Good

Northamptonshire Healthcare NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

St Marys Hospital
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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Trust headquarters Sudborourgh House	RP1X1	North crisis resolution and home treatment team	NN15 7PW
Trust headquarters Sudborough House	RP1X1	South crisis resolution and home treatment team	NN56UD
Trust headquarters Sudborough House	RP1X1	Health based place of safety - Berrywood Hospital	NN5 6UD
Trust headquarters Sudborough House	RP1X1	Health based place of safety - St Marys Hospital	NN15 7PW
Trust headquarters	RP1X1	Psychiatric liaison team	NN16 8UZ

Summary of findings

Sudborough House			NN1 5 BD
Trust headquarters Sudborough House	RP1X1	The crisis and telephone support service (CATSS)	NN15 7PW

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

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

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

Summary of findings

Ratings

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

Overall rating for Mental health crisis services and health-based places of safety	Good
Are Mental health crisis services and health-based places of safety safe?	Good
Are Mental health crisis services and health-based places safety effective?	Good
Are Mental health crisis services and health-based places of safety caring?	Good
Are Mental health crisis services and health-based places of safety responsive?	Good
Are Mental health crisis services and health-based places of safety well-led?	Good

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

The different crisis teams had a clear vision in using the least restrictive option to care for people in crisis. This vision related to the trusts overall vision and values. There were staffing levels that enabled referral targets to be met and caseloads to be managed. Staff undertook risk assessments and related them to care plans. The wellness recovery action plan (WRAP) tools were used to assist patients & staff plan & monitor recovery. Patients had choices and the teams took into account individual needs, making efforts to link patients to support net works, employment , education and social networks. Carers were involved in patients care and were able to have carers assessments. Staff followed the lone working policy and carried out assessments of people not know to hospital services in GP clinics and outpatient hubs to manage risk.

The number of incidents, serious untoward incidents and safeguarding's were low. Staff had been trained in reporting incidents and making safeguarding referrals and this was done appropriately. Lessons learnt were shared in team and business meetings.

There was a good induction programme that staff had completed. Staff appraisals were up to date. Management supervision was carried out regularly by staff. Mandatory training was up to date and monitored in performance reports.Staff told us they had good job satisfaction and would recommend the trust as a good place to work.

There was inter agency working taking place. There were individual information sharing agreements in place between the trust and agencies such as local councils, police, and Northamptonshire carers. There was a multi-agency partnership agreement in place for the Health Based Place of Safety (HBPoS). Regular meetings took place to look at the performance data for the HBPoS.

- There were few audits carried out by crisis teams
- There were gaps in the medicine management policy which did not support primary dispensing. We found that teams were able to dispense medications from their stock cupboard which should not happen, as nurses should only be able to secondary dispense medications.
- There were no crisis plans. Staff told us that a “future safety plan” had just been introduced. Records reviewed did not have any completed ones.
- There was a lack of psychologist input in to crisis teams to provide therapies for patients.
- There was a local crisis concordat plan in place. However crisis teams were not familiar with it, nor had they seen the CQC crisis thematic data for their area.

Summary of findings

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

Are services safe?

Good

Staffing levels enabled referrals and caseload to be managed well and agency staff were not used. Staff carried out face to face risk assessments using the skills based training risk management (STORM) tool for the prevention of suicide. All staff had undergone STORM training. Risk assessments were completed by the psychiatric liaison team and in the HBPoS. Records reviewed showed that risk assessments in the teams were well documented. Staff followed the trust lone working policy and where necessary visited in pairs to patients homes.

The number of incidents, serious untoward incidents and safeguarding's were low. Staff had been trained in reporting incidents and making safeguarding referrals and this had been done appropriately. Lessons learnt were shared in team and business meetings.

- We found that there were gaps in the medicine management policy which did not support primary dispensing. We found that teams were able to dispense medications from their stock cupboard which should not happen, as nurses should only be able to secondary dispense medications.
- There were no crisis plans. Staff told us that a “future safety plan” had just been introduced. The records reviewed records showed no completed ones.

Are services effective?

Good

Care plans reviewed demonstrated that conclusions were reached based on assessments. The WRAP tools were used with patients which helped patients plan their recovery.

There was a good induction programme that staff had completed. Staff appraisals were up to date. Management supervision was carried out regularly by staff. Mandatory training was up to date and monitored in performance reports.

There were individual information sharing agreements in place between the trust and agencies such as local councils, police, and Northamptonshire carers. There was a multi-agency partnership agreement in place for the HBPoS. Regular meetings took place to look at the performance data for the HBPoS.

- There was a limited amount of audits undertaken by crisis teams

Summary of findings

Are services caring?

Good

People were being treated with respect and dignity. Most patients we spoke with felt they had choices that they could make. Patients told us that medication and the side effects were explained to them. Case notes reviewed demonstrated and visits observed showed that staff tried to meet individual needs by linking patients to social networks, voluntary organisation, housing and employment. Carers were involved in care planning with the patients consent . Carer's assessments were offered and carried out by the carers support service.

- Patients did not know about their care plans and had not signed them.
- Several patients did not know about their discharge plans.
- There was lack of carer and patient involvement in developing the crisis services and contributing to policies.

Are services responsive to people's needs?

Good

All teams met their target times following referral. The AMHPs carrying out assessments did not meet the national target time. There was access to a CAMHS consultant and learning disability consultants out of hours. Crisis teams could visit up to three times a day , and took into consideration patient needs when planning visit times.

