding Children (Version 2) - Level 2 - 3 Years	30	28	93%	✓
Health, Safety and Welfare - 3 Years	31	28	90%	✓
Resuscitation - Level 1 - 1 Year	31	28	90%	✓
Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year	9	8	89%	✗
Moving and Handling - Level 1 - 3 Years	31	27	87%	✗
Information Governance and Data Security - 1 Year	31	26	84%	✗
Infection Prevention and Control - Level 2 - 1 Year	30	25	83%	✗
Moving and Handling - Level 2 - 1 Year	28	22	79%	✗
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year	22	16	73%	✗
Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year	22	16	73%	✗
Total	**329**	**285**	**87%**	

The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed a risk assessment for each patient when they were admitted and reviewed this regularly, including after any incident.

Staff used the trust's risk assessment tool and the Historical, Clinical Risk Management-HCR-20 recognised tool.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, patients.

Staff followed procedures to minimise risks where they could not easily observe patients.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. The service used a device that selected patients at random to be searched.

Staff applied blanket restrictions on patients' freedom only when justified and in line with standards for low secure units. The service promoted least restrictive practices through assessing patient access to mobile phones, electronic devices and the internet.

Staff adhered to best practice in implementing a smoke free policy. The service allowed patients to use electronic cigarettes in the hospital grounds.

Use of restrictive interventions

The ward manager told us that the service had taken patients with increased behaviours that challenge. This resulted in an increase in the use of restrictive interventions when the patients first

arrived. The service recently introduced the use of specially designed furniture which decreased the number of restraints.

This service had 14 incidences of restraint (six different service users) and 12 incidences of seclusion between 1 April 2018 and 31 March 2019.
The below table focuses on the last 12 months' worth of data: 1 April 2018 to 31 March 2019.
The number of restraint incidences reported during this inspection was higher than the five reported at the time of the last inspection.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidents of mechanical restraint	Of restraints, incidences of rapid tranquilisation
Wheatfield Unit	12	14	6	2 (14%)	6 (43%)	2 (14%)
Core service total	**12**	**14**	**6**	**2 (14%)**	**6 (43%)**	**2 (14%)**

There were two incidences of prone restraint, which accounted for 14% of the restraint incidents. The number of incidences (two) had decreased from the previous 12-month period (three).

There were two incidences of rapid tranquilisation over the reporting period. The number of incidences (two) had increased from the previous 12-month period (none).

There have been six instances of mechanical restraint over the reporting period. The number of incidences (six) had increased from the number of incidences from the previous 12-month period (nil). The service provided details of five of the incidents of mechanical restraint. The five incidents involved two patients. Staff had care planned three incidences and two were emergencies. All uses of mechanical restraint related to absconsion risks and one also related to risk of assault.

There have been 12 instances of seclusion over the reporting period. Over the 12 months, incidences of seclusion ranged from one to three per month. The number of incidences (12) had increased from the previous 12-month period (six).

The number of seclusion incidences reported during this inspection was higher than the none reported at the time of the last inspection.

There have been no instances of long-term segregation over the 12-month reporting period. The number of incidences (none) was the same as the previous 12-month period (none).

The number of segregation incidences reported during this inspection was the same as the none reported at the time of the last inspection.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques. Staff restrained patients only when these failed and when necessary to keep the patient or others safe. Staff were trained in prevention and management of violence and aggression. Staff recorded all instances of restraint as an incident. Bank staff were not allowed to work shifts if they had not completed this training.

Staff followed National Institute of Health and Care Excellence guidance when using rapid tranquillisation.

When a patient was placed in seclusion, staff followed best practice guidelines.

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff were kept up to date with their safeguarding training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them, for example, the local authority safeguarding team and police.

Staff followed clear procedures to keep children visiting the ward safe, this included using child friendly visiting rooms located off the ward.

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 adult at risk 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 adult at risk, 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 no safeguarding referrals between 1 April 2018 and 31 March 2019.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

The ward manager told us that the service had been referring all safeguarding concerns, including low level incidents, to the local authority. Due to the high volume of referrals received the local authority recently issued revised guidance on the threshold for reporting. The ward manager showed the inspection team referral forms that staff submitted to the local authority and email responses acknowledging receipt.