The CQC thematic crisis data base showed that more people were seen face to face for assessments by crisis teams than the national average. A higher proportion (than the national average) of people assessed by the crisis team were admitted to hospital.. The number of visits per person by the crisis team were significantly higher than the national average. The crisis team acted as gatekeepers to hospital admissions and these were similar to the national average.

- The number of young people admitted to adult wards was higher than the national average.

Are services well-led?

Good

All the crisis teams had a clear vision in using the least restrictive option to care for people in crisis. This vision linked to the trusts overall vision and values. Some of the executive team were visible to the crisis teams. Managers created calm environment for people to work and with a degree of independence. Staff told us they had good job satisfaction. Staff we spoke with were familiar with the whistle blowing , bullying and harassment policies and would use them if necessary.

Summary of findings

- There was a local crisis concordant plan in place. However crisis teams were not familiar with it, nor had they seen the CQC crisis thematic data for their area.

Summary of findings

Background to the service

- The crisis and telephone support service (CATSS) provides a daily 24 hours service to people with mental health problems. The service is open to patients, carers and friends. Calls are free from landlines. The service provides advice and signposts people to other services. It is not an emergency service
- The health based places' of safety (HBPoS) were based at Berrywood hospital and St Marys Hospital. Section 136 of the Mental Health Act allows for someone believed by the police to have a mental disorder, and who may cause harm to themselves or another, to be detained in a public place and taken to a safe place for professional assessment.
- Northamptonshire Healthcare employ the psychiatric liaison team to see people in mental health crisis arriving in the accident and emergency department (A&E) or on the wards in the acute general trust. Once seen people may be referred back to their GP, admitted to the general wards, admitted to a mental health ward, allocated to the crisis resolution team or referred to the community mental health team.
- There are two crisis resolution and home treatment teams, one in the north and one in the south of Northamptonshire. They provide a daily 24 hour service. They provide short term support to people suffering from a mental health crisis, or to people who require intensive community support following discharge from hospital. The crisis teams act as the gate keepers to hospital admission.
- The CQC crisis thematic database found that A&E, specialist crisis teams and HBPoS scores were similar to other local authorities nationally.
- The crisis services have not previously been inspected by CQC.

Our inspection team

The team included one CQC inspector and a variety of specialists: a consultant psychiatrist , a nurse, an expert by experience service user and a Mental Health Act reviewer .

Why we carried out this inspection

We inspected this core service as part of our on going comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services. We looked at the crisis thematic review data we published and keep up to date on http://www.cqc.org.uk/content/thematic-review-mental-health-crisis-care-initial-data-review.

We also collected further evidence during this inspection to support our findings in the national report on crisis services we will published this year.

During the inspection visit, the inspection team:

- Accompanied staff on eight home visits

Summary of findings

- Spoke with 22 ward patients about their experience of crisis services
- Spoke with five patients at home by telephone
- Spoke with three carers by phone
- Spoke with 31 staff
- Reviewed 31 case records
- Reviewed 31 medication charts
- Observe two clinical review meetings, one shift handover and one business meeting
- Carried out a focus group with black and ethnic minority service users

What people who use the provider's services say

- We observed home visits in which patients were being treated with respect and dignity. They were provided with information. Patients choices in terms of visiting times were negotiated and respected.
- We carried out a focus group with nine people and interviews on the 2nd September 2014 and 30th September 2014 in a specialist housing scheme for black and minority ethnic people with serious mental illnesses, provided by a housing association. People told us that the hospital and police do not know enough about the services in the community that could help people going through crisis or post-crisis. Referrals to crisis services by those close to them or self referrals were difficult. Several participants said they did not know what to do in a crisis and would rely on the support worker at the housing scheme. None of the participants knew how to complain about services. All the participants said that the housing scheme had helped them break their cycle of crisis.

Good practice

The street triage project was supported by a mental health trained professional who could carry out an initial assessment to help ensure that patients received prompt treatment where required, or referral to other agencies as appropriate. Police, ambulance services and the trust reported a significant reduction in the number of admissions for s136 assessments from 284 to 174 in the year that the street car has been operating.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must review its medicine management policy in relation to primary dispensing within crisis teams.
- The crisis service should carry out regular clinical audits.
- The trust should ensure that patients have crisis plans,contingency plans and discharge plans in place that they have been involved in.
- The trust should ensure operational staff are familiar and are involved in the local crisis concordat plan.

Northamptonshire Healthcare NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
North crisis resolution and home treatment team	Trust headquarters ,Sudborough House
South crisis resolution and home treatment team	Trust headquarters, Sudborough House
Health based places of safety	Trust headquarters, Sudborough House
Psychiatric liaison team	Trust headquarters, Sudborough House
The crisis and telephone support service (CATSS)	Trust headquarters, Sudborough House

Mental Health Act responsibilities

- The HBPoS was not aware of the existence of the relevant MHA section 132 patient rights leaflets to be offered to those detained under section 135 or section 136 of the MHA..
- One person had been admitted under MHA section 135 and the patients records stated that police had removed the person from their home. The relevant legal paperwork could not be produced and it was noted they had not been informed of their rights. The records reviewed of four other patients were in order.
- Staff had recieved MHA training as part of their mandatory training. They had access to the MHA and Code of Practice; there was access to legal advice when required. The MHA administration office provided support in implementing and monitoring of the MHA.
- There were adequate numbers of MHA section 12 doctors who carried out mental health act assessments when required.
- There was a Northamptonshire wide policy for the application of section 136 of the Mental Health Act

Detailed findings

dated January 2014.The inter-agency policy includes all of the areas set out in paragraph 10.17 of the Code of Practice for the Mental Health Act 1983. The signatories to the inter-agency policy do not include the acute trust or the CCG and they were not represented on the inter-agency group. The ambulance service was not represented on the multi-agency group. The Trust report that the inter-agency group met monthly.

Mental Capacity Act and Deprivation of Liberty Safeguards

There was a policy on the MCA that staff could refer too. All staff had MCA training. However staff had not received updates relating to the Cheshire West legal judgment and its impact on their patient group. A copy of the MCA Code of Practice was not available in the team office.

Good

Are services safe?

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

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

Summary of findings

Staffing levels enabled referrals and caseload to be managed well and agency staff were not used. Staff undertook face to face risk assessments using the skills based training risk management (STORM) tool for the prevention of suicide. Staff had all undergone STORM training. Risk assessments were completed by the psychiatric liaison team and in the HBPoS. Records reviewed showed that risk assessments in the teams were well documented. Staff adhered to the trust lone working policy and where necessary visited in pairs to patients homes.

The number of incidents, serious untoward incidents and safeguarding's were low. Staff had been trained in reporting incidents and making safeguarding referrals and did so appropriately. Lessons learnt were shared in team and business meetings.

- We found that there were gaps in the medicine management policy which did not support primary dispensing. We found that teams were able to dispense medications from their stock cupboard which should not happen, as nurses should only be able to secondary dispense medications.
- There were no crisis plans. Staff told us that a “future safety plan” had just been introduced;. When we reviewed records we did not see any completed versions.

Our findings

Safe environment

- The HBPoS facility at St Mary's Hospital met with the Royal College of Psychiatrists section 136 HBPoS standards. It is separate from the main ward area, suitably furnished, clean and with toilet facilities. It offers both privacy and dignity and where appropriate was able to meet gender and age specific requirements.
- The HBPoS environment did not offer patients with any access to fresh air within a safe setting and we were informed that these patients were either expected to enter the adjoining acute admission ward to use the garden area or were allowed access into the immediate open hospital grounds and were then at risk of absconding. One person we spoke with said that they felt abandoned in the HBPOS and could not go out for a smoke.
- Resuscitation equipment was kept on the acute wards and was be brought over to the HBPoS by staff if required. Those staffing the s136 had intermediate life support training, and healthcare workers had basic life support training.
- The trust MHA section 136 operation policies did not describe the process of undertaking patient search arrangements on admission to the suite.
- The psychiatric liaison room to see patients in the Northampton General site was not fit for purpose. It did not meet the psychiatric liaison accreditation network standards. It did not have two doors or a panic alarm. It was a room that was also used by A&E staff to see relatives and during bereavements.
- The psychiatric liaison room at St Marys was fit for purpose, it had two doors and a panic alarm.

Safe staffing

- The psychiatric liaison team was newly established in November 2014. The team had occupational therapists (OT), social workers, nurses and consultants. It had just achieved its full complement of staff.
- The HBPoS suites were staffed from the acute wards. A designated qualified professional and support worker were on the staff rota to undertake duties.
- Agency staff were not used by the crisis teams. There was a reliance on bank staff to cover vacancies. There was a low number of vacancies. Team leaders reported that staffing levels generally enabled referrals and caseload to be managed well. In one team there was only one shift coordinator, who was an OT and therefore found that there were limitations on the number of OT assessments that could be done.
- Crisis teams received information regarding their staff turnover, sickness and absence rates which were below the national average. Staff rotas showed that shifts were fully staffed.

Good

Are services safe?

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

- There was a consultant post that had been vacant in one crisis team for six months. The post was covered by a locum consultant and was being advertised. The locum confirmed that a full induction training had been received.
- The crisis and telephone support Team offered a good telephone service, while reporting challenges due to increased demand. The demands on the service were reviewed to ensure that staffing levels were appropriate to keep people safe.