The trust submitted details of no serious case reviews commenced or published in the last 12 months (1 April 2018 and 31 March 2019) that relate to this service.

Staff access to essential information

Patient notes were comprehensive, and all staff could access them easily. The service used the trust wide patient electronic records system. Staff reported that this system was easy to use. The ward manager set up paper folders with key patient information as part of the service business continuity plan.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. However, we found one T2 form which medical staff had not updated following a change to a patient's medication. A T2 form is a certificate confirming the patient's consent to treatment.

Staff reviewed patient’s medicines regularly as part of the multidisciplinary meeting and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy.

Staff followed current national practice to check patients had the correct medicines. Patients had a medicines reconciliation completed to ensure that their medicines were appropriately prescribed.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. There had been no use of rapid tranquilisation recently on this ward.

Staff reviewed the effects of each patient’s medication on their physical health according to National Institute of Health and Care Excellence guidance, particularly when the patient was prescribed a high dose of antipsychotic medication.

Track record on safety

The service had a good track record on safety.

Recent adverse events included a patient going absent without leave during a planned period of unescorted leave with his family.

Between 1 April 2018 and 31 March 2019 there were five serious incidents reported by this service. Of the total number of incidents reported, all five incidents have a different reason type – Unauthorised absence meeting SI criteria, pending review (a category must be selected before closing), Abuse/alleged abuse of adult by third party, Disruptive/aggressive/violent behaviour meeting SI criteria and confidential information leak/information governance breach meeting SI criteria. There were no unexpected deaths reported in this period.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with five reported.

A ‘never event’ is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported no never events during this reporting period.

The number of serious incidents reported during this inspection was higher than the none reported at the last inspection.

Type of incident reported (SIRI)	Number of incidents reported					
	Unauthorised absence meeting SI criteria	Confidential Information	Disruptive/ aggressive/ violent behaviour meeting SI criteria	Abuse/alleged abuse of adult by third party	Pending review (a category must be selected before closing	**Total**
Wheatfield	1	1	1	1	1	**5**

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff reported all incidents that they should report. Staff reported serious incidents clearly and in line with trust policy.

The service had no never events.

Staff understood the duty of candour. They were open, transparent and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. The ward manager advised that the trust patient safety team passed on learning from incidents elsewhere to service managers, who then discussed with ward managers and the staff team. We reviewed minutes of staff meetings which confirmed this. The trust health and safety manager sent out safety alerts. Recent examples included a patient using a fire door strip as a ligature, and issues with secure transport. The trust acted by cutting these strips into shorter lengths.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback, which included providing additional staff to patients, improving medication records and ensuring appropriate boundaries with families.

Managers shared learning with their staff about never events that happened elsewhere.

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

The inspection team examined seven patient records. Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Staff assessed each patient's physical health upon admission, and routinely throughout their stay.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. For example, we saw care plans to support patients with diabetes.

Staff regularly reviewed and updated care plans when patient's needs changed.

Care plans were personalised, holistic and recovery-orientated.

Best practice in treatment and care

Staff provided a range of care and treatment suitable for the patients in the service. These included treatment for substance misuse and group work including 'reasoning and rehabilitation', 'healthy relationships' and 'understanding mental health'.

The service had an ethos of 'rehabilitation starts here'. Staff supported patients to do their own shopping, cooking and cleaning following individual risk assessments and care plans.

Staff delivered care in line with best practice and national guidance from relevant bodies, for example, the National Institute for Health and Care Excellence.

Staff identified patients' physical health needs and recorded them in their care plans.

Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. For example, staff developed plans to support patients who were malnourished on admission.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The service employed a nutritionist who supported patients to plan and cook healthy lunch options. The service had developed a 'Better Body' programme, with input from patients. Staff devised individual programmes for patients to help them lead healthier lifestyles. Staff provided 'tasting' sessions for patients to try healthier food options and sugar free drinks.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. For example, National Early Warning Scores and Health of the Nation Outcome Scales.

Staff used technology to support patients effectively. For example, an on-line physical health tool that provided patients with a personalised physical health report and action plan.