Assessing and managing risk to patients and staff

- Risk assessments were carried out by police, ambulance when taking people to the HBPoS.
  Qualified professionals carried out risk assessments in the HBPOS. Records reviewed showed that the generally information was documented.
- Staff carried out face to face risk assessments using the skills based training risk management (STORM) tool for the prevention of suicide. All staff had recieved STORM training.
- Records reviewed showed that risk assessments in the crisis teams were well documented. Members of the clinical team all carried assessments individually. These were discussed in the shift handovers we observed. Risk assessments and plans were discussed in the clinical team meetings and clinical supervision. Support workers contributed to risk assessments following home visits.
- There were no crisis plans. Staff told us that a "future safety plan" had just been introduced; that was completed and scanned in to the patient electronic record. When we reviewed records we did not see any completed versions. Advance decisions were not promoted.
- The number of safeguarding concerns across the teams was low. All staff had received training in adult and child safe guarding procedures, including administrative staff.
- Staff described to us the processes they would use to report safeguarding concerns. This involved making reports to their line manager. The trust safeguarding lead was used to get advice when necessary. Staff stated that direct referrals to the local authority safeguarding team were made.
- We reviewed a safeguarding alert which involved a patient expressing thoughts of harm to their children. This was reported to the multi agency safeguarding hub (MASH) who wrote back to the team stating the action they were taking. Care plans showed this patient was initially visited daily and was supported by friend and spouse. Risk assessment and care plans were in place. The safeguarding alert was linked to notes. The safeguarding concerns were discussed in the clinical team meetings and shift handover meetings.
- Staff we spoke with from the trust and other agencies were aware of their joint and individual responsibilities for safeguarding patients while in their care.
- A lone working policy was in place. Teams had shift co coordinators who monitored staffs whereabouts. Staff recorded their daily visits on white board so that their whereabouts were clear. Some staff called in following a visit before going onto the next. Staff whereabouts was observed to be considered at time of shift hand over Staff used a code word if a situation of concern occurred during a home visit.
- If a patient was not known to the services then home visits were not carried out. The patient would be seen in the outpatients' hub or at the GP surgery.
- Patient records would carry an alert if they required to be visited in pairs due to risks posed. Additional staff from the bank were used in these cases.
- Patient records would also carry alerts, for example, if home visits were to be undertaken by staff in pairs, or if staff gender was specified.
- Staff undertook medicines management training with their manager annually. Pharmacy was based on site and provided take home drugs.
- We observed that controlled drugs were not stored. Routine medication stock was monitored using a controlled drug book. One team used two nurses to sign and check drugs.
- Teams did not prescribe drugs, although dispensing of up to three days' supply drugs were made at weekends .Nurses filled in the patient name, drug, quantity and date on labels provided by the pharmacy.
- We looked at the medication cupboard and the associated documentation for checking medicines and their dispensing and administration. There were medicines management and operational policies in place which staff were adhering too. We found that there were gaps in the policies which did not support primary dispensing. This was defined as the preparation, packaging, labelling, record keeping and transfer of a prescription drug to a patient or an

intermediary (in this case the crisis team) who would be responsible for administering of the drug. Primary dispensing would be the role of the pharmacy department.

- We found that teams were able to dispense medicines from their stock cupboard which is contrary to good practice. Nurses should only be able to secondary dispense medicines for named patients take home drugs following appropriate training. This means that staff were putting themselves at risk if they dispensed the wrong medicines or dosages which could have an impact on the patients in their care, if mistakes occurred. Safeguards were not in place to ensure that staff were competent to fulfil this role.
- The teams did not have adequate pharmacy input and there was no evidence of audits taking place. The pharmacy should ensure that they have a procedure and policy in place to support staff and ensure that primary dispensing is not happening in the community and that staff have relevant training in secondary dispensing only.
- There was also no evidence of a trust approved process or care pathway to record or administer any relevant medicines, including rapid tranquilisation if applicable, for those requiring treatment whilst being cared for in the HBPoS.
- Clozapine was commenced in the inpatient units and rarely in the community. Qualified staff visited twice daily to monitor baseline observations until titration was completed. Blood tests were taken at the general hospitals. Staff do not administer the drug unless results were available and within normal limits.

Track record on safety

- The number of incidents occurring was low. There were four serious untoward incidents. We saw the reports which showed they were independently investigated by staff from other areas of the trust. Route cause analysis was undertaken to see why the incident had happened and the lessons that could be learned. The reports were detailed and led to recommendations and action plans being implemented.
- The CQC crisis thematic data bases identified there was higher than expected number of deaths in patients within a 30 day spell of treatment or period of assessment. The crisis resolution team were reviewing suicide and self harm assessments, and introducing future safety needs plans.

Reporting incidents and learning from when things go wrong

- All staff knew how to report incidents. Staff reported incidents using the electronic datix system. The Information was sent to the team leader at the same time. The types of incidents reported commonly were staff shortages.
- The psychiatric liaison team explained that when incidents occurred they resolved them quickly so did not report them. This meant that common issues might not have been captured by the incident reporting system to identify lessons that could be learned.
- Team leaders received trend information on the monthly dash board of the Incidents reported. The incidents were discussed at directorate management meetings, supervision meetings and team meetings so that learning could occur.
- The key service risk listed for the crisis teams was the impact of staffing in the community mental health teams (CMHTs), which effected the appointment of care co-ordinators. This was mitigated by offering outpatient appointments until a care co-ordinator was appointed.
- We found that the Trust and other stakeholder agencies shared learning from significant events and other untoward incidents.

Are services effective?

Good

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

Summary of findings

Care plans reviewed demonstrated that conclusions were reached based on assessments. The wellness recovery action plan (WRAP) tools were used with patients which helped patients plot their recovery.

There was a good induction programme that staff had completed. Staff appraisals were up to date. Management supervision was undertaken regularly by staff. Mandatory training was up to date and monitored in performance reports.

There were individual information sharing agreements in place between the trust and agencies such as local councils, police, and Northamptonshire carers. There was a multi-agency partnership agreement in place for the HBPoS. Regular meetings took place to look at the performance data for the HBPoS.

- There was a limited amount of audits undertaken by crisis teams.

Our findings

Assessment of needs and planning of care

- Staff in the HBPoS confirmed they had electronic access to patients care plans. There was an integrated data collection and handover form used and a police check list form. We found that the data collection was poor in four out of the 12 records randomly selected.
- Staff had a folder for taking out paperwork to see a patient for the first time. Some staff took out printed out copies of risk assessment and care plans. We observed staff updating the main records electronically, with administrative support in the office.
- Care plans reviewed demonstrated that conclusions were reached based on assessments. The plans were brief stating the crisis team were taking them on and addressing the immediate needs. There were no formal crisis care plans or contingency plan seen in the records reviewed. The impact of this was that patients did not have well written documentation. The national institute for health and care excellence (NICE) guidance suggests that plans should state the frequency of visits, early warning signs, medication management, carer's involvement, any advance statements directives, and out of hours' numbers.

Best practice in treatment and care

- NICE guidance underpinned policies to support evidence based care being given. Staff told us that information about NICE guidance was cascaded by the trust to teams and it was discussed at staff handover and team meetings. Staff could not give examples of specific NICE guidance that was being used and that they did not know if any NICE audits had been done.
- There were very few audits carried out by the crisis teams. Audits of records had been carried out in September 2014. Recommendations for teams were to record allergies, occupation, and informed consent. The results after the audit were very positive showing improviements. There was a plan of short audits to be undertaken, these related to for example medication and consent.
- Medical staff had carried out few audits. Medical staff had carried out an audit into the use of hypnotics in January 2014. The key finding revealed that giving people advice on sleeping before prescribing hypnotics was documented in 45% of the patient's case notes. 100% patients were prescribed hypnotics according to guidelines. GPs were advised of hypnotic's management plan in 47% cases only. No evidence of documentation of explaining side effects of hypnotics to the patients. Actions were identified for the crisis teams to implement. We did see leaflets that promoted sleep hygiene. One patient told us that she appreciated the team calling her to see if she was out of bed.
- An audit was carried out in March 2014 by medical staff of assessments completed for people with drug and alcohol problems. The audit showed that a high percentage of patients were assessed regarding drug and alcohol use. It recommended that improvements could be made in increasing percentage of those with management plan for the alcohol and drug misuse and by filling the dual diagnosis tool where applicable.
- Staff we spoke with were not able to give examples of changes in practice as a result of audits carried out in teams or across the trust.

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- We saw that the WRAP tools were used. This is a self-management tool for patients to set their own goals and identify what keeps them well. One patient we spoke with confirmed they had attended a WRAP course and found the tool useful.

Skilled staff to deliver care

- There was a good induction programme that staff had completed. Staff appraisals were up to date. Management supervision was undertaken regularly by staff. The trust had a target of 10 clinical supervision annually for staff. Staff we spoke with said that they achieved approximately eight sessions formally, informal sessions were given on request and during handovers.
- There was a mixed picture in relation to staff having undertaken training related to dual diagnosis, personality disorder and dementia awareness training. There had been little training for crisis teams relating to older people, with whom they came into contact out of hours.
- Mandatory training was up to date and monitored through performance reports. Staff had undertaken equality and diversity training and breakaway training as part of their mandatory requirements.
- Staff had received training to work in the HBPoS as part of their induction training.

Multi-disciplinary and inter-agency team work

- We found that there were good working partnerships between the Trust and other stakeholders including Northamptonshire Police, East Midlands Ambulance Services, social services, GPs, commissioners, and CAMHS. Representatives from these agencies reported improvements in joint working and sharing information, procedures and systems to improve safety and prompt assessment and treatment of people experiencing a mental health crisis.
- There were individual information sharing agreements in place between the trust and agencies such as local councils , police, and Northamptonshire carers.
- There was a multi-agency partnership agreement in place for the HBPoS. Regular meetings took place to look at the performance data for the HBPoS.
- The psychiatric liaison team reported good working relationships with the acute trust and a service level agreement was in place. There were systems in place to ensure that information between the psychiatric liaison team was shared with primary care services.
- There was recognition that there were challenges in the handover of information about patients when they moved between agencies, which related to risks to their safety. In January 2015 an inter-agency data collection handover form had been developed and was being piloted. This assessment document was to be used by police, ambulance services, and hospital ward staff so that there was an on-going record of assessment and interventions.
- Ambulance and police services reported that there had been improvements in the safe and effective handover of patients when both were involved in the assessment of patients between them and the trust. Both parties reported improvements in waiting times involved in the handover of patients from one organisation to another. However we found that on occasions particularly outside of normal working hours that patients experienced delays when being transferred from one agency to another and one incident where a patients waited 17 hours before being transferred to a HSPoS, this was discussed as part of section136 meetings. Some agencies reported challenges in the handover of patients due to different IT systems and working with multiple care pathways.
- The mental health trust, police and ambulance services all reported improvements in the assessment of patients to ensure that they were treated appropriately to their needs and to reduce the number of inappropriate attendances at the s136 suite. The street triage was supported by a mental health trained professional who could carry out an initial assessment to help ensure that patients received prompt treatment where required or referral to other agencies as appropriate. Police, ambulance services and the trust reported a significant reduction in the number of admissions for s136 assessments from 284 to 174 in the year that the street car has been operating. There were discussions in place regarding future funding for the street triage care and the use of additional resources with a paramedic to be deployed as part of the triage team. A mental health trained professional was also

Are services effective?

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deployed to work within the police custody suite to assess patients. Sharing of individual crisis plans had started to take place between the mental health trust and the police.

- Crisis teams had good handovers between shifts, emphasising changes in risk and risk management. Joint visits were undertaken with other teams such as CMHT, to provide continuity of service and as part of the handover between the various teams.
- Record reviewed showed that liaison and joint visits took place with community mental health teams, social workers, health visitors and early intervention service for older adult services showing good inter team working and interagency working.
- The trust had reported that they routinely collect data from each health-based place of safety to monitor the service. This included information about age and gender, however, we did not see evidence of information gathering on ethnicity, disability or other protected characteristics during the inspection. Data was also collected on the outcome of the assessment, delays in initiating a MHA assessment for people brought to the place of safety, how many times people were turned away from the place of safety and the reason why people were turned away from the place of safety. They do not collect data on the number of people who are transferred between places of safety.