Staff took part in numerous clinical audits, benchmarking and quality improvement initiatives. Examples included audits of National Early Warning signs, record keeping, CQC self-assessment, infection control and emergency trolley. Quality improvement initiatives included the better body programme, use of body worn cameras, the nutritionist role, securing funds for gym membership and supporting patients to access the gym, as well as and other community activities. The multi-disciplinary team completed patients' Historical, Clinical Risk Management-HCR20 together.

Managers used results from audits to make improvements.

This service participated in seven clinical audits as part of their clinical audit programme 2018 – 2019.

Audit name	Audit scope	Date completed	Key actions following the audit
National Early Warning Scores – Mental Health & Adult & Child Q1, Q2, Q3, Q4	Wheatfield unit	04/04/2019	• To ensure continual improvement NEWS audits will remain weekly/monthly • Ward Managers and Modern Matrons to continue to feedback to all clinical staff to ensure: • Those areas who have not achieved 90% to have further training, either on line or face to face to improve concordance with standards which is provided by Clinical Skills Team. • The Quality team have aligned with the Adult and Child pathway and are currently implementing a new audit tool. • The CQF has been visiting ward areas and discussing NEWS with staff and Managers, as well as providing up to date audit data for wards to work from. • The CQF provides DMT with regular updates on progress of outliers. • Areas that have access to an RGN, to share these results and complete an action plan.
Quarterly Photographic ID Audit	Wheatfield unit	04/04/2019	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.
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	Wheatfield unit	ongoing	• Creation of dedicated role for STORM training, update of trainers arranged, and comprehensive rolling training package being delivered. • Wrote and submitted zero ambition plan for NHS England – awaiting feedback (which was initially presented and approved at Trust Board) • Supported development of "Common sense Confidentiality" leaflet to support involvement of family/friends in planning of care • Delivered a number of ½ day briefing sessions on work of Suicide Prevention

Audit name	Audit scope	Date completed	Key actions following the audit
			group and suicide prevention more broadly • Support development of suicide prevention course through recovery college • Continued participation in Countywide suicide prevention group, with plans to launch public-facing multi-agency campaign later in year
Tobacco and Alcohol Audit	Wheatfield unit	31/03/2019	Regular updates using a variety of media and meetings around health promotion and good record keeping standards given to all ward areas using Staff Training And Retention (STAR) days, team meetings, e- brief and emails. AUDIT-C Cards posters were distributed to all ward areas NHFT has implemented an automatic smoking referral system within its clinical systems for every patient that is screened as a smoker; however, patients are given the choice to opt out if they are not yet ready to quit. There are trained Smoking Cessation Specialists on the wards.
Bi-annual Ligature Audit	Wheatfield unit	Clinical	The trust now has a tool which has been developed to help staff address the risk of ligatures in a balanced, objective and systematic way. Actions must be taken to eliminate or reduce those risks identified immediately or as soon as reasonably practicable. The trust actively pursues an objective to eradicate as far as reasonably practicable all potential ligature and anchor points and where this is not practicable to control the risks by monitoring them. The trust's primary aim is to eliminate all high-risk ligature anchor points that are scored at 81 using the tool. All risk assessment and mitigation plans produced as a result of the ligature audit must be reviewed at least bi-annually or when a change occurs to the environment, the service provided or as the needs of the patient changes.

Audit name	Audit scope	Date completed	Key actions following the audit
			Replacement of bed frames with anti-ligature bed bases.
Prone Restraint	Wheatfield unit	01/05/2019	Continue to measure and monitor specifically our use of prone restraint in the context of our overall use of restraint to ensure prone restraint is being used as a last resort. Continue to search for alternative restraint positions for the higher risk incidents. Continue to publicise the trusts restraint reduction strategy, which includes specific actions relating to the use of prone restraint around the trust Continue to measure and monitor staff and patient injuries related to restraint
Falls and Fragility Fracture Audit	Wheatfield unit	Ongoing	

Skilled staff to deliver care

The service had access to a full range of specialists to meet the needs of the patients on the ward. The ward team included doctors, nurses, healthcare support workers, occupational therapists, psychologists, a nutritionist, gym instructor, employment specialist and music therapist.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. This included a one week local induction on the ward, as well as a two day corporate induction.