Adherence to the MHA and the MHA Code of Practice

- We examined the detention papers of four patients in the HBPOS. All of the paperwork which we scrutinised in relation to patients' detentions appeared to be in order.
- The HBPoS was not aware of the existence of the relevant section 132 patient rights leaflets to be offered to those detained under section 135 or section 136 of the MHA.
- Documents showed that there was no record to demonstrate that these patients were offered access to legal advice whenever it is requested.
- On the day of our visit neither the Mental Health Act administration or clinical staff could produce any detention documents in relation to a patient admitted under section 135 or that they were served with the relevant legal paperwork. as the patient's documented notes stated that the police had forced their way into the home to remove them to the hospital's place of safety , and whether the patient had been informed of their rights.
- Staff had undertaken MHA training as part of their mandatory requirements. They had access to the MHA and Code of Practice; there was access to legal advice when required. The MHA administration office provided support in implementing and monitoring of the MHA.
- There were adequate numbers of MHA section 12 doctors who undertook mental health act assessments when required.
- There was a Northamptonshire wide policy for the application of section 136 of the Mental Health Act dated January 2014.The inter-agency policy includes all of the areas set out in paragraph 10.17 of the Code of Practice for the Mental Health Act 1983. No audit had been completed against the requirements of the inter-agency policy. The signatories to the inter-agency policy do not include the acute trusts or the CCG and they were not represented on the inter-agency group. The ambulance service was not represented on the multi-agency group. The Trust report that the inter-agency group met every three months.

Good practice in applying the MCA

- There was a policy on the MCA that staff could refer too. All staff had MCA mandatory training. However staff had not received updates relating to the Cheshire West legal judgment and its impact on there patient group. A copy of the MCA Code of Practice was not available in the team office.

Good

Are services caring?

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

Summary of findings

We saw people being treated with respect and dignity. Most patients we spoke with felt they had choices that they could make. There was access to interpreters and which staff told used they used regularly. Patients told us that medication was explained and the side effects. Case notes we reviewed demonstrated and visits showed that staff tried to meet individual needs by linking patients to social networks, voluntary organisation, housing and employment. Carers were involved in care with the patients consent . Carer's assessments were offered and carried out by the carers support service.

- Patients did not know about their care plans and had not signed them.
- Several patients did not know about discharge plans.
- Staff had not had training in the needs of black and ethnic minorities.
- There was lack of carer and patient involvement in developing the crisis services and contributing to policies.

Our findings

Kindness, dignity, respect and compassion

- We saw a young person in the HBPoS suite, who informed us that they were treated with respect and sensitivity and that the CAMHS team was very supportive to them. The young person stated that this was the second time they had been detained under a section 136 and that the after care arrangements were good. We were able to confirm this through our own observations of positive interaction and communication that occurred between the patient and staff during our visit.
- Patients had mixed views about the crisis and telephone support service (CATSS), ranging from good feedback that they were signposted to the NHS 111, To negative experiences of delays due to being signposted to other services in a way that did not make them feel safe or their needs being addressed. We saw staff speaking over the phone to people professionally.
- Patients we spoke with gave positive feedback about the kindness of police and the crisis team staff.
- We observed staff treating people with dignity and respect during home visits.
- Most patients we spoke with felt they had choices that they could make. Some patients told us that they had been given choices in terms of where they were seen and the time of the appointment. Staff considered people's needs for example when patients requested female only staff. Although one male patient requested that no male staff visited and this was not followed too. Patients told us that they were visited according to their needs, some two or three times a day and others alternate days for up to two months.
- There were six people we spoke with who said they did not have crisis plans. Only two people said they had care plans. Four people said they felt safe with the arrangements made. Several patients said they did not know about discharge plans.
- Two people said they had not been given information about advocacy and five people said they knew about advocacy. Information about advocacy was displayed in areas such as foyer and restaurant at Berrywood Hospital and was visible to people who used services.
- Patients told us that medication and side effects was explained to them.
- We carried out a focus group and interviews on the 2nd September 2014 and 30th September 2014 in Wellingborough in a specialist housing scheme for black and minority ethnic people with serious mental illnesses, provided by a housing association. People there told us that the hospital did not know enough about the services in the community that could help people going through crisis or post-crisis. Referrals by those close to them or self referrals were difficult. Several participants said they did not know what to do in a crisis and would rely on the support worker at the housing scheme. None of the participants knew how to complain about services. All the participants said that the housing scheme had helped them break their cycle of mental health crisis.
- However the case notes we reviewed demonstrated and our visits showed that staff tried to meet individual needs by linking patients to social networks and voluntary organisation. They also helped patients by linking them to housing and employment
- Patients completed a consent form for information to be shared actively with other agencies as appropriate, this was scanned into the electronic notes.

Good

Are services caring?

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

- Staff also informed us that they have not received any updated or current training on supporting and managing people's cultural or diverse needs and this was also not evidenced as a requirement or expectation in the Trust MHA section 136 operational policies.

The involvement of people in the care they receive.