Managers supported staff through regular, constructive appraisals of their work.

Managers made sure that the number of permanent non-medical staff who had appraisals met or exceeded the trust target by the end of the year.
The trust’s target rate for appraisal compliance was 90%. At the end of last year (1 April 2018 and 31 March 2019), the overall appraisal rate for non-medical staff within this service was 93%. This year so far, the overall appraisal rates was 100% (as at 24 May 2019).

The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 96% reported at the last inspection.

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 (as at 24 May 2019)	% appraisals (previous year 1 April 2018-31 March 2019)
Wheatfield unit	28	28	100%	93%
Core service total	**28**	**28**	**100%**	**93%**
Trust wide	**3719**	**3413**	**92%**	**92%**

The trust's target rate for appraisal compliance was 90%. At the end of last year (1 April 2018 to 31 March 2019), the overall appraisal rate for medical staff within this service was 0%. This year so far, the overall appraisal rates this was 0% (as at 24 May 2019). This was due to the recent recruitment of medical staff.

The rate of appraisal compliance for medical staff reported during this inspection could not be compared to the previous inspection as the data was not comparable due to the information not being provided at ward level.

Ward name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals (as at 24 May 2019)	% appraisals (previous year 1 April 2018-31 March 2019)
Wheatfield unit	1	0	0%	0%
Core service total	**1**	**0**	**0%**	**0%**
Trust wide	**90**	**78**	**87%**	**80%**

Managers supported non-medical staff through regular, constructive clinical supervision of their work.

The trust's target of clinical supervision for non-medical staff was 90% of the sessions required. Between 1 April 2018 and 31 March 2019, the average rate across adult inpatient low secure (F&R) was 253%.

The rate of clinical supervision reported during this inspection was higher than the 216% reported at the last inspection.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide. In addition, the trust has advised that the trust policy requires a minimum of 2 supervision sessions/quarter which would explain the higher supervision rates in the table below.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Adult inpatients Low Secure (F&R)	192	485	253%
Core service total	**192**	**485**	**253%**
Trust Total	**6128**	**12673**	**207%**

Managers supported medical staff through regular, constructive clinical supervision of their work.

The trust's target of clinical supervision for medical staff was 90% of the sessions required. Between 1 April 2018 and 31 March 2019 there was no clinical supervision data for medical staff.

Figures submitted by the trust showed compliance rates of over 100% in some teams. The trust captured various forms of meetings which they classed as supervision, including clinical, managerial, group supervision, reflective practice and safeguarding supervision. However, we were assured that the team met regularly for clinical supervision.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We reviewed meeting minutes, which confirmed this.

A psychologist from another team facilitated reflective practice sessions for staff. The ward psychologist led regular case formulation meetings for the team.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. This included supporting healthcare assistants to train to be nurses. An occupational therapist had applied for Approved Mental Health Practitioner training. The service held protected learning sessions every week and topics included motivational interviewing, coeliac disease (to support a specific patient), quality initiative project briefings, Autistic Spectrum Disorder and Asperger's, Structured Assessment of Protective Factors for violence risk and personality disorder.

Managers made sure staff received any specialist training for their role, this included relational security and phlebotomy training.

Managers recognised poor performance, could identify the reasons and dealt with these. We reviewed staff records which evidenced this.

The service supported a previous patient to take on a visiting therapist role providing weekly music sessions for patients.

Multi-disciplinary and interagency team work

Staff held regular multidisciplinary meetings to discuss patients and improve their care. These included daily multidisciplinary handovers where staff shared information about patients, which we observed on site.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation, for example, community teams. The consultant met weekly with the community team to keep them updated on

patients' progress. The service worked with social services to develop individual packages of care to support patients moving into the community.