- The majority of patients we spoke with had not seen their care plan. Not all care plans were signed by patients. Some patients told us that they did not always know who their care co-ordinator was**.**
- Staff took account of whether family support was available when deciding pathway. Families and carers were involved in patient care with the consent of the patient. However carers we spoke with said that the staff did not always give them information directly. Carer's assessments were offered and carried out by the carers support service.
- The CQC crisis thematic database gave results from the carers survey. This showed a much higher than expected responses, that carers did not feel the care received provided the right response or helped to resolve the crisis for the person cared for
- We saw leaflets giving emergency and out of hours contact numbers and information about the services which staff said they gave out to patients. Some patients we spoke with said they had this information, others said they had not been given appropriate information and told to ring the NHS number 111. We saw relevant literature on the notice boards for patients in the psychiatric liaison rooms.
- There was access to leaflets in other languages although they had to be ordered.
- Patients we spoke with said they had not been asked for feedback by the crisis and HBPoS teams. The teams had introduced a "I want good care" survey and data was not available to evaluate.
- The call for evidence in the CQC crisis thematic data base received more negative comments than positive for access, responsiveness, care and attitude.
- Staff we spoke with told us that patients were not involved in the review of the policies relating to crisis services or staff employment interviews. Neither was there carers or black and ethnic minority involvement in the development or review of the MHA s136 policy.

Are services responsive to people's needs?

Good

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

Summary of findings

Each of the various teams met their target times following referral. Apart from the AMHPs carrying out assessments who did not meet the national target time. There was access to a CAMHS consultant and learning disability consultants out of hours. Crisis teams could visit up to three times a day and took into consideration patient needs when planning visit times.

The CQC thematic crisis data base showed that the percentage of face to face assessments by crisis teams were higher than the national percentage. Hospital admissions as result of referrals to crisis teams were higher than the national percentage. The number of contacts per person were significantly higher than the national average. The crisis team acted as gatekeepers to hospital admissions. The percentage of emergency admissions to mental health specialist services that were gate kept by the crisis team was similar to the national average.

- The number of young people admitted to adult wards was higher than the national average.

Our findings

Access, discharge and transfer.

- Details of services and how to access them were available on the trust website. Local GPs and out of hours service providers had a good understanding of crisis care pathways and how to access them, including supporting a patient through a joint assessment. They were aware of the referral systems.
- In 2014 the emergency duty team completed 407 MHA assessments. Of these 190 were during the weekend between 9am and 9pm and 217 were during evenings or late at night early morning. Of the 217 that took place in the evening 161 were Section 136s with 114 taking place at the HBPoS and 47at a police station, 35 took place in A&E or another hospital environment, 15 at the service users home and the remainder in residential homes or primary care out of hours call in centre.
- The HBPoS was accessible by patients under 16 years and over. People were excluded if they presented with the following conditions; acute medical needs, disturbed behaviour, intoxicated and violent behaviour. Where these exclusion criteria applied patients were taken to the nearest A&E units or into police custody for assessments to take place.
- The CAMHS team was also located within the Berrywood hospital HBPoS site, all assessment were carried out as soon as practicable by a specialist CAMHS doctor in the HBPoS.
- We were informed that there are advanced discussions in place with the clinical commissioning group to develop a specific section 136 suite within the CAMHS in-patient unit based at Berrywood Hospital.
- The local target time for AMPHs to arrive in the HBPOS was two hours. We were told that there were frequent delays of mental health assessments due to the lack of available and suitably trained AMHPs. Section 136 audits and multi agency minutes confirmed this. We were told that the trust was considering training band six nurses/practitioners to take on the additional AMHP functions.
- In January 2015 Berrywood Hospital assessed 12 patients under MHA section136, of these four were brought in by the police following risk assessments, and the remaining eight by the East Midlands Ambulance Service (EMAS). For the Welland Centre between September 2014 and January 2015 we were told that there were 33 136 detentions and of this eight were admitted to the hospital.
- Patient could not self refer to the crisis teams. They were directed to the NHS 111 out of hours by the CATSS phone line. This meant that patients in crisis could be unnecessarily distressed and presented to the A&E department, or faced a higher likelihood of involvement of police. The concordat states is 24 hour access to crisis services should occur.
- The local psychiatric liaison team response times in the A&E were one hour and were being met. Patients on acute wards seen within four hours of referral by the ward. There were clear pathways set out for example there was a child and adolescent emergency pathway for self harm where young people would stay overnight in the paediatric ward. There was access to a CAMHS consultant out of hours. There was also access to a learning disability consultant out of hours. The CQC thematic crisis data base showed that the number of young people admitted to adult wards was higher than the national average.

Are services responsive to people's needs?

Good

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

- The CQC thematic crisis data base showed that the percentage of people seen face to face for assessments by crisis teams were higher than the national average. More people were admitted to hospital as result of referrals to crisis teams than the national average. The number of visits per person were significantly higher than the national average.
- There was a crisis team operational policy in place. The crisis team acted as gatekeepers to hospital admissions. The CQC thematic crisis database showed that percentage of emergency admissions to mental health specialist services that were gate kept by the crisis team was similar to the national average.
- The crisis team functions 24 hours a day, 7 days a week. At night there is one crisis worker for the north and one for the south. In addition to the ALHMS professional who finishes at midnight, there is a Crisis and Telephone Support Service (CATSS) member of staff on duty to provide telephone crisis support (24 hours).
- The crisis team had clear criteria for which people would be offered services. Self referrals were not accepted and nor are direct referrals from voluntary organisations.
- The response times for the crisis team were four hours with face to face contact within 24 hours in line with national guidance. Generally teams were making contact within 30 – 60 minutes. Staff were not sure if an audit had been done to monitor this. We looked at three records which showed target times had been met. It was also confirmed by patients on visit we spoke with. We saw the crisis team responding rapidly to an emergency referral.
- The number of first time assessments carried out in people's homes was low; they were carried out in GP surgeries and outpatient hubs. People previously known to services did have home assessments.
- Records reviewed showed that where referrals were not taken on by the crisis team the referral would be signposted to the appropriate service by the shift coordinators.
- Records reviewed showed that discharge planning started to be considered within days of being taken on by the crisis team, and also on admission to the HBPoS. However patients we spoke with did not have an awareness of their discharge plan.
- The number of people sent out of area for hospital admission appeared to be low, however no data was being kept to confirm this. It was therefore unclear how it would be possible to follow up people once they returned back into the area.

Meeting the needs of all people who use the service

- There was access to interpreters and these were used regularly. One person we spoke with said that an interpreter could not be accessed. Family members were not used as interpreters which is good practice. We saw an example where a letter sent to a patient in respect of their referral to another agency was written in their first language, which was not English.

Listening to and learning from concerns and complaints

- The teams rarely received complaints. We were told a GP had telephoned to complain. The team leader had discussed the issue with the GP and resolved it locally. The PALs department was contacted by the team leader to log the complaint and actions taken. Another team leader told us that a patient had complained about a staff member's attitude. The team leader had gone out to see the patient to listen to the complaint and told them what action was going to be taken. The issue was discussed within clinical supervision with the staff member and the patient received an apology.
- In 2013-2014 there were no recorded complaints and one recorded incident relating to the health-based places of safety provided by Northamptonshire Healthcare NHS Foundation Trust. This incident was reported to the Board via the serious incident report

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

The various crisis teams had a clear vision in using the least restrictive option to care for people in crisis. This linked to the trusts overall vision and values. Some of the executive team were visible to the crisis teams. Managers created calm environment for people to work and with a degree of autonomy. Staff told us they had good job satisfaction. Staff we spoke with were familiar with the whistle blowing , bullying and harassment policies and would use them if necessary.

- There was a local crisis concordat plan in place. However crisis teams were not familiar with it, nor had they seen the CQC crisis thematic data for their area.

Our findings

Vision and values

- Teams were focused upon providing the least restrictive option when assessing patients and were committed to looking at alternatives to hospital admissions. Their vision of providing safe therapeutic personalised approaches fitted with the trust overall vision.
- The crisis teams gave examples of the CEO and Director of Nursing visiting. Staff reported reading the CEO weekly blogs on the intranet. The psychiatric liaison team was a newly implemented service and had close links with senior managers. Staff told us that the HBPoS had not received visits from the executive team members.

Good governance

- There were arrangements in place to monitor incidents, safeguarding's and complaints. Staff were up to date with mandatory training and understood how to report incidents, refer to safeguarding and complaints. There were arrangements in place to monitor these through directorate and trust committees. Feedback in the form of performance monitoring reports were provided to teams so that lessons learnt could be discussed in business meetings and supervision meetings. .
- Operational policies for the crisis teams, CATSS and the psychiatric liaison teams were being reviewed involving the team members. The psychiatric liaison team wanted to see changes in the skill mix so that there were more front line staff who could undertake direct assessments.
- Whilst there was no section 75 agreement in place for Northamptonshire, representatives from the trust, CCG and Northamptonshire County Council reported positive working relationships and working to ensure that commissioned services were appropriate for the needs of people living within the county.
- There was a draft crisis concordat plan which the trust was a signatory to. The Health & Wellbeing Board in September 2014 confirmed it supported the Mental Health Crisis Care Concordat Local Declaration. An action plan had been developed with clear targets that would be achieved throughout 2015 and these were being reviewed regularly Whist work was taking place at strategic level operational staff in the teams were not fully aware of what the crisis concordat was about and were not aware of the CQC crisis thematic data base results for Northamptonshire.
- There were regular inter agency and multidisciplinary meetings in place in Northamptonshire which allowed information sharing between the police, trust representatives and representatives of the local authority. We saw a sample of the minutes from meetings held between November 2014 and January 2015. These meetings were attended by a number of different stakeholders to allow sharing of information more widely. The minutes form these meetings indicated that challenges to services, risks and suggestions for improvements were communicated in an open and transparent manner and that action points were followed up and reviewed.

Leadership, morale and staff engagement

- Staff we spoke with said they were comfortable raising concerns for example relating to staffing levels. We saw incident reports relating to this and saw that staffing was increased as a result of this.
- There were whistleblowing and grievance and harassment policies in place. Staff said they would use them if required.
- Staff we spoke with said they felt supported following incidents from the risk team, within their own team and management.
- Managers created a calm environment for people to work and with a degree of independence. Staff told us

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

they had good job satisfaction. The retention of staff was good, morale was described generally as good, and staff told us they would recommend it as a place to work.

- Staff had opportunities for leadership and management development. Team leader meetings and business meetings occurred to support the development of services and share information and learning.

Commitment to quality improvement and innovation

- The crisis team had applied in 2012 for home treatment accreditation scheme with the Royal College of Psychiatrists and were not successful. There were no immediate plans to seek accreditation.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **13. The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.** How the regulation was not met:- • There were gaps in the policies which did not support primary dispensing. • Teams were undertaking primary dispensing. Nurses should only be able to secondary dispense medicines for named patients take home drugs following appropriate training. This means that staff were putting themselves at risk if they dispensed the wrong medicines or dosages which could have an impact on the patients in their care, if mistakes occurred. Safeguards were not in place to ensure that staff were competent to fulfil this role.