Ward teams had effective working relationships with external teams and organisations, including local authorities, GP's and third sector providers. The ward psychologist trained staff at a third sector provider to deliver substance misuse services for ward patients in a community setting. The psychologist also set up a partnership with a local university to provide training to psychologists, and secured student placements on the ward.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff received Mental Health Act training every three years. Compliance with this, as of the end of August 2019, was 96%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. A member of the trust Mental Health Act team recently attended a team meeting to discuss the Mental Health Act and capacity.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up to date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had access to information about independent mental health advocacy. We observed posters displayed in the ward with details of local independent mental health advocacy. Patients spoken with told us how they had support from advocacy.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. This included explaining rights following any absent without leave incident.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and / or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. We reviewed nine patients' 'authorisation for leave of absence forms - section 17. Medical staff had not recorded an expiry or review date. However, we observed a multidisciplinary meeting, and reviewed car notes that evidenced patients' leave being regularly reviewed. We raised this with the ward manager who advised they would rectify this.

The service only provided care and treatment to patients detained under the Mental Health Act and were not required to display a poster to tell informal patients they could leave the ward freely.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff received training in applying the Mental Capacity Act. At the end of August, compliance with this training was 96%.

Staff had a good understanding of the Mental Capacity Act, including the five statutory principles.

The trust told us that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 April 2018 to 31 March 2019.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients. Staff considered the patient's wishes, feelings, culture and history. An example of this was an acutely unwell patient who did not have capacity to consent to treatment and was refusing to take medication. The ward team worked with the pharmacy and Mental Health Act teams to explore options. A best interest meeting was held, which was attended by an advocate on behalf of the patient. The meeting agreed it was in the patient's best interests for staff to administer medication covertly. The team devised a plan for staff to follow. The patient's mental health improved, and he later regained capacity to consent to treatment, and no longer required covert medication.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We observed that staff were very discreet, respectful, and responsive when caring for patients. Staff always gave patients help, emotional support and advice when they needed it.

Staff consistently supported patients to understand and manage their own care, treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help. The ward manager sourced additional staffing resources to provide support to a patient requiring an extended stay in an acute hospital.

Three patients spoken with told us this was the best hospital they had been in. Patients said most staff treated them well and behaved kindly. However, three patients raised concerns about the approach of two staff members. We raised this with the ward manager, who advised they would speak with the staff.

Patients we spoke with told us that although staff did their best to support them, they wanted staff to spend more time getting to know them.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

The site which delivers secure wards/forensic inpatient within Northamptonshire Healthcare NHS Foundation Trust was compared to other sites of the same type and the score it received for 'privacy, dignity and wellbeing' were found to be about the same as the England average.

Involvement in care

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. There was a patient in the role of ward representative who helped new admissions settle into the service.

Staff involved patients and gave them access to their care planning and risk assessments.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties).

Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment. Staff supported them to do this. We reviewed minutes of community meetings which evidenced this.

Involvement of families and carers

Staff supported, informed and involved families or carers. The service invited carers to reviews of their relative's care. Carers were invited to attend a monthly forum at which they chose topics for discussion. The service offered lifts to carers who had difficulties travelling. The psychologist supported carers to access support. Staff also offered to visit families at home, if they preferred.

Staff helped families to give feedback on the service via the carer's forum or informal discussion.

We spoke with two carers of patients currently using the service. Both carers were happy with the care and treatment staff provided to their relatives. One carer told us that their relative had done really well and they had seen a big improvement. They told us that staff kept them updated and they were able to ring anytime for updates.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for one ward in this service between 1 April 2018 to 31 March 2019.

Wheatfield reported average bed occupancies ranging above the minimum benchmark of 85% for six months of the 12-month period.

Ward name	Average bed occupancy range (1 April 2018 – 31 March 2019)
Wheatfield unit	67% - 100%

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The trust reduced the average length of stay to 18 months for patients, by reducing the number of forensic beds and increasing the number of rehabilitation beds.

The trust provided information for average length of stay for the period 1 April 2018 to 31 March 2019.

Ward name	Average length of stay range (1 April 2018 – 31 March 2019) (on discharge)
Wheatfield unit	23-427

Ward name	Average length of stay range (1 April 2018 – 31 March 2019) (current patients on month end)
Wheatfield unit	44-386

This service reported no out of area placements between 1 April 2018 to 31 March 2019.

This service reported no readmissions within 28 days between 1 April 2018 to 31 March 2019.

The ward team planned discharge at the point of admission. The team had 48 hours from admission to agree which discharge pathway the patient would be placed on. Either a pathway to step down to another inpatient service, or a pathway out to the community.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interests of the patient.

Staff did not move or discharge patients at night or very early in the morning.

The ward manager advised that patients did not require access to a psychiatric intensive care unit.

Discharge and transfers of care

Managers and staff worked to make sure they did not discharge patients before they were ready.

The service had not reported any delayed discharges in the past year.

Between 1 April 2018 to 31 March 2019 there were 31 discharges within this service. This amounts to <1% of the total discharges from the trust overall (6890).

There were no delayed discharges across the 12-month period for this core service.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred to or transferred between services.

Facilities that promote comfort, dignity and privacy

Each patient had their own bedroom, which they could personalise.

Patients had a secure place to store personal possessions.

The service had a full range of rooms and equipment to support treatment and care. Staff and patients could access the rooms.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private. Patients had a basic model of mobile phone, which they could use to make phone calls and send / receive text messages.

The service had an outside space that patients could access easily.

Patients could make their own hot drinks and snacks throughout the day and night and were not dependent on staff.

Patients and staff told us that the quality and variety of the food was poor. This had been escalated within the trust. Staff were supporting patients to make their own lunches and were in discussions to support them to make their own dinners. Patients told us that the quality of the lunches they were supported to make was good.

The site which delivers secure wards/forensic inpatient within Northamptonshire Healthcare NHS Foundation Trust were compared to other sites of the same type and the score it received for ‘ward food’ were found to be about the same as the England average.

Patients’ engagement with the wider community

Staff made sure patients had access to opportunities for education and work, and supported patients. Staff supported patients to access substance misuse groups in the community and accessed an employment specialist to support patients into paid employment.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships.

Meeting the needs of all people who use the service

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

The site which delivers secure wards/forensic inpatient within Northamptonshire Healthcare NHS Foundation Trust were compared to other sites of the same type and the scores it received for ‘disability’ and dementia friendliness’ were found to be about the same as the England average.

Staff made sure patients could access information on treatment, local services, their rights and how to complain.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided food to meet the dietary and cultural needs of individual patients, for example, halal, kosher and gluten free meals. However, patients told us that if they had specific dietary requirements, they would receive the same dish every day.

Patients had access to spiritual, religious and cultural support. The service had a multi-faith room for patients. The service accessed a Rabbi to provide support to a Jewish patient. A volunteer from another service was visiting another patient to meet their religious needs.

Listening to and learning from concerns and complaints

Patients knew how to complain or raise concerns.

Staff understood the policy on complaints and knew how to handle them. Staff described how they would try and resolve concerns locally if possible. Staff escalated complaints that could not be easily resolved to the ward manager or the trust complaints team.

The service received a low number of complaints reflecting that patients were satisfied with their care.

This service received two complaints between 1 April 2018 to 31 March 2019. None of these were upheld, one was partially upheld, and one was not upheld. None were referred to the Ombudsman.

Ward name	Total Complaints	Fully upheld	rtially upheld	Not upheld
Wheatfield Low Secure Unit	2	0	1	1

Managers or the complaints team investigated complaints and identified themes.
Staff protected patients who raised concerns or complaints from discrimination and harassment.
Patients received feedback from managers after the investigation into their complaint.

Staff received feedback from managers after investigations.

This service received three compliments during the last 12 months from 1 April 2018 to 31 March 2019 which accounted for <1% of all compliments received by the trust as a whole (1752).

Is the service well led?

Leadership

Leaders had the skills, knowledge and experience to perform their roles.

Leaders had a good understanding of the services they managed. They could clearly explain how the team worked to provide high quality care.

Leaders were visible in the service and approachable for patients and staff.

Leadership opportunities were available, including opportunities for staff below team manager level.

Vision and Strategy

Staff knew and understood the provider’s vision and values and how they were applied to the work of the team. The providers senior leadership team had successfully communicated the provider’s vision and values to frontline staff in the service.

Staff had the opportunity to contribute to discussions about the strategy for the service and had attended an away day to do this.

Culture

Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff felt respected, supported and valued. Staff at all levels were actively encouraged to speak up and raise concerns. All policies and procedures positively supported this process. Staff knew how to use the whistle blowing process.

Managers dealt well with poor staff performance when needed.

There was strong collaboration, team-working and support across all functions. Staff shared a common focus upon improving the quality and sustainability of care and people's experiences.

Staff appraisals included conversations about career development and how it could be supported.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. The ward manager participated in a 'reverse mentoring' scheme with the chief executive of the trust. The ward manager reported that this scheme resulted in changes being made to support the career progression of staff with protected characteristics under the Equality Act.

The service's staff sickness and absence at 1.9% were lower than the trust target.

Staff had access to support for their own physical and emotional health needs through an occupational health service.

The inpatient lead for forensic and rehabilitation psychological services, won the NHS Ambassador round of the trust quality awards in 2018.

Governance

There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings. Staff ensured that essential information, such as learning from incidents and complaints, was shared and discussed. We reviewed minutes of weekly matron's meetings and team meetings that confirmed this.

Staff implemented recommendations from reviews of incidents, complaints and safeguarding alerts at service level, for example changing how to deliver bad news to a patient.

Staff undertook or participated in local clinical audits. The audits were sufficient to provide assurance. Staff acted on the results when needed, for example providing staff with training to improve recording of National Early Warning signs.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of patients.

Management of risk, issues and performance

Staff escalated issues for the risk register via the ward manager and service manager.

The service had business continuity plans for emergencies, for example, adverse weather or a flu outbreak.

Information Management

The service used systems to collect data from wards that were not overburdensome for staff.

Staff had access to the equipment and information technology to do their work. The information technology system worked well, and staff reported it helped them with their work.

Information governance systems included confidentiality of patient records.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Information was in an accessible format, was timely, accurate and identified areas for improvement.

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 trust's monthly newsletter.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected individual needs, for example, at community meetings, carer's forums or on a one to one basis.

Managers and staff had access to feedback from patients, families and carers and used it to make improvements. For example, introducing lunches cooked on the ward following negative feedback about the quality of the food.

Patients were involved in decision making about changes to the service through community meetings and the opportunity to be a ward representative.

Patients and staff had the opportunity to meet with members of the provider's senior leadership team and governors when they visited the ward.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to change. Innovations were taking place within the service.

The service used innovative methods to support patients to live healthier lifestyles. For example, the ward manager secured funds to provide a nutritionist role to support patients to improve their diets through the planning and cooking of healthy meals. Staff and patients developed a 'better body programme' as a quality initiative. The ward manager sourced funds to access self help technology to support patients' physical health. This application produced a personalised report for patients. Staff role modelled healthy lifestyles to patients by following the healthy living advice they provided to patients.

The service introduced the use of body worn cameras as part of a pilot scheme. The trust co-produced this pilot with patients and carers. The service was using the footage to improve staff support, enhance patient therapy and help with investigations of incidents and complaints. Patients and staff were positive about the use of body worn cameras, telling us that they provided protection and increased safety. The trust published a research paper into the use of body worn cameras in an inpatient mental health setting. Staff from other providers visited the ward to learn about the use of body worn cameras.

Patients had the opportunity to be selected through an interview process to be a ward representative. This role involved representing patients on the ward, attended meetings with managers and supporting new patients to settle in.

The psychologist trained a third-party provider to deliver substance misuse support to the ward patients in a community setting. An employment specialist supported patients to access paid work opportunities through partnerships with local employers.

Staff had the opportunity to work shifts at the psychiatric intensive care unit to improve their knowledge and skills.

Staff had opportunities to participate in research, this included research as part of the pilot use of body worn cameras and the better body project.

Staff used quality improvement methods and knew how to apply them. There were several quality initiatives taking place during our inspection. These included the better body programme, use of body worn cameras, the nutritionist role, securing funds for gym membership and a car to support patients to access the gym and other community activities, and completing patients' Historical, Clinical Risk Management-HCR20 as a team.

The service participated in the Quality Network for Forensic Mental Health Services and was last reviewed in April 2019. The Quality Network for Forensic Mental Health Services is a Royal College of Psychiatrists quality improvement network for low and medium secure inpatient forensic mental health services in the UK.

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 trust provided a list of services which have been awarded an accreditation together with the relevant dates of accreditation. However, there is no information pertaining to this core service.